STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455824	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wurzbach Nursing and Rehabilitation	8300 Wurzbach Rd San Antonio, TX 78229

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on observation, interview and record review the facility failed to provide reasonable accommodation of resident needs and preferences for 3 (Resident #3, #6, and #8) of 54 residents who resided on A and B hall reviewed for call lights. In that: Resident #3 had no access to his call light which had been clipped to the privacy curtain at the foot of his bed. Resident # 6 had no access to her call light which was on the floor under the roommate's bed and on the floor next to her bed. Resident #8 had no access to her call light which was on the floor under the foot of her bed. This deficient practice could place residents not being able to use call lights for assistance in maintaining and/or achieving independent functioning, dignity, and well-being. Findings included: Record review of Resident's #3's face sheet, revealed he was a [AGE] year-old male, admitted on [DATE]. He had diagnoses that included: anxiety disorder and Epilepsy (a brain disorder that causes seizures). Record review of Resident #3's quarterly MDS dated [DATE], revealed a BIMS score of 13 indicating intact cognition. The MDS reflected Resident #3 needed supervision with transfers and partial assistance with toileting and dressing. Record review of Resident #3's care plan, revised 8/22/2023 with a target date of 06/05/2024, revealed Resident #3 was a high fall risk related to a history of seizures and poor safety awareness. An intervention, dated 8/29/2023, stated be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Record review of Resident #3's Fall Risk Evaluation, dated 04/06/2024, indicated resident was a high fall risk and stated Resident #3 had 1-2 falls in the past 3 months. The Fall Risk Evaluation instructions revealed that a score of 10 or greater was considered a High Risk for falls. Resident # 3's score was 19. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 04/15/2024 at 3:15 p.m., Resident #3 was lying in bed with the call light attached to the privacy curtain behind the foot of the bed. Resident #3 stated his call light should have been on his bed where he can reach it. He stated he did not place the call light on the privacy curtain and stated that he used his call light to reach staff if he needed assistance with anything. Record review of Resident #6's face sheet revealed she was a [AGE] year-old female, admitted on [DATE]. She had diagnoses that included: Anxiety Disorder, Seizures (a sudden, uncontrolled electrical disturbance in the brain which can causes changes in behavior, movements, or feelings) and schizoaffective disorder (a chronic mental illness involving symptoms of schizophrenia and characterized by symptoms such as delusions and hallucinations). Record review of Resident #6's quarterly MDS, dated [DATE], revealed a BIMS score of 12 indicating mild cognitive impairment. The MDS indicated Resident #6 required moderate to maximum assistance with dressing and bed mobility and was dependent for assistance with transfers. Record review of Resident #6's care plan, revised 11/24/2023 with a target date of 05/21/2024, revealed resident was a high fall risk related to weakness, confusion, and poor impulse control. An intervention, dated 12/14/2022, stated be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Record review of Resident #6's Fall Risk Evaluation, dated 03/06/2024, indicated Resident #6 was a high fall risk. The Fall Risk Evaluation instructions revealed that a score of 10 or greater was considered a High Risk for falls. Resident # 6's score was 14. Observation and interview on 04/15/2024 at 12:45 p.m., Resident #6 was lying in bed with her call light underneath her roommate's bed. Resident #6 stated she did not realize her call light was not on her bed. She stated she did not place it on the floor, and she stated staff usually place her call light within reach. Resident #6 stated she used the call light to call for help. Observation and interview on 4/15/2024 at 3:35 p.m., Resident #6 was lying in bed with her call light on the floor by the left side of her bed. Resident #6 stated she did not realize her call light was on the floor. She stated she did not place it on the floor, and she stated staff usually place her call light within reach. Resident #6 stated she used the call light to call for help. Observation on 04/15/2024 at 3:38 p.m., Resident #6 heard from the doorway of her room yelling help, I need help. Upon entering resident room with RN MDS, resident stated I need my call light. During an interview, 04/15/2024 at 3:42pm, RN MDS said Resident #6's call light was on the floor beside the bed. RN MDS stated call lights should be within a resident's reach and stated staff are responsible for making sure the call lights are within reach. RN MDS stated it is important to keep the call lights within reach and that it could be detrimental for a resident to not have the call light in reach. Record review of Resident #8's face sheet revealed she was a [AGE] year-old female, admitted on [DATE]. Resident #8's diagnoses included: Alzheimer's Disease (a progressive disease that affects memory and other important mental functions). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's quarterly MDS, dated [DATE], revealed she had short term and long-term memory deficits and a severe impairment for cognitive decision-making skills. The MDS revealed Resident #8 is dependent on staff for all ADL's. Record review of Resident #8's care plan, revised 08/27/2023 and target date 04/23/2024, revealed resident was a high fall risk related to confusion, incontinence, poor communication/comprehension, vision/hearing problems, unsteady trunk control, cognitive impairment, and history of falls. An intervention, dated 08/27/2023, stated be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Record review of Resident #8's Fall Risk Evaluation, dated 02/06/2024, revealed resident was a high fall risk. The Fall Risk Evaluation instructions revealed that a score of 10 or greater was considered a High Risk for falls. Resident # 8's score was 24. Observation on 04/15/2024 at 3:40 p.m., revealed Resident #8 lying in bed with her call light on the floor under the foot of her bed. During an interview on 04/15/2024 at 3:42 p.m., RN MDS said Resident #8's call light was on the floor under the resident's bed. During an interview on 04/15/2024 at 4:50 p.m., CNA A stated resident call lights should be within reach when a resident is in their bed. He stated the CNA's, nurses and any staff who enter the room are responsible for making sure the call lights are in reach. CNA A stated it was important to keep the call lights in reach because a resident could fall or become soiled if they laid there too long. CNA A revealed he had received training in facility orientation he attended when hired two weeks ago. During an interview on 04/16/2024 at 2:20 p.m., the DON stated call lights should be in reach of a resident and it was the responsibility of all staff to make sure they were in reach. She stated it was important to keep the call lights in reach of a resident because they could fall or lots of things could happen. The DON stated staff were trained on call light placement during in-services and we check them daily and talk to staff if we find one not close to a resident. Record review of facility policy, Strategies for Reducing the Risk of Falls, revised 04/2022, stated call light within reach was a strategy to an environmental risk factor. Record review of facility policy, Falls Prevention-Potential Interventions, revised 04/2022, stated call light as an intervention with a description of placed within reach at all times.

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on observation, interview, and record review, the facility failed to provide food that accommodated the preferences for 2 of 13 residents reviewed for food preferences and the accommodation of resident's meal choices (Resident #'s 5 and 7). The facility did not honor Resident #5's allergy to foods and continued to serve her foods she was allergic to. The facility did not honor Resident #7's food preferences and continued to serve him foods he asked not to receive. This failure could place residents who report likes/dislikes and allergies at risk for dissatisfaction, poor intake, weight loss, and/or allergic reaction. Findings included: Record review of Resident # 5's face sheet revealed she was a [AGE] year-old female, admitted [DATE]. Resident #5's diagnoses include: anxiety disorder and Hemiplegia (paralysis of one side of the body) and Hemiparesis (muscle weakness of one side of the body) following a Cerebral Infarction (a disruption in the brain's blood flow). Record review of Resident # 5's admission MDS assessment, dated [DATE], revealed a BIMS score of 15 indicating no cognitive impairment. Record review of Resident #5's care plan, dated [DATE] with a target date of [DATE], stated resident is allergic to penicillin, chicken, chocolate, oats, spinach. Interventions dated [DATE] included: Do not administer medications, offer food/drink or expose to allergens the resident is known to be allergic to. Have appropriate documentation of allergies/alerts on chart, per facility protocol. Record review of Resident # 5's Resident Food Preference Form, dated [DATE], listed food allergies as chicken, chocolate, oats and spinach. Record review of Resident # 5's tray card served with her lunch and dinner meal tray, undated, revealed food allergies as chicken, chocolate, oats and spinach. During an interview and observation on [DATE] at 1:25 p.m., revealed Resident #5's tray card on the table listed food allergies that included chicken and chocolate. Resident #5 stated she is allergic to chocolate and chicken and had been served these items several times since admission on [DATE]. Resident #5 further stated eating these items gives her a stomachache. Observation on [DATE] at 5:00 p.m., revealed LVN A checking resident meal trays in A Hall dining room prior to passing the trays to the residents. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on [DATE] at 5:02 p.m., revealed Resident #5 received her meal tray with a chocolate milk shake on the tray. Resident #5 upon seeing the chocolate shake, said I cannot have the chocolate shake, I am allergic to it. During an interview, [DATE] at 5:05 p.m., LVN A verified he did check Resident #5's tray card against the meal on her tray. He stated he must have missed it when asked about Resident #5's listed allergies. He stated he had received training on verifying trays with the tray card. Furthermore, he stated serving a resident a food item that they are allergic too could have resulted in the resident having an allergic reaction. Record review of Resident #7's face sheet revealed he is a [AGE] year-old male, admitted [DATE]. Resident #7's diagnoses include: anxiety disorder, Depression and Dementia (a general term for impaired ability to remember, think, or make decisions). Record review of Resident #7's quarterly MDS, dated [DATE], revealed a BIMS score of 15 indicating no cognitive impairment. Record review of Resident #7's care plan, revised [DATE], revealed Resident #7's food preferences and dislikes were not included in the plan of care. Record review of Resident #7's Resident Food Preference Form, dated [DATE], revealed no dislikes listed under Section D. Dislikes. Record review of Resident #7's tray card, undated, revealed a list of Dislikes/Intolerances to include: sweet potatoes/Yams; Zucchini. Observation on [DATE] at 5:15 p.m., revealed RN A verifying trays in the memory care dining room before the trays were passed out to the residents. Observation on [DATE] at 5:21 p.m., revealed Resident #7's meal tray consisted of ham, candied yams and mixed vegetables including zucchini. During an interview on [DATE] at 5:22 p.m., Resident #7 stated he did not like yams or zucchini and planned to not eat those items. During an interview on [DATE] at 5:25 p.m., RN A verified she checked the tray card and the resident meal tray. RN A responded No, I must have missed it when asked if she observed Resident #7's dislikes listed on the tray card. RN A stated it was important to make sure each resident has the appropriate food and if the resident received food they do not like, they could not be eating a sufficient amount of food. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:20 p.m., the Dietary Manager stated resident food allergies and food preferences were obtained from the resident or their representative upon admission, quarterly and as needed. He stated he entered the information onto the resident meal tray card system and a tray card was provided at every meal. He stated three people were responsible for verifying the tray accuracy in the kitchen which included the cook, dietary aide, and dishwasher (whom he stated brought the trays out to the dining room). He stated a nurse then verified the accuracy of the trays in the dining room before being handed to a resident. Furthermore, he stated his staff had received training on verifying tray accuracy and the importance of the accuracy was to make sure a resident did not have an allergic reaction and enjoyed the food they were provided. When asked about Resident #5 and Resident #7's trays he stated, it must have been overlooked. During an interview on [DATE] at 2:20 p.m., the DON stated resident allergies and preferences were listed on the resident's tray cards. She stated dietary checks the trays before they are sent to the dining room and then a nurse checks the trays before being handed to a resident. She stated it was important to verify the accuracy of the meals to prevent a resident from having an allergic reaction and residents had the right to follow the resident's preferences. Furthermore, she stated staff had received training on verifying the accuracy of meal trays. Record review of facility policy, Alternate Food Choices and Substitutions and Honoring Preferences, copyright 2018, stated the policy was the facility also supports resident choice and allowing residents to choose foods by honoring their food preferences. Steps listed in the procedure for the policy included: The Nutrition and Foodservice Manager or designee will obtain the resident's food preferences upon admission and record preferences in the tray card system. If a resident's preferences indicate they dislike the main meal, the alternate will be served unless the resident requests a substitution.