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	12/06/2024

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 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 observation, interview and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, dispensing, and administering of all drugs and biologicals to meet the needs of 3 (Resident #1, Resident #2, and Resident #3) of 3 residents reviewed for pharmacy services. 1. The facility failed to ensure MA A accurately documented on Resident #1's Controlled Substance Administration Record the administration time for scheduled pain medication, Tramadol HCl Oral Tablet 50mg. 2. The facility failed to ensure MA A accurately documented on Resident #2's Controlled Substance Administration Record the administration time for scheduled pain medication, Tramadol HCl Oral Tablet 50 mg. 3. The facility failed to ensure MA A accurately documented on Resident #3's Controlled Substance Administration Record the administration times for scheduled pain medication, Tylenol with Codeine #3 Tablet 300-30 mg, and for a scheduled anti-anxiety medication, Diazepam Oral Tablet 2 mg. These failures could place residents at risk for medication overdose, medication under-dose, ineffective therapeutic outcomes, and drug diversion. The findings included: 1. Record review of Resident #1's Administration Record, dated 12/06/2024, reflected Resident #1 was admitted on [DATE]. Resident #1 was noted to be [AGE] years old. Record review of Resident #1's Diagnosis Report, dated 12/06/2024, reflected Resident #1 was diagnosed with metabolic encephalopathy (a chemical imbalance in the blood that causes problems in the brain), acute kidney failure (a sudden condition when the kidneys stop working or being able to filter waste products from the blood), and hypercalcemia (a condition in which the calcium level is above normal in the blood). (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	Record review of Resident #1's Admission MDS, dated [DATE], reflected Resident #1 had a BIMS Score of 03, indicating he was severely cognitively impaired. He was documented as having received a scheduled pain medication regimen. His pain assessment noted that Resident #1 had frequent pain with his worst pain over the last five (5) days to have been at 04, with zero (00) being no pain and ten (10) as the worst pain he could imagine. Record review of Resident #1's Order Audit Report, dated 12/06/2024, reflected Resident #1 was ordered Tramadol HCl Oral Tablet 50 mg (Tramadol HCl) on 12/02/2024. The order reflected to give 1 tablet by mouth three times a day for osteoarthritis hold for oversedation. The Supplementary Documentation Details noted the medication was scheduled to be administered at 0900 (09:00 a.m.), 1500 (03:00 p.m.), and 2100 (09:00 p.m.). During an observation of MA A administering medications on 12/05/2024, Resident #1's scheduled pain medication, Tramadol 50 mg was observed to be administered on 12/05/2024 at 02:26 p.m. Record review of Resident #1's Controlled Substance Administration Record for Tramadol HCl Tab (tablet) 50 mg, reflected the medication was received by the facility on 11/25/2024. The record reflected on 12/05/2024, Resident #1 received 1 tablet of Tramadol HCl at 1500 (03:00 p.m.). The record reflected the administration at 1500 on 12/05/2024 was administered by MA A. Record review of Resident #1's MAR (Medication Administration Record), dated as printed on 12/06/2024, reflected Resident #1 was administered his Tramadol HCl Oral Tablet 50 mg scheduled on 12/05/2024 at 1500 (03:00 p.m.) by MA A. The MAR did not notate the time of administration. Record review of Resident #1's Medication Admin (Administration) Audit Report, dated as accessed by the DON on 12/06/2024, reflected Resident #1 was administered his Tramadol HCl Oral Tablet 50 mg scheduled on 12/05/2024 at 1500 (03:00 p.m.) on 12/05/2024 at 02:28 p.m. by MA A. During an observation of MA A administering medications on 12/05/2024, Resident #2's scheduled pain medication, Tramadol 50 mg was observed to be administered on 12/05/2024 at 03:11 p.m. 2. Record review of Resident #2's Administration Record, dated 12/06/2024, reflected Resident #2 was admitted on [DATE]. Resident #2 was noted to be [AGE] years old. Record review of Resident #2's Diagnosis Report, dated 12/06/2024, reflected Resident #2 was diagnosed with dementia (a general term for impaired ability to remember, think, or make decisions), cerebral palsy (a disorder that affects a person's ability to move and maintain balance and posture), and osteoarthritis (a joint disease where the cartilage that cushions the ends of bones wears down over time leading to pain, stiffness, and a loss of flexibility). Record review of Resident #2's Significant Change MDS, dated [DATE], reflected Resident #2 had a BIMS Score of 00, indicating she was severely cognitively impaired. She was documented as having received a scheduled pain medication regimen. Her pain assessment interview was not conducted due to having been rarely or never understood. She was noted as not having had any indicators for pain or possible pain in the last 5 days. (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 Order Audit Report, dated 12/06/2024, reflected Resident #2 was ordered Tramadol HCl Oral Tablet 50 mg (Tramadol HCl) on 09/09/2024. The order reflected to give 1 tablet by mouth three times a day for pain. The Supplementary Documentation Details noted the medication was scheduled to be administered at 0900 (09:00 a.m.), 1500 (03:00 p.m.), and 2100 (09:00 p.m.). Record review of Resident #2's Controlled Substance Administration Record for Tramadol HCl Tab (tablet) 50 mg, reflected the medication was sent to the facility on [DATE]. The record reflected on 12/05/2024, Resident #2 received 1 tablet of Tramadol HCl at 1500 (03:00 p.m.). The record reflected the administration at 1500 on 12/05/2024 was administered by MA A. Record review of Resident #2's MAR, dated as printed on 12/06/2024, reflected Resident #2 was administered her Tramadol HCl Oral Tablet 50 mg scheduled on 12/05/2024 at 1500 (03:00 p.m.) by MA A. The MAR did not notate the time of administration. Record review of Resident #2's Medication Admin Audit Report, dated as accessed by the DON on 12/06/2024, reflected Resident #2 was administered her Tramadol HCl Oral Tablet 50 mg scheduled on 12/05/2024 at 1500 (03:00 p.m.) on 12/05/2024 at 03:14 p.m. by MA A. 3. Record review of Resident #3's Administration Record, dated 12/06/2024, reflected Resident #3 was admitted on [DATE]. Resident #3 was noted to be [AGE] years old. Record review of Resident #3's Diagnosis Report, dated 12/06/2024, reflected Resident #3 was diagnosed with anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), schizoaffective disorder, bipolar type (a chronic mental illness involving symptoms of schizophrenia and bipolar disorder and characterized by symptoms such as delusions, hallucinations, depression, and high-energy mood), and rheumatoid arthritis (a chronic autoimmune disorder that typically results in warm, swollen, and painful joints). Record review of Resident #3's Quarterly MDS, dated [DATE], reflected Resident #3 had a BIMS score of 15, indicating she was cognitively intact. She was documented as having received a scheduled pain medication regimen. Her pain assessment noted that Resident #3 denied having had experienced pain over the last five (5) days. Record review of Resident #3's Order Audit Report, dated 12/06/2024, reflected Resident #3 was ordered Tylenol with Codeine #3 Tablet 300-30 mg (Acetaminophen-Codeine) on 10/29/2022. The order reflected to give 1 tablet by mouth three times a day for pain. The Supplementary Documentation Details noted the medication was scheduled to be administered at 0700 (07:00 a.m.), 1500 (03:00 p.m.), and 2100 (09:00 p.m.). Record review of Resident #3's Order Audit Report, dated 12/06/2024, reflected Resident #3 was ordered Diazepam Oral Tablet 2 mg (Diazepam) on 02/29/2024. The order reflected to give 1 tablet by mouth three times a day for schizoaffective disorder, depressive type gdr [gradual dose reduction] was on 2.5 [02/05/2024]. The Supplementary Documentation Details did not notate the medication schedule. During an observation of MA A administering medications on 12/05/2024, Resident #3's scheduled pain medication, Tylenol with Codeine #3 Tablet 300-30 mg, and scheduled anti-anxiety medication, Diazepam Oral Tablet 2 mg was observed to be administered on 12/05/2024 at 03:29 p.m. (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 Controlled Substance Administration Record for APAP/Codeine (Tylenol with Codeine #3) Tab 300-30 mg, reflected the medication was received by the facility on 11/24/2024. The record reflected on 12/05/2024, Resident #3 received 1 tablet of Tylenol with Codeine #3 at 1500 (03:00 p.m.). The record reflected the administration at 1500 on 12/05/2024 was administered by MA A. Record review of Resident #3's Controlled Substance Administration Record for Diazepam Tab (tablet) 2 mg, reflected the medication was received by the facility on 11/24/2024. The record reflected on 12/05/2024, Resident #3 received 1 tablet of Diazepam at 1500 (03:00 p.m.). The record reflected the administration at 1500 on 12/05/2024 was administered by MA A. Record review of Resident #3's MAR, dated as printed on 12/06/2024, reflected Resident #3 was administered her Tylenol with Codeine #3 Tablet 300-30 mg scheduled on 12/05/2024 at 1500 (03:00 p.m.) by MA A. The MAR reflected Resident #3 was administered her Diazepam Oral Tablet 2 mg scheduled on 12/05/2024 at 1500 (03:00 p.m.) by MA A. The MAR did not notate the times of administration. Record review of Resident #3's Medication Admin Audit Report, dated as accessed by the DON on 12/06/2024, reflected Resident #3 was administered her Tylenol with Codeine #3 Tablet 300-30 mg and her Diazepam Oral Tablet 2 mg scheduled on 12/05/2024 at 1500 (03:00 p.m.) on 12/05/2024 at 03:31 p.m. by MA A. During an interview on 12/06/2024 at 02:01 p.m., the DON stated the procedure for documenting a scheduled controlled medication would be to punch out the medication and immediately sign it out on the narcotics sheet (Controlled Substance Administration Record). He stated that the staff member would administer the medication and would then document in the eMAR (electronic Medication Administration Record) that the medication was given. He stated that for the narcotics sheet, the staff member would sign their name, document the amount given, the time the medication was given, and subtract the amount given to document a running total of the medication remaining. The DON stated for the time documented, the staff member should be putting the time that they are giving the medication. The DON stated the importance for documenting the time a medication was given would be that medications can only be given every so often and it would be nice to know exactly when a medication was given to ensure compliance. The DON stated that for scheduled medications, not having the exact time of administration would probably not impact the resident because the medications are scheduled with enough time between each administration to avoid non-compliance. The DON stated he had just started an in-service for the nurses and medication aides on 12/04/2024 regarding documentation of administration. The DON stated MA A was missing on the in-service document. During an interview on 12/06/2024 at 03:27 p.m., MA A stated he had not been trained on how to fill out the Controlled Substance Administration Records. He stated that he documented the date of administration, the time the medication was scheduled to be administrated, the count of the medication after subtracting the amount (number of tablets or capsules) he administered, and his signature. He stated the time that he enters on the record is the time the eMAR noted the medication was scheduled for. (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 an in-service titled Shift-to-Shift Narcotics Count and dated 12/04/2024, revealed the objective for the in-service: A shift-to-shift narcotics count must be performed during shift change. Both individuals must be able to visualize the card of meds & the count sheets. Both individuals (i.e. 2 nurses, or nurse & CMA) must sign the sheet at this time. Missing signatures are not acceptable & will lead to disciplinary action, up to & including termination. The card/bottle item count sheet must also be performed. Do not remove zeroed out cards, & meds that are for discharged residents. The DON/ADON are the only ones to remove these items. The in-service document was signed by 2 RNs, 6 LVNs, and 2 CMAs. MA A's signature was not on the in-service document. Record review of facility policy, Controlled Substances, dated revised November 2022, revealed: Policy Statement The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976). Policy Interpretation and Implementation Handling Controlled Substances . 4. If the count is correct, an individual resident controlled substance record is made for each resident who will be receiving a controlled substance .This record contains: . i. time of administration;.