

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455824	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER Wurzbach Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on interviews and record reviews the facility failed to immediately inform the resident and notify, consistent with his or her authority, the residents' representative(s) when there is a significant change in the resident's physical, mental, or psychosocial status and or a need to alter treatment significantly, for 1 of 3 residents (Resident #1) reviewed for being informed of their health status. The facility failed to ensure they reported to Resident #1's Representative on 08/14/2024 of Resident #1's change of condition (episodic high blood pressure) to include new orders for anti-high blood pressure and anti-nausea / vomit medication. This failure could place residents at risk for harm by not reporting a residents health status and the opportunity for consent of care . The Findings included: A record review of Resident #1's admission record dated 09/11/2024 revealed an admitted [DATE] with diagnoses which included dementia (a group of symptoms affecting memory, thinking and social abilities. In people who have dementia, the symptoms interfere with their daily lives), schizoaffective disorder, bipolar type (a mental disorder characterized by symptoms of both schizophrenia (psychosis) and mood disorder - either bipolar disorder or depression). Further review revealed Resident #1's (family member) was identified as Resident #1's Medical and Financial Power of Attorney, Responsible Party, and Emergency Contact. A record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 was a medically complex [AGE] year-old female admitted for long term care and assessed with a BIMS score of 13 out of a possible 15 which indicated intact cognition. Further review revealed Resident #1's family was documented as participating in the MDS Assessment and Goal Setting. A record review of Resident #1's nursing progress notes revealed LVN A documented on 08/14/2024 a change of condition with high blood pressure, vomiting, and low oxygen levels. LVN A reported the change of condition to the on-call Nurse Practitioner who gave new orders for oxygen, anti-high blood pressure medication, and anti-nausea medication: Type: Nurse's Note (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Effective Date: 8/14/2024 22:12:00 Department: Nursing Position: LVN/CHR Created By: (LVN A) Created Date : 8/14/2024 22:19:32 Note Text: resident was [being] changed when she threw up. She started shivering and vitals were taken. O2=84, HR=112, BR=198/98 and RR=22. O2 given. TeamHealth was notified and gave an order for 2L of O2 and 4Mg of Zofran. O2 came up to 95 and BP down to 178/88 and HR of 102. Message was left for TeamHealth informing them of improved O2 and high BP and HR. A record review of Resident #1's August 2024 medication administration record and August 2024 physician's orders revealed LVN A documented on 08/14/2024, the Nurse Practitioners new order for hydralazine 10mg for high blood pressure, ondansetron 4mg for nausea and vomiting, and oxygen via a nasal canula at 2 liters for blood oxygen to be kept above 92%. During an interview on 09/11/2024 at 15:55 AM, LVN A stated on 08/14/2024 he worked the 02:00 PM to 10:00 PM shift assigned to Resident #1's care. LVN A stated after dinner, Resident #1 had an episode of confusion, altered mental status, shortness of breath, high blood pressure, and vomiting. LVN A stated he reported the change of condition to the on-call nurse practitioner and received new orders for Resident #1 to receive an anti-high blood pressure medication, anti-nausea medication, and some oxygen to keep her oxygen level above 92%. LVN A stated he documented the new orders and assessments but did not consider reporting the change of condition and / or the new medication treatments to Resident #1's (family) representative. LVN A stated he understood Resident #1 and her representatives were not provided an opportunity to participate in their plan of care to include a report of their change of health status. (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint interview on 09/11/2024 at 10:00 AM, with the Administrator, the DON, and the ADON, the ADON stated Resident #1 was discharged from the facility on 08/17/2024 due to increased vomiting and high blood pressure. The ADON stated Resident #1 was treated at the hospital for a week. During Resident #1's hospitalization, the ADON stated she had been contacted by Resident #1's POA and the POA was given a report to Resident #1's health condition prior to hospitalization. The ADON stated she became aware that Resident #1's representative had not received a change of condition report on 08/14/2024 and when Resident #1's representative visited Resident #1 on 08/17/2024, the day Resident #1 was transferred to the hospital, Resident #1's representative was unaware of Resident #1's declined health status. The ADON stated she had reported the finding to the DON and the Administrator. The administrator stated she began an investigation and reported an allegation of neglect to the state agency and coordinated with the DON for a root cause analysis and development of a plan of correction. The administrator stated the facility developed re-enforced trainings for all the nursing and CNA staff to cover change of conditions protocols to include notifications for residents and their representatives any new orders and or treatments in their care. The administrator stated she and her team identified LVN A as not having reported to Resident #1's representative the change of condition, new orders, and interventions to address Resident #1 new episodes of SOB, high blood pressure, and nausea. LVN A has since received further training and supervision from the DON and the ADON. The facility surveilled other residents for similar deficiencies and had not identified anyone else. During an interview on 9/11/2024 at 11:50 AM, Resident #1's representative stated Resident #1 had her own cell phone and had a practice of calling family frequently at least every 2 days, if not daily, when on 8/16/2024, the family recognized Resident #1 had not called anyone. Resident #1's representative visited Resident #1 on the morning of 08/17/2024 and discovered she had not been well. Resident #1's representative received a report Resident #1 had not been eating, had been throwing up, and had high blood pressure. Resident #1's representative requested for the facility to transfer Resident #1 to the hospital for evaluation. Resident #1 was transferred out to the hospital that afternoon. Resident #1's representative stated she had not received any communication her loved one was ill until she learned herself by visiting Resident #1 on 08/17/2024 and was denied any earlier intervention and or participation in Resident #1's plan of care. A record review of the facility's 2021 Change in a Resident's Condition or Status policy revealed, Policy Statement: Our community promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). Policy Interpretation and Implementation: 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: . b. there is a significant change in the resident's physical, mental, or psychosocial status. Regardless of the resident's current mental or physical condition, a nurse or healthcare provider will inform the resident of any changes in his/her medical care or nursing treatments		