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	03/05/2026

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

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 4 of 8 residents (Resident #1, Resident #2, Resident #6, and Resident #14) reviewed for medical records.1. The facility failed to ensure RN C did not document a blood sugar of 2 on Resident #1's MAR when she refused finger sticks and insulin on 23 of 23 opportunities from 02/01/26 to 03/05/26.2. The facility failed to ensure LVN B, RN C, LVN D, LVN F, LVN G, and LVN H documented accurate Neuro Check vital signs for Resident #2 after he fell on [DATE].3. The facility failed to ensure RN C documented Resident #6's blood pressure on the MAR when the resident's blood pressure altering medication was not administered because it was outside of the parameters for administration on 17 of 20 opportunities from 02/04/26 to 03/05/26.4a. The facility failed to ensure LVN G documented accurate vital signs on Resident #14's Admission/re-admission assessment when he returned from the hospital on [DATE].4b. The facility failed to ensure RN C did not document a blood sugar of 2 on Resident #14's MAR when he refused finger sticks and insulin on 13 of 13 opportunities from 02/09/26 to 03/05/26.This failure could affect residents whose records are maintained by the facility and could place them at risk for errors in care and treatment.1. Record review of Resident #1's admission record reflected a [AGE] year-old female originally admitted to the facility on [DATE] with most recent admission on [DATE]. Her diagnoses included type 2 diabetes (chronic condition that happens when blood sugar levels are persistently high which can lead to heart disease, kidney disease, and stroke), essential (primary) hypertension (high blood pressure), non-traumatic subdural, intracerebral, and subarachnoid hemorrhages (brain bleeds/strokes not caused by trauma), and dementia (loss of memory, language, problem solving and other thinking abilities which significantly impair a person's ability to perform daily activities).Record review of Resident #1's quarterly MDS dated [DATE] reflected a BIMS score of 00 which indicated severe cognitive impairment.Record review of Resident #1's care plan dated 03/26/25 reflected the focus, I have diabetes and am at risk for complications associated with diabetes. Interventions included, Administer my medications as recommended by my doctor, monitor labs as indicated. Promptly report abnormal lab results and significant clinical findings to my doctor as indicated, initiated on 04/02/25.Record review of Resident #1's physician's order summary on 03/04/26 reflected the following active order: Insulin Lispro (1 Unit Dial) 100 UNIT/ML Solution pen-injector. Inject as per sliding scale: if 180 - 200 = 2 units; 201 - 230 = 3 units; 231 - 260 = 4 units; 261 -290 = 5 units; 291 - 320 = 6 units; 321 - 350 = 7 units; 351 + = 8 units- Administer and notify MD., subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus. Start date was 04/23/25.Record review of Resident #1's February 2026 MAR reflected RN C documented a blood sugar of 2 and documented code 10 which indicated, resident refused- nurse aware in the space for administered/not administered on:6:00 am on 02/01/26 through 02/04/26 (4 opportunities to check resident #1's blood sugar/administer insulin),6:00am on 02/07/26 through 02/10/26 (4 opportunities),6:00 am on 02/13/26 through 02/16/26 (4 opportunities),6:00 am on 02/19/26 through 02/22/26 (4 (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	opportunities), and6:00 am on 02/25/26 through 02/28/26 (4 opportunities).Further review of Resident #1's February 2026 MAR reflected 6 other instances when another nurse documented Resident #1 refused her fingerstick and documented an X in the space for blood sugar documentation, which indicated a numeric value did not have to be entered in that space.Record review of Resident #1's March 2026 MAR reflected RN C documented a blood sugar of 2 and documented code 10 which indicated, resident refused- nurse aware in the space for administered/not administered on:6:00 am on 03/03/26 through 03/05/26 (3 opportunities).An interview with Resident #1 was attempted on 03/04/26 at 1:45 pm, however she was not able to answer any questions appropriately.2. Record review of Resident #2's admission record reflected a [AGE] year-old female resident originally admitted to the facility on [DATE] with most recent admission on [DATE]. Her diagnoses included congestive heart failure (when the heart does not pump blood as well as it should causing fluid to build up in the lungs), chronic respiratory failure (a condition in which your lungs have a hard time loading your blood with oxygen or removing carbon dioxide), atrial fibrillation (an irregular, often fast heartbeat), presence of cardiac pacemaker (device that is implanted in the chest with wires into the heart that send electrical signals to keep the heart beat regular), essential (primary) hypertension (high blood pressure), and dementia (loss of memory, language, problem solving and other thinking abilities which significantly impair a person's ability to perform daily activities).Record review of Resident #2's quarterly MDS dated [DATE] reflected a BIMS score of 6 which indicated severe cognitive impairment.Record review of Resident #2's progress note dated 02/21/26 at 11:00 pm, RN C wrote, [Resident #2] was found sitting on the floor next to bed, confused and disoriented, 110/64, 98.2, 64, 97%r a, 20, assessed and assisted back to bed, able to flex and extend all 4 extremities as before, has a approximately 2 superficial skin tear to outer right elbow, cleansed and dressing applied, no c/o pain and in no acute distress.Record review of Resident #2's Neuro Checks form effective 02/21/26 at 11:00 pm reflected the following:RN C documented Resident #2's fall was not witnessed, and she did not have evidence of a possible head injury. RN C documented on neuro checks: 15 minute #'s 1-4, 30 minute #'s 1-4, and 60 minute #'s 1-4 (12 total opportunities from 02/21/26 at 11:00 am through 02/22/26 5:45 am) Resident #2 was alert, pupils were equal and reactive to light, she was able to move all extremities, was unable to follow commands, and had an appropriate response to pain. RN C did not document any vital signs for those 12 checks.LVN B documented on neuro checks 2 hour #'s 1-4 (4 opportunities: 02/22/26 at 7:45 am through 02/22/26 at 1:45pm).LVN G documented on neuro checks 4 hour #'s 1-2 (2 opportunities: 02/22/26 at 5:45 pm and 02/22/26 at 9:45 pm) Resident #2 was alert, pupils were equal and reactive to light, left and right pupils were brisk, hand grasps were equal, she moved all extremities, was able to follow commands, and had an appropriate pain response.Further review of LVN B and LVN G's documentation reflected the most recent pain level: 0, most recent blood pressure: 122/78, most recent temperature: 97.4, most recent pulse: 76, and most recent respiration: 18. All 6 sets of vital signs were dated 02/22/26 at 12:39 am.LVN H documented on neuro check 8 hour #1, Resident #2 was alert, pupils were equal and reactive to light and hand grasps were equal. LVN H documented most recent pain level and most recent vital signs as 02/22/26 at 12:39 am and were all the same as LVN B and LVN G documented.LVN B documented on neuro check 8 hour #2 (02/22/26 at 1:45 pm) Resident #2 was alert, pupils were equal and reactive to light, hand grasps were equal, she moved all extremities and had an appropriate pain response. LVN B documented Resident #2's most recent pain level: 0 on 02/23/25 at 9:10 am, most recent blood pressure: 119/80 on 02/23/26 at 11:51 am, most recent temperature: 97.1 on 02/23/26 at 9:11 am, most recent pulse: 80 on 02/23/26 at 12:43 pm, and most recent respiration: 18 on 02/23/26 at 9:11 am.LVN G documented on 8 hour #3 (02/23/26 at 9:45 pm), Resident #2's most recent vital signs were done on 02/22/26 at 12:39am.LVN H documented on 8 hour #4 (02/24/26 at 5:45 am), Resident #2's most recent vital signs were done on 02/22/26 at 12:39am.LNV D documented on 8 hour #5 (02/24/26 at 1:45 pm), Resident #2's most recent vital signs were done on 02/22/26 at 12:39am.LVN F documented on 8 hour #6 (02/24/26 at 9:45 pm), Resident #2's most recent vital signs were done on (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/22/26 at 12:39 am.In an interview on 03/05/26 at 10:15 am, Resident #'2 RP stated Resident #2 fell because she would forget she could not get out of bed on her own. The RP stated she visited Resident #2 the morning after the fall for at least a couple of hours and did not recall the nurse checking vital signs while she was there.3. Record review of Resident #6's admission record reflected a [AGE] year-old female originally admitted to the facility on [DATE] with most recent admission on [DATE]. Her diagnoses included essential (primary) hypertension (high blood pressure), type 2 diabetes (chronic condition that happens when blood sugar levels are persistently high which can lead to heart disease, kidney disease, and stroke), hemiplegia and hemiparesis following cerebral infarction (weakness and paralysis on one side of the body after a stroke), unspecified bradycardia (slow heartbeat), presence of a cardiac pacemaker (a small, battery-powered device surgically implanted under the skin to treat slow or irregular heartbeats), end stage renal disease (when the kidneys lose the ability to remove waste and balance fluids), aphasia (an impairment in the ability to read, write, and speak), dysphagia (difficulty swallowing), and gastrostomy status (a tube surgically implanted through the abdomen into the stomach used to provide nutrition, hydration, and medication).Record review of Resident #6's care plan dated 11/20/25 reflected the focus of heart disease and hypertension created on 12/04/25 and revised on 01/15/26. Interventions included: administer medications as ordered, educate and encourage compliance with medications, and monitor vital signs as indicated and report abnormal findings to provider as indicated, all initiated 12/04/25.Record review of Resident #6's order summary report on 03/05/26 reflected the following order:Hydralazine Hcl Oral tablet 100mg. Give 1 tablet via PEG-tube three times a day related to essential (primary) hypertension. Hold if systolic blood pressure (top number) is less than 110. Start date 02/01/26. Administration times were 6:00 am, 2:00 pm, and 10:00 pm.Record review of Resident #6's February MAR reflected:6:00 am on 02/04/26, (1 of 1 opportunity)6:00 am on 02/08/26 through 02/10/26 (3 opportunities),6:00 am on 02/15/26 and 02/16/26 (2 opportunities),6:00 am on 02/19/26 through 02/22/26 (4 opportunities), and6:00 am on 02/25/26 through 02/28/26 (4 opportunities).Record review of Resident #6's March 2026 MAR reflected:6:00 am on 03/03/26 through 03/05/26 (3 opportunities).Further review reflected on 16 of 19 total opportunities, RN C documented Resident #6's blood pressure as X and documented code 3 which indicated, Held: BP outside parameters in the space for administered/not administered.Record review of Resident #6's February and March 2026 progress notes reflected the following:02/04/26 at 5:11 am by RN C. eMAR-Medication Administration Note. Note text: Hydralazine HCl Oral Tablet 100mg. Give 1 tablet via PEG-Tube three times a day for Hypertension. Hold if systolic pressure is less than 100. (No blood pressure or other information documented.)Further review reflected there were no eMAR Medication Administration notes documented by RN C regarding Resident #6's hydralazine non-administration on 02/08/26 through 02/10/26, 02/15/26 and 02/16/26, 02/19/26 through 02/22/26, 02/25/26 through 02/28/26, or 03/03/26 through 03/05/26.Record review of Resident #6's blood pressure summary from 02/04/26 through 03/05/26 reflected RN C did not document any blood pressures for Resident #6 on the dates that her blood pressure medication was not administered due to other or BP outside parameters.An interview was attempted with Resident #6 on 03/05/26 at 10:45 am but was not possible due to her diagnosis of aphasia.4. Record review of Resident #14's admission record reflected a 96-yeear-old male admitted to the facility on [DATE]. His diagnoses included cerebral ischemia (stroke caused by decreased blood flow and oxygen to the brain due to a clot or narrowed arteries), type 2 diabetes (chronic condition that happens when blood sugar levels are persistently high which can lead to heart disease, kidney disease, and stroke), essential (primary) hypertension (high blood pressure), persistent atrial fibrillation (irregular, often fast heartbeat), unspecified heart failure (when the heart does not pump blood as well as it should causing fluid to build up in the lungs), and traumatic subdural hemorrhage with diffuse traumatic brain injury (stroke caused by bleeding in the brain due to trauma such as a fall).Record review of Resident #14's admission MDS dated [DATE] reflected a BIMS score of 8 which indicated moderate cognitive impairment.Record review of Resident (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#14's care plan dated 12/28/25 reflected a focus of diabetes created on 12/28/25. Interventions included: provide teaching and education regarding my diabetes diagnosis and treatment recommendations to resident and/or care support person as indicated, administer medications as recommended, monitor labs as indicated, and promptly report abnormal lab results and significant clinical findings to the doctor as indicated. Created on 12/29/25.Record review of Resident #14's Nursing Admission/readmission form dated 02/28/26 and signed by LVN G reflected the following:Most recent blood pressure was dated 02/24/26 at 9:06 pm and most recent temperature, pulse, respirations, oxygen saturation, and pain level were dated 02/24/26 at 3:07 pm.Record review of Resident #14's order summary on 03/05/26 reflected the following active order: NovoLog Flex:Pen Subcutaneous Solution Pen-Injector 100 UNIT/ML (insulin Aspart) Inject as per sliding scale: if 181 - 250 = 1 unit; 251 - 300 = 2 units; 301 - 350 = 3 units; 351 - 400 = 4 units; 401 + advise MD if above 400, subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus. Start date was 02/07/26.Record review of Resident #14's February MAR reflected the following:6:00 am on 02/09/26 and 02/10/26 (2 opportunities),6:00 am on 02/13/26 through 02/16/26 (4 opportunities), and6:00 am on 02/19/26 through 02/22/26 (4 opportunities).Record review of Resident #14's March 2026 MAR reflected:6:00 am on 03/03/26 through 03/05/26 (3 opportunities).Further review reflected on 13 of 13 total opportunities, RN C documented Resident #14's blood sugar as 2 and documented code 10 which indicated, resident refused-nurse aware in the space for administered/not administered.In an interview on 03/04/26 at 9:40 am, Resident #14 stated he did not like to be woken up to check his blood sugar but if he was already awake he was usually ok with the fingerstick. He stated he needed insulin every once in a while. Resident #14 stated he does not recall having any issues with his blood sugar being too low.In an interview on 03/05/26 at 11:15 am, LVN D stated RN C sometimes told her when he did not give early morning medications to residents. She stated she would not know that a medication was not given unless she went back into the MAR and looked at it. LVN D stated when medications were due during her shift, they would show up as red on the screen when she pulled up the resident's MAR. She stated Resident #1 and Resident #14, had not had any issues with their blood sugars on her shift and she did not have to give them insulin at lunch as their blood sugars were below the limit to give it. LVN D stated when blood sugars were checked, they were documented in the MAR. If a resident refused a fingerstick, in the old system they would leave the space blank for the fingerstick result and document refused. She stated in the new PCC system, she was not sure if there had to be a numerical value in the space or not. LVN D stated if she saw a 2 documented for the blood sugar, she would have thought she needed to go do a fingerstick to see what the sugar was and looked to see if interventions were done to manage hypoglycemia. LVN D stated if a resident refused a medication or the VS were not within parameters to give, the MAR automatically generated a progress note and auto-populated the order, but the nurse had to document the reason for not giving the medication or any other comments either at the beginning or at the end of the order. LVN D stated she was not notified by RN C on 03/05/26 at shift change that Resident #14 did not receive his Novolog, Resident #1 did not receive her Insulin, and Resident #6 did not receive her hydralazine. LVN D stated it was important to tell the oncoming nurse that a medication was not given during the shift so the oncoming nurse could either give the medication or check the resident and/or notify the physician. She stated if a resident refused a mediation because it was too early in the morning on her shift, she would not mark it as not given if it was within 30 minutes to an hour before shift change so the oncoming nurse could try to give it when they were on shift or contact the provider to ask about changing the administration time. LVN D stated when a resident fell, they were assessed, vital signs were checked, and if something was abnormal, they called 911; if things were ok, the nurse notified the provider and RP then completed the Post Fall Review form and initiated the Neuro Checks form in PCC. LVN D stated VS were to be checked at each neuro check interval and documented in the Neuro Check form in PCC. She stated the Neuro Check form auto- populated the most recent documented vital signs and the nurse had to make sure to change them to the VS for that interval. LVN D stated if (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	VS were not done and documented with each neuro check interval, the nurse was not doing a complete assessment and could miss a change in condition. LVN D stated if the resident had a change in condition that was not caught, the resident could decline. She stated they could document VS in the tab for weights/vitals or in the MAR and they would cross over both directions. LVN D stated medication administration was in-serviced once a month, and the last one was a few days ago. She stated fall/post-fall and documentation in general were done about once a month.In an interview on 03/05/26 at 1:25 pm, RN E stated if she had a resident refuse a medication at the end of her shift, she would notify the physician and see if he had any new orders, then notify the family. She stated if the resident complained about the timing of the medication, she would talk to the physician to see if they could change the order time. She stated she would let the next nurse know that the resident refused the medication. RN E stated it was important to let the other nurses know that the resident did not get his medication due to refusal or not VS not in parameters so that they were aware of what was going on with the resident and if their VS or blood sugar was high, it would explain why. RN E stated if a resident refused a fingerstick, the MAR would let you leave the BS blank and it would only accept numbers, not an X. If she saw a BS of 2 with resident refused, she would still do an assessment to ensure that the BS was not too low. RN E stated if a resident had a blood pressure that was outside of parameters she would document the BP in the MAR and in the progress notes. She stated if a medication was not administered because VS or blood sugar were outside of parameters and it was not passed down in report or documented, she would not have a way to know what the resident's blood pressure (or blood sugar) was. RN E stated if a resident fell, she would assess resident and check VS. After notifications and if the resident did not need to go to the hospital she initiated neuro checks. RN E stated when the neuro checks form was started, it automatically put in the most recent vital signs for the first check and those would have to be replaced with the ones she got during the assessment. RN E stated from the 2nd 15 minute check on, it would auto populate the VS she entered on the 1st 15 minute check, so she had to change the VS to the most recent ones. She stated it was important to document everything in the proper places so that everyone would know what was going on with the resident and if things were not documented, things could get missed. RN E stated if things were not documented or passed down, it could cause delays in care or treatment or adverse outcomes.On 03/05/26 at 2:05 pm, an attempt was made to contact RN C by phone. There was no answer and a message that said the mailbox was full, so a text message was sent at 2:07 pm. There was no response from RN C.In an interview on 03/05/26 at 2:35 pm, LVN F stated when she pulled up a new neuro check form, it auto populated the most recent vital signs that were in the system for that resident, and she had to manually go in and change the VS for each check. LVN F stated if a resident had a sliding scale insulin and they refused the fingerstick, the MAR required a number to be put in the space for the blood sugar, or it would not let her continue on. She stated she had tried to put an x or leave it blank, but it would not work. LVN F stated VS were put into the MAR or the vital signs tab. She stated if a resident's BP was outside of parameters to give a medication, she documented it in the space for the BP on the MAR and in the progress notes under the medication order. LVN F stated if a resident refused a medication, she entered it in a progress note and passed it on to the next nurse. She stated it was important so the next nurse knew what was going on and knew whether or not they needed to recheck something.In an interview on 03/05/26 at 2:50 pm, ADON I stated it was important to document the results of VS or blood sugars in the MAR and progress notes so everyone was aware of what was happening with the resident and could recheck or reassess as necessary. ADON I stated if non-administration of medications, and vital signs, and/or blood sugars were not documented it could lead to residents having adverse outcomes. She stated it was important to document accurate VS on neuro checks because resident conditions could change and could be missed leading to bad outcomes.In an interview on 03/05/26 at 3:26 pm, the DON stated it was important to document results (VS, blood sugars) to monitor trends/changes that might require doctor intervention. He stated sometimes the MAR auto populated a progress note if a medication was not (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 (Resident #87) of 3 residents reviewed for respiratory care.The facility failed to ensure Resident # 87's oxygen was administered at the correct setting of 2 liters per minute on 3/03/2026 as ordered by the physician.This deficient practice could place residents at an increased risk of developing respiratory complications and a decreased quality of care.The Findings included:Record review of Resident #87's admission record dated 3/03/26 indicated an [AGE] year-old female with an admission date of 2/19/2026. The resident had a diagnoses which included: Chronic Obstructive Pulmonary Disease (a progressive and irreversible lung disease that makes breathing difficult by damaging airways and air sacs, causing inflammation), Acute Respiratory Failure with Hypoxia (a condition defined by the respiratory system's failure to maintain adequate blood oxygen levels), and Interstitial Pulmonary Diseases (a group of chronic, often progressive, lung conditions causing inflammation and scarring of the lung tissue).Record review of Resident #87's Quarterly MDS assessment, dated 2/26/2026, indicated Resident #87's BIMS score of 4 (indicated severe cognitive impairment). Section O- Special Treatments, Procedures, and Programs. Respiratory Treatments indicated Oxygen therapy was checked off.Record review of Resident #87's active orders as of 3/03/2026 indicated Continuous Oxygen 2 liters per N/C every shift. Order Date:2/19/2026.Record review of Resident # 87's care plan dated 11/28/2026 indicated FOCUS: Oxygen therapy r/t Chronic Lung Disease. GOAL: Will have no s/sx of poor oxygen absorption through the review date. Interventions: .Provide oxygen as ordered/recommended by my physician.During an observation of Resident #87 on 3/03/2026 at 10:56 AM revealed the setting on the portable oxygen tank was at 2.5 Liters Per Minute via Nasal Canula. Observation of Resident # 87 revealed the resident was sitting up in her wheelchair. No signs of respiratory distress noted.In an interview on 3/03/2026 at 11:00 AM with LVN B, she said she was not sure who had placed the resident on the portable oxygen tank with the setting at 2.5 Liters. She said she had checked the oxygen setting at the beginning of her shift and was set at 2 liters on the oxygen concentrator. LVN B checked Resident #87's oxygen saturation and was at 94%. She said the resident had COPD and too much oxygen could cause the residents lungs to expand and cause hyperoxygenation. LVN B said she had an in-service on respiratory services three months ago.In an interview on 3/05/2026 at 1:43 PM with ADON I, she said Resident #87's family possibly increased the oxygen setting. She said the managers were assigned Residents' rooms to check in the residents and ensured the resident's needs were being met. ADON I said oxygen settings were checked during the managers' rounds. She said a negative outcome of not receiving the prescribed dose of oxygen could cause altered mental status due to over oxygenation. ADON I said the oxygen setting should be set at the prescribed rate.In an interview on 3/05/2026 at 2:00 PM with the DON, he said Angel rounds (manager rounds assigned residents' rooms) were performed in the morning to check oxygen settings and the care plan order set which includes interventions. He said nurses made rounds and received alerts from EMR software to check Oxygen settings which they then signed off in the MAR as done. The DON said a negative outcome for a residents that had COPD was SOB and respiratory failure due to too much oxygen. He said in-services on respiratory services were done upon hire, annually, and as needed.Record review of the facility's policy titled Medication Administration dated March 2019 indicated Compliance Guidelines: Resident medications are administered in an accurate, safe, timely, and sanitary manner.6. Administer medications as ordered by the physician.Record review of the facility's policy titled Oxygen Administration dated March 14, 2019 indicated Compliance Guidelines: A resident receives oxygen therapy when there is an order by a physician.3. Obtain physician orders for oxygen administration.c. flow rate of delivery.

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	03/05/2026

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

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments and labeled in accordance with currently accepted professional principles reviewed for medications stored in 1 of 1 medication refrigerators in the medication storage room. The facility failed to ensure medications in the medication room refrigerator were stored at an appropriate temperature. The failure could place residents in the facility at risk of receiving expired medications from staff.Findings included:Record review of the March 2026 medication room refrigerator temperature log revealed the temperature was signed off by ADON J on 03/04/26 stating the temperature was 37 degrees Fahrenheit. Further review revealed the instructions Adjustments To Refrigerator - Record adjustments to correct temperature that is not between 36 to 46 F During an observation of the medication room refrigerator at 4:05 PM on 03/04/26, the refrigerator had two different thermometers placed inside. The refrigerator contained various medications for several residents. One thermometer in the center back area of the top shelf read 24 degrees Fahrenheit. The other thermometer in the back left area of the bottom shelf read 28 degrees Fahrenheit. The DON saw these temperatures and adjusted the refrigerator's setting to increase the temperature. In an interview with ADON J at 10:35 AM on 03/05/26, ADON J stated she checked on the temperature of the medication room refrigerator at around 8:30 AM on 03/04/26. ADON J stated she had never seen the temperature outside of the appropriate range between 36 and 46 degrees Fahrenheit. ADON J stated if the medications were stored outside of the appropriate temperature then some could go bad and become less effective when administered to a resident. In an interview with the PC at 2:23 PM on 03/05/26, the PC stated, per the FDA, refrigerators storing medications should not be below 36 degrees Fahrenheit. The PC stated the refrigerator was audited quarterly and there had been no previous issues noted with the temperature of the refrigerator. The PC stated if the temperature in the refrigerator was below 36 degrees for an extended period of time of at least several hours medications could start to crystalize becoming less effective. The PC stated it was possible for the thermometers to give a false low reading if they were too close to the refrigeration unit. In an interview with the DON at 3:13 PM on 03/05/26, the DON stated he observed the temperature readings in the refrigerator at 4:05 PM on 03/04/26 to be 24 degrees and 28 degrees Fahrenheit from the thermometers in the medication room refrigerator. The DON stated there were various medications stored in the medication room refrigerator for residents in the facility. The DON stated the appropriate temperature range to store medications in the refrigerator was between 36 and 46 degrees Fahrenheit. The DON stated the medications could lose potency and become less effective if left outside of the correct temperature range for too long. The DON stated they did not have a facility policy covering the appropriate storage temperature for medications. In an interview with the DON at 9:25 AM on 03/05/26, the DON was asked for a policy covering the appropriate storage conditions for medications in the refrigerator in the medication room, but none was provided.

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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 control program designed to prevent the development and transmission of disease and infection for 1 (Resident #118) of 2 residents observed for contact precautions.SW did not don PPE before entering Resident #118's room on 3/03/2026. Resident #118 was under Contact Precautions as per physician orders.This failure could place residents who resided in the facility, as well as employees and visitors, at risk of communicable diseases.The findings included:Record review of Resident #118's admission record dated 3/03/2026, with an admission date of 2/26/2026, indicated a [AGE] year-old female with diagnoses of Bacteremia (presence of bacteria in the blood stream), Extended Spectrum Beta Lactamase [ESBL] Resistance (bacteria that have developed superbug enzymes capable of breaking down and destroying, last-resort antibiotics like penicillin), and Unspecified Escherichia Coli [E. Coli] as the Cause of Diseases Classified Elsewhere (bacteria commonly found in the intestines of humans and animals).Record review of Resident # 118's MDS assessment dated [DATE], indicated a blank section under C0500 BIMS Summary Score. Section I- Active diagnoses indicated I1700. Multidrug-Resistant Organism (MDRO) and I2000. Pneumonia were checked off. I8000 Additional active diagnoses indicated B. UNSP ESCHRICHIA COLI AS THE CAUSE OF DIEASES ELSWHR C. BACTEREMIA.Record review of Resident #118's care plan dated 2/26/26 indicated FOCUS: At [NAME] for infection or recurrent/chronic infection r/t compromised medical condition.Record review of Resident #118's order summary dated as of 3/03/2026, indicated Isolation: Contact Isolation Precautions: ensure infection site is contained prior to leaving room. If not able to contain infection source, then resident/patient should remain in room for all care/services. Every shift for E coli ESBL in blood and urine until 3/05/2026. Date Ordered: 2/27/2026.In an observation on 3/03/3026 at 9:05 AM, SW was seen in Resident # 118's room without the required PPE (gown). There was a sign at the entrance to the resident's room stating Contact Precautions which listed the type of PPE staff were supposed to don when entering the resident's room. The Contact Precautions sign indicated wearing a gown when entering the resident's room.In an interview on 3/03/2026 at 9:10 AM with SW, she said that she had gone into the room because the resident was under hospice services and was nearing the end and the family had wanted to speak to her. She said she went into the resident's room and afterwards realized the resident was under contact precautions. The SW said a negative outcome to not wearing the appropriate PPE was that the staff can be contaminated and that cross contamination was an infection control problem. She said infection control in-services and reminders were given every week.In an interview on 3/03/2026 at 9:36 AM with RN A, Infection Preventionist, said she held in-services monthly on PPE and handwashing. She said she was going to re-educate the staff on Contact Precautions. RN A said the negative outcome to not wearing the appropriate PPE was that infections could be transmitted to other residents and staff which could create cross contamination. She said the resident was under contact precautions due to positive blood and urine cultures.In an interview on 3/05/3036 at 2:00 PM with the DON, he said Contact Precautions were ordered by the physician and were included in the resident's care plan. He said sign specifying Contact Precautions were placed under the resident's room number which identified the resident under the precautions. The DON said shelving, which included the PPE, was placed outside the resident's room which served as an extra cue to the staff. He said all staff received in-services on TBP upon hire, annually, and as needed. He said the negative outcome of not wearing appropriate PPE was cross contamination between staff, family, and other residents.Record review of policy titled Infection Prevention and Control dated March 13, 2019, indicated .11. Categories: Types of Isolation Precautions: .Contact Precautions may be implemented for a resident known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or patient-care items in the resident's environment.d.wear a gown (clean, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	non-sterile) when entering the room if you anticipate that your clothing will have substantial contact with the resident of contaminated surfaces.