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	04/10/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents' choices for one (Resident #1) of five residents reviewed for quality of care. The facility failed to ensure LVN B accurately assessed and documented Resident #1's newly identified skin impairment including but not limited to characteristics such as measurements, shape, or condition of the surrounding tissue on 02/01/26, in accordance with facility policy. On 02/02/26, record review revealed the wound had progressed and was identified as a Stage IV pressure ulcer (full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone).This failure could place residents at risk for not receiving the appropriate care and treatment.The findings include:Record review of Resident #1's face sheet dated 04/10/26 reflected a [AGE] year-old-woman with an original admission date of 01/19/26. Diagnoses included displaced intertrochanteric fracture of right femur (break in the upper part of the thigh bone) and orthopedic aftercare.Record review of Resident #1's quarterly MDS dated [DATE], an assessment and formal assessment instrument/tool determined Resident #1 was at risk of developing pressure ulcers/injuries.Record review of Resident #1's SBAR Form Communication Form dated 02/01/26 reflected:LVN B documented: During routine rounds, SN notified by nurse aide (nurse aide unknown) that resident was noted with skin issue to sacrum. Upon assessment, resident noted with redness and dark discoloration to sacrumRecord review of skin assessment dated [DATE], Resident #1's wound went from redness and dark discoloration to a stage 4 on 02/02/26.Record review of Resident #1's progress note dated 02/02/26 reflected: New skin Issue. Location: Sacrum. Laterality / Orientation: Medial (situated in the middle). Issue type: Other skin issue. Progress: New wound. Wound acquired in-house. Wound is new. Painful: No. Length (cm): 7.38 Width (cm): 3.9 Depth (cm): 0 Area (cm2): 19.11Undermining: No. Tunneling: No. Odor after cleansing: None. Surrounding tissue: Erythema.(redness of skin) Edema: No swelling or edema. Periwound (around wound)temperature: Normal. Dressing appearance: Intact. Dressing saturation: None 0%.MD and RP notified.Record review on 04/10/26 of Resident #2's task documentation reflected that the resident was repositioned every two hours in accordance with the established care plan. Documentation entries consistently indicated that staff performed routine repositioning interventions to reduce the risk of skin breakdown and promote skin integrity. Interview attempted via phone on 04/10/26 at 11:23 am and 04/10/26 at 11:57 am, to LVN B, were unsuccessful.A text message was sent to LVN B on 04/10/26 at 1:28 pm, unsuccessful.During an observation on 04/10/26 at 12:15 pm revealed, the WCN and CNA A performed wound care for Resident #2 in accordance with physician orders. No concerns were identified at that time, aside from infection control practices.In an interview on 04/10/26 at 2:07 pm, CNA C stated she frequently assisted Resident #2 with bathing and had not observed any skin concerns. CNA C further stated if any skin concerns were identified, she would have reported it immediately. In an interview on 04/10/26 at 2:12 pm, CNA D stated she frequently assisted Resident #2 with bathing and had not observed any skin discoloration or redness prior to 02/01/26. CNA D stated Resident #2 did not exhibit signs or symptoms of pain. In an interview on 04/10/26 at 4:34 pm the DON stated, nursing (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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff are expected to assess all new areas of skin concern, including determining size, stage, if applicable. The DON stated that, based on the description of the skin discoloration, LVN B should have assessed and measured the area evaluating whether it was blanchable.The DON indicated that photographing wounds was not consistently completed unless prompted by the documentation system, noting that when a photograph was entered, the system prompts for wound measurements. The DON stated since Resident #1's skin concern was not photographed; the system did not prompt for measurements.In an interview on 04/10/26 at 4:44 pm, the WCN stated all skin concerns are assessed and measured. The WCN further stated that residents should be assessed for pain in relation to skin concerns.Record review of the facilities Skin and Wound Prevention and Management policy dated January 2023 reflected: Guideline Statement:An individual's skin is the largest organ of the body. At times skin failure may occur; however, the community will ensure that a resident admitting into the community will evaluated and identify the associated risks that may result in skin breakdown. The medical provider should consider the resident's current health status, function abilities, comorbidities as well as medications to determine if a pressure ulcer injury should be considered avoidable or unavoidable in etiology. Thus, a plan of care will be developed and implemented based on the identified needs, associated risks, and current skin conditions. Each resident will receive the care and services necessary to retain or regain optimal skin integrity. Skin Prevention Program will: Identify associated risks for alterations in skin integrity or development of pressure ulcers injuries. Identify early onset skin breakdown so that the IDT may implement appropriate interventions as clinically indicated. Guideline:7. A licensed nurse or therapist will measure the wounds as in order of length, width, and depthDocumentation:Exception to normal skin integrity such as abnormal skin conditions should be documented within the E.H.R: Type of skin injury/ulcer Location, shape, ulcer edges, and wound bed: Measurements of wound/skin injury Condition of surrounding tissues; Determine the etiology of the wound.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for one (Resident #2) of five residents reviewed for infection control practices. 1) The facility failed to ensure the WCN performed hand hygiene for at least 20 seconds prior and after performing Resident #2's wound care. 2) 1)The facility failed to ensure the WCN performed hand hygiene in between glove changes during Resident #2's wound care.3) The facility failed to ensure CNA A performed hand hygiene in between glove changes while aiding in Resident #2's wound care.These failures could place residents that require wound care at risk for healthcare associated cross-contamination and infections.Findings include:Record review of Resident #2's face sheet dated 04/10/26 reflected an [AGE] year-old-female with an original admission date of 05/30/24. Diagnoses included Parkinson's disease (progressive neurological disorder that primarily affects movement. It is characterized by the degeneration of nerve cells in the brain, chronic (long term) kidney disease, seizures, and high blood pressure. Record review of Resident #2's quarterly MDS dated [DATE] revealed a BIMS of 6 (severe cognitive impairment). Resident #2 functional abilities revealed dependent for Eating, Oral hygiene, toileting, shower/bathing, dressing, and personal hygiene.Record review of Resident #2's care plan revised on 03/04/26 reflected:Resident #2 had a stage 3 pressure ulcer (issue damage that results in full-thickness loss of skin and the layer of fat under the skin may be visible) to the sacrum (triangular bone in the lower back formed from fused vertebrae and situated between the two hip bones of the pelvis) and was at risk for skin impairment due to co-morbidities, chronic medical conditions that could lead to worsening. Interventions included: Enhanced barrier precautions as clinically indicated Interventions necessary to promote skin healing/resolving of injuriesRecord review of Resident #2's physician orders dated 02/26/26 reflected:Cleanse stage 3 sacrum wound with wound cleanser or normal saline, pat dry only, do not scrub. Apply collagen dressing to wound bed. Secure with dry dressing or bordered dressing. PRN if soiled or dislodged one time a day every Monday, Wednesday, and Friday. Observation of wound care on 04/10/26 at 12:15 pm revealed:-The WCN performed hand hygiene for approximately 10 seconds prior to initiating wound care for Resident #2.-The WCN did not perform hand hygiene between glove changes prior to wound care.-During wound care, CNA A did not perform hand hygiene between glove changes.-After completion of wound care for Resident #2, the WCN performed hand hygiene for approximately 17 seconds.In an interview on 04/10/26 at 12:52 pm, the WCN stated she believed she performed hand hygiene after removing her gloves each time. The WCN stated that proper handwashing should be performed for at least 20 seconds to remove contaminants and help prevent infection. In an interview on 04/10/26 at 12:56 pm, CNA A stated that proper hand hygiene was important to prevent infection. CNA A further stated Resident #2 was bedbound with co-morbidities and that proper handwashing was necessary to prevent cross contamination and possible infections. CNA A stated hands should be washed for 20 to 30 seconds. CNA A stated she had hands on training for handwashing about a month ago.In an interview on 04/10/26 at 1:04 pm, the ICP stated staff should perform hand hygiene for at least 20 seconds, as it was the amount of time needed to remove bacteria and dirt from the hands and wrist. The ICP stated that if a resident's body does not have adequate defense mechanisms to prevent a wound, the wound could become infected or worsen. The ICP further stated the facility provides monthly hands-on in-service training on hand hygiene and infection control. Additionally, the ICP states gloves are not 100% effective in preventing cross-contaminationIn an interview on 04/10/26 at 2:20pm the DON stated handwashing should be performed for 20-30 seconds to ensure hands are thoroughly cleaned and bacteria are effectively removed. The DON stated that if hand hygiene was not performed appropriately, microorganisms could remain on the hands and increase the risk of infection. The DON (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further stated the ICP conducts monthly hands-on in-service training for all staff on infection control. Additionally, the DON stated staff should perform hand hygiene, including handwashing or hand sanitizing, after each glove removal to prevent cross-contamination and the spread of pathogens.Record review of the facilities Handwashing/Hand Hygiene policy dated January 2023 reflected: GuidelineThis facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation2. All personnel should follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the situations such as this)including but not limited to):Between glove changes/After removing gloveswww. cdc.gov guidelines reflected: The CDC provides a clear, five-step process for effective handwashing with soap and water. Here are the steps to follow:1. Wet your hands with clean, running water (warm or cold).2. Apply soap and lather your hands by rubbing them together.3. Scrub your hands for at least 20 seconds, ensuring all areas are covered.4. Rinse your hands well under clean, running water.5. Dry using a clean towel or air dryer.