STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676313	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laredo Nursing and Rehabilitation Center	1701 Tournament Trail Dr Laredo, TX 78041

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents, for one of four residents (Resident #1) reviewed for accidents and supervision. The facility failed to ensure CNA A performed a 2-person assist while conducting incontinent and bed mobility care for Resident #1 on 03/18/2025 which led to Resident #1 sustaining a fall. This failure could place residents at risk for falls, injuries and a decline in health.Findings include: Record review of Resident #1's admission record dated 10/04/2025 revealed Resident #1 was a [AGE] year-old female, who initially admitted on [DATE] and readmitted on [DATE]. Resident #1 was admitted with multiple diagnoses including: Parkinson's disease (movement disorder) with dyskinesia (involuntary muscle movement), age related osteoporosis (weakening bone) without current pathological fracture (break under normal stress), and arthritis (inflammation of joints). Record review of Resident #1's Quarterly MDS dated [DATE] revealed, Resident #1 had a BIMS score of 6 which meant she was severely cognitively impaired. Additionally, Resident #1 was dependent of staff for all ADLs. Record review of Resident #1's care plan date initiated 05/30/2024 revealed, I have a Self-Care deficit r/t Parkinson's, OA multiple sites. Goal: Resident will experience safe transfers through next review date, and I will maintain or improve my ability to participate in my care with ADLs through my next review date. Interventions: Bed mobility: x2-person assistance. Bathing/Showering Care: x 2-person assistance. Toileting/Incontinent care: x 2-person assistance. Record review of CNA A's 03/18/2025 witness statement revealed description of Incident I [DON] called [CNA A] to get information regarding the incident of a fall from bed (witnessed). CNA A stated I was performing incontinent care prior to wound care. She was extremely soiled, so I was providing partial bed bath x1 person. I knew she was a two person assist and knew that was the case on the KARDEX, but I felt I could do it. I rolled her over and fell as a result of my actions. Signed by DON. Record review of CNA A's 03/18/2025 written witness statement revealed, description of incident I was asked by the wound care nurse to clean resident before she could start wound care. As I checked the resident, I found she was extremely soiled about 3 times her usual.At that moment my CNA coworker was busy with another resident. I was afraid the feces would get into her suprapubic hole and wound, I felt it would be careless and loss of dignity if I left her sitting in her own feces for an additional 30 minutes. I took it upon myself to do the incontinent care myself. (knowing she was a 2 person assist like stated on KARDEX) .After I was done, I logged rolled her to change the sheet she was on an air mattress and the air shifted causing her legs to slide first then her torso ultimately caused the fall. I checked on the resident and then called for help immediately. Signed by CNA A on 03/18/2025. Record review of the ER record dated 03/18/2025 and discharged [DATE] revealed resident did not experience any major injury. No fracture or traumatic malalignment is seen. - no concerns noted. During a phone interview on 10/04/2025 at 3:48PM, 10/05/2025 at 8:03AM and 12:58PM CNA A stated she no longer worked at the facility and would call back when she was available. CNA A did not return call prior to exit conference. During an observation and interview on 10/04/2025 at 10:38AM Resident #1 was assisted by CNA B and CNA C to transfer via bed mobility. Both CNA B and CNA C utilized a draw sheet that was situated under Resident #1. Through the duration of the transfer care, there were no observable concerns. During an interview with Resident #1 while Resident #1's family member was present, both stated the fall on 03/18/2025 was an accident, and stated CNA A was a good CNA. Resident #1 and family member stated the clinical staff are nice and provide good care. Both Resident #1 and family member stated when Resident #1 needs assistance the staff help her and verbalized no concerns regarding any form of care. During an interview on 10/05/2025 at 11:35AM with both CNA B and CNA C, both stated they were not present during Resident #1's fall on 03/18/2025. Both stated as part of their normal shift procedure, they will review the plan of care on their KARDEX, to ensure they provide the necessary safety measures when providing care to each resident. Both stated once they review the plan of care in the beginning of their shift, they would begin providing rounding care. Both stated they work with Resident #1, and when Resident #1 needs incontinent care, transfer care, and bed mobility care, they will always utilize a two-person approach. Both stated, if Resident #1 needed care and no person is readily available, they will look for other clinical staff members to assist with care. Both stated they will never provide care for Resident #1 independently when the plan of care necessitates a two-person assist. Both stated the reason they incorporate a two-person assist with Resident #1 was to minimize Resident#1 falling and also to ensure Resident #1's safety. Both stated if they