

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 09/26/2024
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** 46447 Based on interview and record review, the facility failed to immediately inform the resident's physician when there was a significant change in resident's physical, mental, or psychosocial status for 1 of 5 residents (Resident #1) reviewed for resident rights. The facility failed to consult with Resident #1's physician and provide all necessary details, when Resident #1 complained of a worsening wound on 09/22/2024. This failure could place the resident at risk for delay in treatment and a decline in the resident's health and well-being due to the physician not being notified of changes in the resident's condition in a timely manner. The findings include: Record review of Resident #1's Administration Record, dated 09/24/2024, indicated Resident #1 was admitted on [DATE] and she was [AGE] years old. Resident #1 was noted to have discharged on [DATE] to an acute care hospital. MD A was noted as Resident #1's attending physician. NP B was noted as one of Resident #1's nurse practitioners (NP). Record review of Resident #1's Diagnosis Report, dated 09/26/2024, indicated Resident #1 had diagnoses of peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), type 2 diabetes mellitus (a condition that develops with the way the body regulates and uses sugar as fuel), and atherosclerosis of native arteries of right leg with ulceration of other part of foot (a buildup of fats in the arterial walls of the right leg with an open sore or break in the skin that does not heal, takes a long time to heal, or keeps returning). Record review of Resident #1's Quarterly MDS assessment, dated 08/24/2024, indicated Resident #1 had a BIMS score of 15 indicating she was cognitively intact. Resident #1 required supervision or touching assistance with bed mobility and for chair/bed-to-chair transfers. She used a wheelchair with supervision or touching assistance. Record review of Resident #1's Care Plan, accessed 09/24/2024, indicated Resident #1 had a diabetic ulcer to her right medial foot (inner edge of the right foot, extending from the heel to the big toe). The focus was initiated on 07/01/2024 and revised on 09/11/2024. The interventions included: (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	- Monitor/document wound: Size, Depth, Margins: .Document progress in wound healing on an ongoing basis. Notify MD (medical doctor/medical director) as indicated. The intervention was initiated on 07/01/2024. - Monitor/document/report PRN (pro re nata or as needed) any s/sx (signs or symptoms) of infection: [NAME] drainage, Foul odor, Redness and swelling . The intervention was initiated on 07/01/2024. Record review of facility's Resident #1's Nurse's Note, dated 09/23/2024 at 11:53 a.m. by RN C, revealed Note Text: late entry: on Sunday 9/22, went down A wing to talk to residents that were in hallway, [Resident #1's name] complaining to other residents that her foot was not getting better, and she was going to have to reach out to her Doctor, I offered to do dressing and take a look, she stated that night shift nurse did her dressing change before they left. I told her if she changed her mind to let me know. Record review of Resident #1 Wound Care Note, dated 09/19/2024 by NP D, revealed under Other/General Wound: . 9/12/24 Patient seen in follow up for wound to R [right] medial foot. Stable and improving with pink granular tissue (appears red and bumpy and consists of new connective tissue). 9/19/24 Patient is seen in follow up to R medial foot. Periwound (skin around a wound) appears macerated (appears lighter in color and wrinkly and occurs when skin was exposed to moisture too long). Record review of Resident #1's Progress Note, dated 09/23/2024 by MD A, revealed She was seen today per nursing request, noted over the weekend to have worsening right medial foot wound. She is being followed by wound NP [NP D] and wound nurse [LPN E]. She reportedly was told by someone that the wound is worsening. Her [family member] was here earlier and was upset that worsening wound 'was not being addressed' the resident call [name of local vascular clinic] this morning and was able to get a schedule at 1 PM. She was seen prior to leaving for appointment.Of note, the right medial foot wound was observed to be worsening over this past weekend. During an interview with Resident #1 on 09/25/2024 at 10:00 a.m., Resident #1 stated on Saturday night, 09/21/2024, she had asked LPN F, the nurse that works from 10:00 p.m. to 06:00 a.m., for a favor, to take a picture of her foot since she couldn't see it herself but could tell that it was bigger than it had been. Resident #1 stated LPN F expressed the wound had a smell when she had removed the dressing. During an interview with NP D on 09/25/2024 at 01:44 p.m., NP D stated she was notified of a change in Resident #1's wound on 09/19/2024 during her scheduled wound rounds. NP D stated she did not recall LPN E of notifying her prior to 09/19/2024 of a change in Resident #1's wound. NP D stated Resident #1's wound looked macerated with a small amount of sloughing (dead tissue within the wound) and moderate serous drainage (clear or yellow fluid) on 09/19/2024. NP D stated Resident #1's wound had changed between 09/12/2024 and 09/19/2024. (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LPN G on 09/25/2024 at 01:55 p.m., LPN G stated the nursing process for changes in condition in wounds or skin condition was to notify the treatment nurse (LPN E) and the treatment nurse would notify the treatment NP (NP D). LPN G stated she notified LPN E of a change in Resident #1's wound on 09/16/2024. LPN G stated Resident #1's wound on 09/16/2024 had around a 1-inch maceration around the wound bed, which was new from the last time (Friday, 09/13/2024) that she had provided wound care for Resident #1. During an interview with Resident #1 on 09/26/2024 at 09:30 a.m., Resident #1 stated on Monday morning, 09/23/2024, LPN F did her wound care around 04:00 a.m. She stated LPN F told her she was not going to do too much to the wound because it smelled so much. Resident #1 stated LPN F just cleaned it a little. During an interview with MD A on 09/25/2024 at 03:56 p.m., MD A stated he was informed on Monday morning, 09/23/2024, during his scheduled facility visit Resident #1's wound had been reported to look very bad over the weekend. MD A stated he looked at Resident #1's wound on Monday, 09/23/2024, and felt the wound looked bad and was much worse than it had looked two weeks prior. MD A stated he and NP B, who was on-call over the weekend, did not receive any notification from the facility of Resident #1's worsening wound. MD A stated due to Resident #1's medical conditions, he would not be able to estimate how long Resident #1's foot took to decline from his prior observation of the wound to the wound's current condition. MD A stated if he had been informed prior to his facility visit on Monday, 09/23/2024, he would have started Resident #1 on antibiotics and ordered labs and an x-ray of the foot. LPN E was attempted to be reached via telephone on 09/25/2024 at 03:42 p.m. and on 09/26/2024 at 11:12 a.m. The initial telephone attempt did not allow a voice message to be left. The second telephone attempt included a request for a return call and contact information. Attempts were unsuccessful with no answered or returned phone calls. LPN F was attempted to be reached via telephone on 09/26/2024 at 11:06 a.m. and 11:07 a.m. and text messaged on 09/26/2024 at 11:10 a.m. The second telephone attempt and the text message included a request for a return call and contact information. Attempts were unsuccessful with no answered or returned phone calls or text messages. During an interview with the DON on 09/26/2024 at 01:36 p.m., the DON stated Resident #1's wound appeared worse on Monday, 09/23/2024 than he had previously seen. The DON stated he had last seen Resident #1's wound on Thursday, 09/19/2024 or Friday, 09/20/2024. The DON stated he knew the wound NP (NP D) was aware of the prior week's wound change because the wound NP had made treatment changes and documented her assessment the prior week, on Thursday 09/19/2024. The DON stated he believed someone had notified Resident #1's physician of the change, but he was unable to state who or when. The DON stated the worsening of the wound over the weekend was not reported to him. The DON stated Resident #1's wound change he had observed on Thursday, 09/19/2024 or Friday, 09/20/2024 was not significant enough to be considered a change of condition; however, he stated the wound change he observed on Monday, 09/23/2024 would have been a change of condition. The DON stated Resident's wound change on 09/19/2024 was directly observed by the treatment NP (NP D) and he believed the physician had been notified. The DON stated it was the treatment nurse's (LPN E) responsibility to notify the physician of wound or skin condition changes. (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the ADMIN on 09/26/2024 at 02:43 p.m., the ADMIN stated for skin or wound condition changes, the charge nurse (nurse providing direct care to the resident) should report the change in condition to the resident's physician if the treatment nurse had not reported the change herself. The ADMIN stated if the treatment nurse was not present, the notification would be the responsibility of the charge nurse. The ADMIN stated a resident's physician cannot make an accurate assessment of the resident if they do not have all the information for the resident's current condition. Record review of facility policy Change of Condition Reporting Policy, source information dated 2003 and 1996, reflected When to report to MD/NP/PA [physician assistant]: Immediate Notification Any symptom, sign or apparent discomfort that is: - Acute or Sudden in onset, and: - A Marked change (i.e. [that is] more severe) in relation to usual symptoms and signs, or - Unrelieved by measures already prescribed Non-immediate Notifications - New or worsening symptoms that do not meet above criteria. Record review of facility policy Change in a Resident's Condition or Status, dated as revised February 2021, reflected 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. [for example], changes in level of care, billing/payments, resident rights, etc. [and so forth]) .1. The nurse will notify the resident's attending physician or physician on call when there has been a(an): .d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; . i. specific instruction to notify the physician of changes in the resident's condition.5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.		

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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** 46447 Based on interview and record review, in accordance with accepted professional standards and practices, the facility failed to maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized for 5 of 5 residents (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5) reviewed for reviewed for administration. 1. The facility failed to document wound care was provided for Resident #1 on five (5) occasions on Resident #1's September Treatment Administration Record (TAR). 2. The facility failed to document skin treatment was provided for Resident #2 on six (6) occasions on Resident #2's September TAR. 3. The facility failed to document wound care was provided for Resident #3 on thirty-four (34) occasions on Resident #3's September TAR. 4. The facility failed to document wound care was provided for Resident #4 on two (2) occasions on Resident #1's September TAR. 5. The facility failed to document wound care was provided for Resident #5 on one (1) occasions on Resident #1's September TAR. This failure could place residents at risk of not receiving wound care, wounds worsening, and a lack of oversight of their clinical records by the nursing staff and nursing management. The findings include: 1. Record review of Resident #1's Administration Record, dated 09/24/2024, indicated Resident #1 was admitted on [DATE] and she was [AGE] years old. Resident #1 was noted to have discharged on [DATE] to an acute care hospital. Record review of Resident #1's Diagnosis Report, dated 09/26/2024, indicated Resident #1 had diagnoses of peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), type 2 diabetes mellitus (a condition that develops with the way the body regulates and uses sugar as fuel), and atherosclerosis of native arteries of right leg with ulceration of other part of foot (a buildup of fats in the arterial walls of the right leg with an open sore or break in the skin that does not heal, takes a long time to heal, or keeps returning). Record review of Resident #1's Quarterly MDS assessment, dated 08/24/2024, indicated Resident #1 had a BIMS score of 15 indicating she was cognitively intact. Resident #1 required supervision or touching assistance with bed mobility and for chair/bed-to-chair transfers. She used a wheelchair with supervision or touching assistance. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's Care Plan, accessed 09/24/2024, indicated Resident #1 had a diabetic ulcer to her right medial foot (inner edge of the right foot, extending from the heel to the big toe). The focus was initiated on 07/01/2024 and revised on 09/11/2024. Record review of Resident #1's Order Summary Report, dated 09/26/2024, revealed the following wound order: - WOUND CARE: Right Medial foot Cleanse area with NS [normal saline or a sterile solution of sodium chloride in water], pat dry. Paint periwound [skin around a wound] with betadine [used to treat or prevent skin infection]. Using hydrofera blue [an antibacterial wound dressing] cut to size, gently pack wound. Cover with 4x4 [4 inch by 4 inch] dry dressing daily and PRN [as needed]. every day shift. Order was ordered and started on 08/16/2024 and was active. Record review of Resident #1's September TAR, accessed 09/24/2024, revealed wound care to the resident's right medial foot, order start date of 08/16/2024. The TAR indicated the treatment was to be provided during the Day. Treatment was not documented as provided on 09/01/2024, 09/08/2024, 09/19/2024, 09/22/2024, and 09/23/2024. Record review of Resident #1's progress notes, accessed 09/24/2024 and searched from 08/22/2024 to 09/30/2024, revealed: - 09/01/2024: no note regarding wound care. - 09/08/2024: no note regarding wound care. - 09/19/2024: a note by LPN G regarding the discontinuation of an order for applying a compression stocking due to Resident #1's wound to her right medial foot but did not mention wound care. - 09/22/2024: a note by RN C, dated 09/23/2024 at 11:53 a.m., noted as a late entry note, revealed Resident #1 refused wound care on 09/22/2024 because the night shift nurse had completed wound care the night of 09/21/2024 to 09/22/2024. - 09/23/2024: a note by LPN G, dated 09/23/2024 at 12:45 p.m., stated Wound care changed per orders. During an interview with LPN G, on 09/24/2024 at 01:57 p.m., she stated Resident #1 sometimes refused her medications or treatments. LPN G stated Resident #1 was very independent and active, and because of this, LPN G stated she tried to do Resident #1's treatments in the morning before breakfast. LPN G stated wound care was usually done and generally at the beginning of the day. During an interview with Resident #1 on 09/25/2024 at 10:00 a.m., Resident #1 stated her wound care was supposed to be done daily but for 5-6 days, they missed it and said that her wound was healed. Resident #1 said that this occurred around 3 weeks ago but was unable to provide specific dates. 2. Record review of Resident #2's Administration Record, dated 09/24/2024, indicated Resident #2 was originally admitted on [DATE] and last readmitted on [DATE]. Resident #2 was noted to be a [AGE] year-old female. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's Diagnosis Report, dated 09/26/2024, indicated Resident #2 had diagnoses of adult failure to thrive (a condition where an older adult loses appetite, weight, and interest in activities), atherosclerotic heart disease (a buildup of fats in the arterial walls), and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Record review of Resident #2's Quarterly MDS, dated [DATE], indicated Resident #2 had a BIMS score of 8 indicating she was severely cognitively impaired. Resident #2 required substantial or maximal assistance with bed mobility and for chair/bed-to-chair transfers. She used a wheelchair with partial to moderate assistance. Record review of Resident #2's Care Plan, accessed 09/24/2024, indicated Resident #2 had a potential for pressure ulcer development due to her decreased mobility. The focus was initiated on 05/29/2024. Interventions included: Administer treatments as ordered and monitor for effectiveness. and Follow facility policies/protocols for the prevention/treatment of skin breakdown. Both interventions were initiated on 05/29/2024. Record review of Resident #2's September TAR, accessed 09/24/2024, revealed a treatment order for Miconazole Nitrate Powder 2 % (Miconazole Nitrate (Topical)) Apply to groin/bilateral [both sides] thighs topically every shift for fungal rash for 7 Days, order start date of 09/19/2024. The TAR indicated the last dose would be applied during the *DAY (day) shift on 09/26/2024. Treatment was not documented as provided during the *NGT (night) shift on 09/19/2024, 09/20/2024, 09/21/2024, and 09/22/2024; during the *DAY shift on 09/23/2024, and during the *EVE (evening) shift on 09/23/2024. Record review of Resident #2's progress notes, accessed 09/24/2024 and searched from 09/01/2024 to 09/30/2024, revealed: - 09/19/2024: no note regarding skin treatment provided during time of NGT shift (10:00 p.m. to 06:00 a.m.). - 09/20/2024: no note regarding skin treatment provided during time of NGT shift (10:00 p.m. to 06:00 a.m.). - 09/21/2024: no note regarding skin treatment provided during time of NGT shift (10:00 p.m. to 06:00 a.m.). - 09/22/2024: a note by LPN F, dated 09/23/2024 at 05:50 a.m., stated Resident #2 had returned from a local hospital following a fall. No notes mention skin treatment provided during NGT shift. - 09/23/2024: no note regarding skin treatment provided during DAY shift (06:00 a.m. to 02:00 p.m.) or EVE shift (02:00 p.m. to 10:00 p.m.). During an interview with Resident #2 on 09/26/2024 at 11:32 a.m., Resident #2 stated she thought her skin was getting better and staff were providing it frequently but not every day. Resident #2 stated if she mentioned it was bothering her to staff, they would provide the treatment. Resident #2 stated she does sometimes refuse care and treatments because she gets tired of the same old treatments and will sometimes get agitated. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of Resident #3's Administration Record, dated 09/25/2024, indicated Resident #3 was admitted on [DATE] and he was [AGE] years old. Record review of Resident #2's Diagnosis Report, dated 09/26/2024, indicated Resident #3 had diagnoses of rhabdomyolysis (a breakdown of skeletal muscle due to a muscle injury), chronic obstructive pulmonary disease (a type of progressive lung disease), and atherosclerotic heart disease (a buildup of fats in the arterial walls). Record review of Resident #3's Admission MDS, dated [DATE], indicated Resident #3 had a BIMS score of 5 indicating he was severely cognitively impaired. Resident #3 required substantial or maximal assistance with bed mobility and for chair/bed-to-chair transfers. He was dependent for wheelchair use. Record review of Resident #3's Care Plan, accessed 09/25/2024, indicated Resident #3 had: - a pressure ulcer to his right lateral (side away from the center) toe DTI (deep tissue injury) due to immobility. The focus was initiated on 09/03/2024. Interventions included: Administer treatments as ordered and monitor for effectiveness. and Follow facility policies/protocols for the prevention/treatment of skin breakdown. Both interventions were initiated on 09/03/2024. - a potential/actual impairment of his skin integrity of bilateral heels with suspected DTI. The focus was initiated on 08/23/2024. Interventions included Follow facility protocols for treatment of injury. The intervention was initiated on 08/23/2024. - a skin tear on his right hand. The focus was initiated on 09/03/2024. Interventions included If skin tear occurs, treat per facility protocol and notify MD, family. The intervention was initiated on 09/03/2024. Record review of Resident #3's Order Summary Report, dated 09/26/2024, revealed the following wound or skin treatment orders: - WOUND CARE: Groin/perineal [between pubic arch and tail bone] area Intertrigo [a skin condition caused by friction, heat, and moisture] Cleanse with house wipes, pat dry. Apply Nystatin powder [antifungal] to groin and perineal area, LOTA [leave open to air] BID [twice a day] and PRN for soiling. every shift. Order was ordered and started on 09/03/2024 and was active. - WOUND CARE: Left Arm Skin Tear Cleanse with NS or wound cleanser, pat dry. Apply Xeroform [sterile wound dressing that would not adhere to the wound] and cover with dry dressing 3x [three times] a week and PRN for dislodgement or soiling. one time a day every Mon [Monday], Wed [Wednesday], Fri [Friday]. Order was ordered on 09/03/2024, started on 09/04/2024, and was active. - WOUND CARE: Right hand skin tear Cleanse with NS or wound cleanser, pat dry. Apply Xeroform and cover with dry dressing 3x a week and PRN for dislodgement or soiling. one time a day every Mon, Wed, Fri. Order was ordered on 09/03/2024, started on 09/04/2024, and was active. - WOUND CARE: Right Lateral Toe DTI Cleanse with NS or wound cleanser, pat dry. Apply skin prep to area, LOTA daily. one time a day. Order was ordered and started on 09/03/2024 and was active. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's September TAR, accessed 09/24/2024, revealed the following wound orders: - WOUND CARE: Left Arm Skin Tear Cleanse with NS or wound cleanser, pat dry. Apply Xeroform and cover with dry dressing 3x a week and PRN for dislodgement or soiling. one time a day every Mon, Wed, Fri, order start date of 09/04/2024. The TAR indicated the treatment was to be provided during the Day. The treatment was not documented as provided on 09/13/2024, 09/16/2024, 09/18/2024, and 09/23/2024. - WOUND CARE: Right hand skin tear Cleanse with NS or wound cleanser, pat dry. Apply Xeroform and cover with dry dressing 3x a week and PRN for dislodgement or soiling. one time a day every Mon, Wed, Fri, order start date of 09/04/2024. The TAR indicated the treatment was to be provided during the Day. The treatment was not documented as provided on 09/13/2024, 09/16/2024, 09/18/2024, and 09/23/2024. - WOUND CARE: Right Lateral Toe DTI Cleanse with NS or wound cleanser, pat dry. Apply skin prep to area, LOTA daily. one time a day, order start date of 09/03/2024. The TAR indicated the treatment was to be provided during the Day. The treatment was not documented as provided on 09/08/2024, 09/13/2024, 09/16/2024, 09/19/2024, 09/20/2024, and 09/23/2024. - WOUND CARE: Groin/perineal area Intertrigo Cleanse with house wipes, pat dry. Apply Nystatin powder to groin and perineal area, LOTA BID and PRN for soiling. every shift, order start date of 09/03/2024. The TAR indicated the treatment was to be provided during the *DAY, *EVE, and *NGT. The treatment was not documented as provided during the *DAY shift on 09/08/2024, 09/13/2024, 09/16/2024, 09/19/2024, 09/20/2024, and 09/23/2024; during the *EVE shift on 09/23/2024, and during the *NGT shift on 09/03/2024, 09/04/2024, 09/07/2024, 09/08/2024, 09/09/2024, 09/10/2024, 09/13/2024, 09/14/2024, 09/15/2024, 09/16/2024, 09/19/2024, 09/20/2024, 09/21/2024, and 09/22/2024. Resident #3 was documented as having been provided treatment only one time a day on 09/08/2024, 09/13/2024, 09/16/2024, 09/19/2024, 09/20/2024, and 09/23/2024. Record review of Resident #3's progress notes, accessed 09/25/2024 and searched from 09/01/2024 to 09/30/2024, revealed: - 09/03/2024: no note mentioning wound treatment provided during time of NGT shift (10:00 p.m. to 06:00 a. m.). - 09/04/2024: no note mentioning wound treatment provided during time of NGT shift (10:00 p.m. to 06:00 a. m.). - 09/07/2024: no note mentioning wound treatment provided during time of NGT shift (10:00 p.m. to 06:00 a. m.). - 09/08/2024: no note mentioning wound treatment provided during time of DAY shift (06:00 a.m. to 02:00 p. m.) or NGT shift (10:00 p.m. to 06:00 a.m.). - 09/09/2024: no note mentioning wound treatment provided during time of NGT shift (10:00 p.m. to 06:00 a. m.). (continued on next page)		

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 09/26/2024
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 09/10/2024: no note mentioning wound treatment provided during time of NGT shift (10:00 p.m. to 06:00 a.m.). - 09/13/2024: a note by LPN G (Day shift nurse), dated 09/13/2024 at 02:28 p.m., stated Resident has treatable wounds. Receives wound care. Dressing changed as per treatment orders. The note does not indicate which treatments were provided. No note mentioning wound treatment provided during time of NGT shift (10:00 p.m. to 06:00 a.m.). - 09/14/2024: no note mentioning wound treatment provided during time of NGT shift (10:00 p.m. to 06:00 a.m.). - 09/15/2024: no note mentioning wound treatment provided during time of NGT shift (10:00 p.m. to 06:00 a.m.). - 09/16/2024: no note mentioning wound treatment provided during time of DAY shift (06:00 a.m. to 02:00 p.m.) or NGT shift (10:00 p.m. to 06:00 a.m.). - 09/18/2024: a note by LPN G, dated 09/18/2024 at 02:44 p.m., stated Resident has treatable wounds. Receives wound care. Dressing changed as per treatment orders. The note does not indicate which treatments were provided. - 09/19/2024: a note by LPN G, dated 09/19/2024 at 09:52 a.m., stated Resident has treatable wounds. Receives wound care. The note does not indicate if treatments were provided. No note mentioning wound treatment provided during time of NGT shift (10:00 p.m. to 06:00 a.m.). - 09/20/2024: a note by LPN G, dated 09/18/2024 at 02:44 p.m., stated Resident has treatable wounds. Receives wound care. Dressing changed as per treatment orders. The note does not indicate which treatments were provided. no note mentioning wound treatment provided during time of NGT shift (10:00 p.m. to 06:00 a.m.). - 09/21/2024: no note mentioning wound treatment provided during time of NGT shift (10:00 p.m. to 06:00 a.m.). - 09/22/2024: no note mentioning wound treatment provided during time of NGT shift (10:00 p.m. to 06:00 a.m.). - 09/23/2024: note by LPN G, dated 09/23/2024 at 12:38 p.m., stated Resident has treatable wounds. Receives wound care. The note does not indicate if treatments were provided. Resident #3 was attempted to be interviewed on 09/25/2024 at 01:50 p.m. and on 09/26/2024 at 11:30 a.m. He was asleep at the time of the first attempt and per nursing staff, attending a therapy session at the time of the second attempt. 4. Record review of Resident #4's Administration Record, dated 09/25/2024, indicated Resident #4 was originally admitted on [DATE] and last readmitted on [DATE]. Resident #4 was noted to be a [AGE] year-old female on hospice. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Wurzbach Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 8300 Wurzbach Rd San Antonio, TX 78229	
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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	Record review of Resident #4's Diagnosis Report, dated 09/26/2024, indicated Resident #4 had diagnoses of Alzheimer's disease (a progressive disease that affects memory and other important mental functions), atherosclerotic heart disease (a buildup of fats in the arterial walls), and chronic kidney disease (a condition where the kidneys lose their ability to filter blood and remove wastes). Record review of Resident #4's Annual MDS, dated [DATE], indicated Resident #4 had a BIMS score of 4 indicating she was severely cognitively impaired. Resident #4 required partial to moderate assistance with bed mobility and substantial or maximal assistance for chair/bed-to-chair transfers. She used a wheelchair with supervision or touching assistance. Record review of Resident #4's Care Plan, accessed 09/25/2024, indicated Resident #4 had a potential for pressure ulcer development due to her decreased mobility, and bowel and bladder incontinence. Weight loss and decreased nutrition status with impaired skin integrity was anticipated due to her terminal diagnosis and need for hospice. The focus was initiated on 09/30/2022 and revised on 11/22/2022. Interventions included: Administer treatments as ordered and monitor for effectiveness. and Follow facility policies/protocols for the prevention/treatment of skin breakdown. Both interventions were initiated on 09/30/2022. Record review of Resident #4's September TAR, accessed 09/24/2024, revealed a treatment order for Miconazole Nitrate Powder 2 % (Miconazole Nitrate (Topical)) Apply to bilateral breasts topically two times a day for fungal rash for 7 Days, order start date of 09/19/2024. The TAR indicated the treatment was to be provided during the hours of 6a-10 (06:00 a.m. to 10:00 a.m.) and *6p-1 (06:00 p.m. to 01:00 a.m.). The TAR indicated the last dose would be applied during the hours of 6a-10 on 09/26/2024. The treatment was not documented as provided on 09/23/2024 during the hours of 6a-10 or *6p-1. Record review of Resident #4's progress notes, accessed 09/25/2024 and searched from 09/01/2024 to 09/30/2024, revealed no note entered on 09/23/2024. During an interview with Resident #4's hospice nurse, RN I, on 09/26/2024 at 12:20 p.m., RN I stated Resident #4 seemed to get pretty good wound or skin treatment care. RN I stated she had not had any concerns and Resident #4's rash was almost resolved. 5. Record review of Resident #5's Administration Record, dated 09/25/2024, indicated Resident #5 was originally admitted on [DATE] and last readmitted on [DATE]. Resident #5 was noted to be a [AGE] year-old female on hospice. Record review of Resident #5's Diagnosis Report, dated 09/26/2024, indicated Resident #5 had diagnoses of dementia (a general term for impaired ability to remember, think, or make decisions), atherosclerotic heart disease (a buildup of fats in the arterial walls), and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Record review of Resident #5's Quarterly MDS, dated [DATE], indicated Resident #5 had a BIMS score of 9 indicating she was moderately cognitively impaired. Resident #5 required supervision or touching assistance with bed mobility and for chair/bed-to-chair transfers. She used a wheelchair with supervision or touching assistance. Record review of Resident #5's Care Plan, accessed 09/25/2024, indicated Resident #5 had: (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Wurzbach Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 8300 Wurzbach Rd San Antonio, TX 78229	
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- a potential for pressure ulcer development due to episodes of incontinence and decreased mobility. She spent most of the day in her room, had a history of pressure ulcers, had a right heel deep tissue injury, and was on hospice with anticipated impaired skin integrity due to a terminal diagnosis. The focus was initiated on 11/01/2018 and revised on 01/09/2024. Interventions included: Follow facility policies/protocols for the prevention/treatment of skin breakdown. The intervention was initiated on 11/01/2018. - had an arterial ulcer to her right heel with impaired skin integrity anticipated due to a terminal diagnosis and need for hospice. The focus was initiated on 07/14/2023 and revised on 08/08/2024. The interventions included: - Administer treatments as ordered and monitor for effectiveness. The intervention was initiated on 07/14/2023. - Follow facility policies/protocols for the prevention/treatment of skin breakdown. The intervention was initiated on 07/14/2023. - If The resident refuses treatment, confer with the resident, IDT and family to determine why and try alternative methods to gain compliance. Document alternative methods. The intervention was initiated on 07/14/2023. - Monitor dressing to ensure it is intact and adhering. Report lose dressing to Treatment nurse. The intervention was initiated and revised on 05/28/2024. Record review of Resident #5's Order Summary Report, dated 09/26/2024, revealed the following wound orders: - R heel ulcer cleanse with NS or wound cleanser, pat dry. Apply silver antimicrobial wound gel, apply blue antibacterial foam dressing, cover with dry dressing and secure with gauze wrap and tap. as needed reapply dressing for soiling or dislodgement. Order was ordered and started on 07/25/2024 and was active. - R heel ulcer cleanse with NS or wound cleanser, pat dry. Apply silver antimicrobial wound gel, apply blue antibacterial foam dressing, cover with dry dressing and secure with gauze wrap and tap. every Mon, Wed, Fri. Order was ordered and started on 07/25/2024 and was active. Record review of Resident #5's September TAR, accessed 09/24/2024, revealed the following wound orders: - R heel ulcer cleanse with NS or wound cleanser, pat dry. Apply silver antimicrobial wound gel, apply blue antibacterial foam dressing, cover with dry dressing and secure with gauze wrap and tape. every Mon, Wed, Fri, order start date of 07/26/2024. The TAR indicated the treatment was to be provided during the hours of *7A-5 (07:00 a.m. to 05:00 p.m.). The treatment was not documented as provided on 09/09/2024. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- R heel ulcer cleanse with NS or wound cleanser, pat dry. Apply silver antimicrobial wound gel, apply blue antibacterial foam dressing, cover with dry dressing and secure with gauze wrap and tape. as needed reapply dressing for soiling or dislodgement, order start date of 07/25/2024. The TAR indicated the treatment was to be provided PRN. The treatment was documented as provided on 09/05/2024 and 09/12/2024. Record review of Resident #5's progress notes, accessed 09/25/2024 and searched from 09/01/2024 to 09/30/2024, revealed no note entered on 09/09/2024. During an interview with Resident #5's hospice nurse, RN J, on 09/26/2024 at 03:23 p.m., RN J stated Resident #5's wound was improving but the wound may never heal due to Resident #5's poor circulation. During an interview with LPN G on 09/25/2024 at 01:55 p.m., LPN G stated blanks in the TAR would mean that the treatment wasn't documented. LPN G stated that nursing staff were supposed to use set codes for any deviation (change) from the prescribed order, such as they were to use a specific code if a resident was hospitalized and not in the facility for a scheduled treatment. During an interview and observation with the ADON on 09/25/2024 at 02:53 p.m., the ADON stated a blank in the TAR would mean that the nursing staff member did not select a response but wanted to go confirm her answer. The ADON returned and stated a blank in the TAR meant that the treatment was not done. LPN F was attempted to be reached via telephone on 09/26/2024 at 11:06 a.m. and 11:07 a.m. and text messaged on 09/26/2024 at 11:10 a.m. The second telephone attempt and the text message included a request for a return call and contact information. Attempts were unsuccessful with no answered or returned phone calls or text messages. During an interview with the DON on 09/26/2024 at 01:36 p.m., the DON stated he expected treatments ordered for the DAY to be primarily done by the nursing staff working primarily 06:00 to 02:00 p.m., ordered for the EVE to be done by the 02:00 p.m. to 10:00 p.m. shift, ordered for NGT to be done by the 10:00 p.m. to 06:00 a.m. shift, ordered for 6a-10 to be done between 06:00 a.m. and 10:00 a.m., ordered for 7a-5 to be done between 07:00 a.m. and 05:00 p.m., ordered for 10a- to be done up to an hour before to an hour after 10:00 a.m., and ordered 6p-1 to be done between 06:00 p.m. to 01:00 a.m. or by the evening shift. The DON stated skin treatments or wound care should be signed as completed when the nursing staff member completed it, and a blank in the TAR would mean that either the treatment was not done or the resident was not available, but the staff member should enter the appropriate code for why the resident was not available. The DON stated a progress note could explain why there would be a blank in the TAR, but it should ideally be marked on the TAR. The DON stated a progress note was better than no documentation. The DON stated the person doing the treatment should have signed the TAR. The DON stated after reviewing some of the blanks in the TAR, looking back, it makes it confusing whether the treatment was done as ordered or not. The DON stated he was not sure if the treatment nurse, LPN E was running reports on the TAR, but she was doing the treatments and was there Monday through Friday. He also stated that the facility had a weekend supervisor, RN C who was responsible in making sure treatments were done on the weekend. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the ADMIN on 09/26/2024 at 02:43 p.m., the ADMIN stated she believed treatments were monitored through the facility's EMR (electronic medical record) program, and it would flag them when a treatment was not done. The ADMIN stated she would say that the DON should monitor that the treatments were being completed, if there was not a consistent treatment nurse, but that ultimately it was the charge nurse that was responsible for the treatments having been completed. The ADMIN stated that the lack of documentation could result in not having a clear, consistent, or accurate documentation of treatments and would make the information unverifiable. Record review of facility policy Charting and Documentation, dated as revised July 2017, reflected All services provided to the resident, progress toward the care goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .2. The following information is to be documented in the resident medical record: .c. Treatments or services performed; .7. Documentation of procedures and treatments will include care-specific details, including; a. The date and time the procedure/treatment was provided; b. The name and title of the individual(s) who provided the care; c. The assessment data and/or any unusual findings obtained during the procedure/treatment; .		