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	03/09/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview and record review, the facility failed to ensure residents had the right to be free of misappropriation of resident property and exploitation for 2 of 4 residents (Resident #5 and Resident #6) reviewed for misappropriation and exploitation. The facility failed to ensure Resident #5 and Resident #6's pain medications were secured and not lost. These failures could place residents who received pain medications at risk of decreased quality of life, misappropriation of property and distress. The findings included: 1. Record review of Resident #5's face sheet dated 3/9/25 revealed an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included osteomyelitis (infection of the bone usually caused by bacteria that can cause pain, selling and redness throughout the affected area), peripheral vascular disease (condition in which the blood vessels become narrowed or blocked and affects the blood flow to the legs, feed and sometimes arms), diabetes with neuropathy (condition where high blood sugar levels cause nerve damage), pain in right foot, and chronic ulcer (a long-lasting open wound or sore that does not heal within a typical timeframe due to underlying health conditions, such as diabetes) of the right foot. Record review of Resident #5's most recent quarterly MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills, experienced pain occasionally, and received opioid medications. Record review of Resident #5's comprehensive care plan with revision dated 1/30/25 revealed the resident had acute/chronic pain related to surgical incision/wound with interventions that included to administer analgesics as ordered, anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Record review of Resident #5's MAR (Medication Administration Record) for February 2025 included the following: (continued on next page)

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- HYDROcodone-Acetaminophen Oral Tablet 10-325 MG, Give 1 tablet by mouth every 4 hours as needed for pain with start date 11/4/24 and no stop date. Further review of the MAR revealed the resident received one dose on 2/25/25 at 7:16 p.m. - Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen), Give 2 tablets by mouth every 6 hours as needed for Pain until Hydrocodone comes in, with start date 11/4/24 and no stop date. Further review of the MAR revealed did not receive any does of the Tylenol Extra Strength for the month of February. - MONITOR FOR PAIN EVERY SHIFT, USE 0-10 SCALE (A) FOR ALERT RESIDENTS USE PAIN AD (B) FOR CONFUSED RESIDENTS DOCUENT WHICH PAIN SCALE USED TO ASSESS RESIDENTS PAIN RATING, every shift with order date 2/5/25 and no stop date. Further review of the MAR revealed the resident scored a 0, indicating no pain recorded for every shift, except 2/24/25 with a score of 4 recorded on the evening shift, and 2/26/25-2/27/25 with a score of 3 recorded on the day shift. Record review of Resident #5's MAR for March 2025 included the following: - HYDROcodone-Acetaminophen Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen), Give 1 tablet by mouth every 4 hours as needed for pain with start date 11/4/24 and no end date. Further review of the MAR revealed the resident did not receive any doses of the HYDROcodone-Acetaminophen. - MONITOR FOR PAIN EVERY SHIFT, USE 0-10 SCALE (A) FOR ALERT RESIDENTS USE PAIN AD (B) FOR CONFUSED RESIDENTS DOCUENT WHICH PAIN SCALE USED TO ASSESS RESIDENTS PAIN RATING, every shift with start date 2/5/25 and no stop date. Further review of the MAR revealed the resident rated 0 for pain level during all three shifts for the month. -Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen), Give 2 tablet by mouth every 6 hours as needed for Pain until Hydrocodone comes in, with start date 11/4/24 and no end date. Further review of the MAR revealed the resident received the Tylenol Extra Strength on 3/5/25 at 12:00 a.m., and again on 3/6/25 at 12:27p.m. 2. Record review of Resident #6's face sheet dated 3/9/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (symptoms associated with a decline in memory, reasoning and other cognitive abilities severe enough to interfere with daily life), bipolar disorder (mental health condition characterized by extreme mood swings), primary osteoarthritis of knee (degenerative joint disease that affects the same joints on both sides of the body), and age-related osteoporosis (condition characterized by a gradual decrease in bone mineral density and mas leading to weakened bones that are more susceptible to fractures) without current pathological fracture. Record review of Resident #6's most recent quarterly MDS assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills and did not receive antipsychotic or opioid medications. Record review of Resident #6's comprehensive care plan with revision date 11/18/24 revealed the resident had osteoporosis with a history of fractures and interventions that included to give analgesics as needed for pain and medications as ordered. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #6's MAR for February 2025 included the following: - Tramadol HCL Oral Tablet 50 mg, Give 1 tablet by mouth every 6 hours as needed for pain, with start date 11/7/24 and no end date - HYDROcodone-Acetaminophen Oral Tablet 10-300 MG, Give 1 tablet by mouth every 6 hours as needed for pain with start dated 11/7/24 and discontinue date 2/14/25. Further review of the MAR revealed the resident was not given any HYDROcodone-Acetaminophen during that timeframe. - MONITOR FOR PAIN EVERY SHIFT, USE 0-10 SCALE (A) FOR ALEFT RESIDENTS USE PAIN AD (B) FOR CONFUSED RESIDENTS DOCUMENT WHICH PAIN SCALE USED TO ASSESS RESIDENTS PAIN RATING, every shift with start date 2/5/25 and no end date. Further review of the MAR revealed the resident rated a pain level of 6 on 2/19/25 during the day shift and was administered Tramadol 50 mg used as needed for pain. Record review of Resident #6's MAR for March 2025 included the following: - Tramadol HCL Oral Tablet 50 mg, Give 1 tablet by mouth every 6 hours as needed for pain, with start date 11/7/24 and no end date. Further review of the MAR revealed the resident did not receive any doses of Tramadol up until the investigation on 3/9/25. - MONITOR FOR PAIN EVERY SHIFT, USE 0-10 SCALE (A) FOR ALEFT RESIDENTS USE PAIN AD (B) FOR CONFUSED RESIDENTS DOCUMENT WHICH PAIN SCALE USED TO ASSESS RESIDENTS PAIN RATING, every shift with start date 2/5/25 and no end date. Further review of the MAR revealed the resident rated a pain level of 0 from 3/1/25 up until the investigation on 3/9/25. Record review of the facility provider investigation report written by the facility Administrator, dated 3/12/25 revealed in part, .Staff member reported suspicion of missing narcotics to the DON .Provider Response: Investigation initiated immediately .6 individuals (RN D, RN G, LVN H, LVN K, LVN L and LVN M) were identified to have come in contact during the period that medication went missing, and were sent for UA's [urinalysis] to screen for opioids all with negative findings .In investigation we have found that 208 Norco 10/325 mg tablets, and 15 Phenobarbital Tablets were diverted . (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint interview on 3/8/25 at 9:31 a.m., the Administrator and the DON revealed they were trying to put a timeline together regarding a possible drug diversion. The DON stated he had received a phone call on 3/4/25 at approximately 11:26 p.m. from RN G regarding suspicion of a drug diversion. The DON stated, RN G informed him a blister pack of narcotics belonging to Resident #5 was not in the medication cart that RN G had seen the previous evening. The DON stated the missing blister pack was Resident #5's HYDROcodone-Acetaminophen. The DON stated, RN G assumed responsibility for the medication cart from RN D for two consecutive shifts, 3/3/25 and 3/4/25. The DON stated the facility operated on three shifts, and acknowledged RN D had worked two double shifts on 3/3/25 and 3/4/25 and on both shifts handed over the medication cart to RN G. The Administrator stated an investigation was initiated the following morning on 3/5/25 and it was determined there were 30 doses of HYDROcodone-Acetaminophen missing for Resident #5. After further investigation, the DON stated, he did a look back of the staff who were responsible for the medication cart identified with Resident #5's missing HYDROcodone-Acetaminophen. The DON stated, RN D, RN G, LVN H, LVN K, LVN L and LVN M were identified having worked from the medication cart with Resident #5's medications and had them drug tested . The Administrator stated the police were notified and a police report was completed. The Administrator and the DON acknowledged the missing HYDROcodone-Acetaminophen that belonged to Resident #5 was never found. The DON stated he further expanded his investigation to include narcotics delivered to the facility for February 2025. The DON acknowledged there were additional narcotics the facility could not account for Resident #6. The DON stated, he determined there were 118 doses of HYDROcodone-Acetaminophen missing for Resident #6. The DON further stated 15 doses of phenobarbital could not be accounted for out of 45 doses delivered on 2/12/25. The DON and Administrator acknowledged the HYDROcodone-Acetaminophen missing for Resident #6 and the phenobarbital doses were never found. The Administrator and the DON stated Resident #5 and Resident #6's narcotics were replaced at no cost to the resident and if the residents had complained of pain, HYDROcodone-Acetaminophen doses were available in the emergency kit if the resident required it. The DON and the Administrator stated they believed RN D was responsible for the drug diversion associated with Resident #5's medications and LVN F was responsible for Resident #6's missing medications. During an observation and interview on 3/8/25 at 11:49 a.m., Resident #5 stated he received pain medications and did not recall having been told by facility staff he did not have any pain medications available. Resident #5 was observed with a bandage on the right lower foot. Resident #5 further stated he asked for pain medication, maybe once or twice and received them pretty quick. During an observation and interview on 3/8/25 at 12:43 p.m., Resident #6 was seen sitting up in the dining room eating lunch without assistance. Resident #6 did not appear to be in any obvious distress or discomfort but was unable to answer any questions. During a telephone interview on 3/8/25 at 1:06 p.m., RN G stated he reported to the DON a possible drug diversion on 3/4/25 at approximately 11:00 p.m. RN G stated he made rounds and was in the process of providing wound care to Resident #5 and asked the resident if he wanted anything for pain. RN G stated Resident #5 was given a choice of HYDROcodone-Acetaminophen or regular acetaminophen. RN G stated Resident #5 asked for the HYDROcodone-Acetaminophen but was unsure if the medication had been discontinued since it had been a while since he (Resident #5) had gotten it. RN G stated, when he returned to the medication cart to retrieve it, there was none in the cart. RN G stated Resident #5 approved taking regular acetaminophen. RN G stated, I know he (Resident #5) had that medication. On Tuesday morning (3/4/25), it was just me and RN D had been working the unit three days in a row. RN G stated, he believed Resident #5's HYDROcodone-Acetaminophen had been discontinued but not until I needed it I realized something was off. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 3/8/25 at 1:45 p.m., LVN F stated she had worked for the facility for approximately a month and self-terminated. LVN F stated she was not working at the facility on 2/17/25 during the time the facility determined a drug diversion. LVN F stated she did not recall ever having given Resident #6 any medications. During a follow up telephone interview on 3/9/25 at 10:05 a.m., LVN F stated she recalled signing for delivered medications, including narcotics, and would have signed for the shipment from the pharmacy driver via an electronic signature. LVN F stated, the medications delivered were verified by a second nurse and both nurses would then have to sign the narcotic log associated with the medication, place the narcotic log in the binder and put the narcotic medications in the medication cart. LVN F denied taking any medications, including narcotics while employed at the facility. During a telephone interview on 3/9/25 at 4:12 p.m., RN D acknowledged she worked double shifts on 3/3/25 and 3/4/25 and did a medication narcotic count with RN G at the end of the shift. RN D stated, I have not had medications missing, but I have heard of other carts missing medications. During a follow up telephone interview on 3/9/25 at 4:43 p.m., RN D stated she had not given Resident #5 any pain medications, and the resident asked for them few and far between. RN D stated Resident #5 had HYDROcodone-Acetaminophen scheduled as needed and had been trying to have the medication placed on a schedule instead of as needed when the residents used to complain of pain but then I backed off. RN D stated she was not aware of a discrepancy with Resident #5's medications. RN D further stated, If the (narcotic) count was off, I would not accept it and call the DON. That has never happened to me. RN D denied taking any medications, including narcotics from residents at the facility. Record review of the e-mail received on 3/12/25 at 3:34 p.m. from the Administrator revealed the drug test results for RN D, RN G, LVN H, LVN K, LVN L and LVN M were negative. Record review of the facility policy and procedure provided by the Administrator, titled Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility (NF) Must Report to the Health and Human Services Commission (HHSC), dated 8/29/24 revealed in part, .2.1 Incidents that a NF Must Report to HHSC .Misappropriation .Drug Theft .HHSC rules define misappropriation as, 'the taking, secretion, misapplication, deprivation, transfer, or attempted transfer to any person not entitled to receive property, real, or personal, or anything of value belonging to or under the legal control of a resident without the effective consent of the resident or other appropriate legal authority, or the taking of any action contrary to any duty imposed by federal or state law prescribing conduct relating to the custody or disposition of property of a resident .CMS defines misappropriation of resident property as, 'the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent' .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47622 Based on interview and record review the facility failed to ensure all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, to other officials (including to the State Survey Agency in accordance with State law through established procedures) for 2 of 2 residents (Resident #3 and Resident #4) reviewed for Freedom from Abuse, Neglect, and Exploitation: The facility failed to report to the state survey agency Resident #4 hit Resident #3 on the head on 9/27/2024. This failure could place residents at risk for abuse, diminished quality of life, physical, and psychosocial harm. The findings were: Record review of Resident #3's face sheet dated 03/07/2025 revealed a [AGE] year-old male admitted to the facility 08/30/2024 with diagnoses that included: dementia, hypertension, and major depression disorder. Record review of Resident #3's QMDS dated [DATE] revealed a BIMS score of 2- indicative of a severe cognitive impairment. Record review of Resident's Care Plan dated 01/08/2025 revealed he had potential behaviors of physical and verbal aggression, wandering and exit seeking, and anti-depressant medication. Record review of Resident #4's face sheet dated 03/05/2025 revealed a [AGE] year-old male admitted to the facility o 09/24/2024 with diagnoses that included: acute kidney failure, left great toe amputation, hypertension, dementia with psychotic disturbance, mood disturbance, and anxiety. Record review of Resident #4's Admission MDS dated [DATE] revealed a BIMS score of 3- indicative of severe cognitive impairment. Record review of Resident #4's Care Plan dated 09/26/2024 revealed he had impaired thought process, behavior with dementia with wandering, physical and verbal aggression, left great toe amputation with infection. During an interview on 3/6/2025 at 12:46PM LVN B was on the secured unit when Resident #4 had the emergency detention (a person discharged to a hospital with behaviors deemed to be harmful to self or others) on 9/27/2024. LVN B said earlier that morning, he hit his roommate in the head, but Resident #3 had no injuries and was moved to another room and just wanted to go back to sleep. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/7/2025 at 11:37AM the DON said from his understanding that 2 residents with a low BIMS score and there was no injury, then it was not reportable but if there was serious injury, then it would be reportable. He said because both residents assessed Resident #3 from head to toe and assessed his psychosocial well-being. and found no harm, The DON said Resident #3 told him he was fine and for him to turn off the light, he wanted to go back to sleep and that guy (Resident #4) was crazy. The Administrator agreed that it was not necessary to report the allegation of abuse between the residents to the state survey agency. Record review of the facility's policy titled Abuse, Neglect, Exploitation not dated stated, in part: Residents have the right to be free from abuse, neglect; Identify and investigate all possible incidents of abuse . Reporting of abuse should be done within 2 hours after the incident or allegation of abuse.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564 Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 2 of 4 residents (Resident #1 and #2) reviewed for accidents and supervision. 1. The facility failed to ensure Resident #1 did not elope from the facility without staff knowing on the evening of 09/24/2024. The noncompliance was identified as PNC . The IJ began on 9/24/2024 and ended on 9/25/2024. The facility had corrected the noncompliance before the survey began. 2. CNA A transferred Resident #2 from the bed to the resident's wheelchair without using a lift on 08/15/2024. It caused Resident #2's toenail to catch on the floor, injuring her nailbed and removing her whole toenail on her left great toe. The noncompliance was identified as PNC. The noncompliance began on 08/15/2024 and ended on 08/16/2024. The facility had corrected the noncompliance before the survey began This deficient practice could place residents at-risk of harm, serious injury, or death. The findings included: 1. Record review of Resident #1's admission record, 03/07/2025, reflected that Resident #1 was a [AGE] year-old male initially admitted on [DATE], with diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), and type 2 diabetes (long-term condition in which the body has trouble controlling blood sugar and using it for energy). Record review of Resident #1's quarterly MDS assessment, dated 09/20/2024, reflected that Resident #1 had a BIMS score of 2, indicating severely impaired cognition. The MDS assessment further reflected that wandering behavior was not exhibited by Resident #1. Record review of Resident #1's Wandering Assessment with a completion date of 09/06/2024 reflected him to be ambulatory without a history of wandering and a score of 9, indicating the resident was At Risk to Wander. Record review of Resident #1's wandering risk scale assessment dated [DATE] reflected that the resident had no history of wandering. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's nursing note, dated 9/24/2024 at 6:25 PM, reflected, Resident observed by this writer walking with walker toward Exit. Name called multiple time. Resident keep walking [sic]. CNA came out of room right beside exit door at same time resident attempted to push door open. This writer was headed that way. This writer asked CNA to ask resident if he was in pain - Resident did say yes. At [6:05 PM] Pain medication given per PRN order. Resident was redirected away from exit. Went walking down the hall. Record review of Facility Provider Investigation Report, undated, reflected that on 09/24/2024 around 6:45 PM, Resident #1 was found approximately .2 miles from the facility in a parking lot down the street by the Admissions Coordinator, who put the resident in his vehicle after completing a quick assessment for injuries and brought him back to the facility. The Provider Investigation Report further reflected that through investigation, it was determined that Resident #1 had likely exited through the front door after being let out by an unknown visitor to the facility. Interview on 03/04/2025 at 1:45 PM, Admissions Coordinator stated he was on his way home from working at the facility when he saw the resident on the corner of an intersection approximately .2 miles from the front door of the facility. Interview on 03/04/2025 at 2:15 PM, LVN C stated that Resident #1 was attempting to leave through a fire door on A Hall, and after providing him pain medication and dinner it seemed as though he had calmed down and was not wandering anymore. LVN C stated she did the assessment after the resident came back after the elopement event and had worked with him prior to the event. LVN C stated she did not see him ever attempt elopement before and that the resident did not wander any more than the average resident prior to the event. Interview on 03/04/2025 at 2:36 PM, the DON stated Resident #1 was not an elopement risk prior to this incident. The DON stated in-servicing had been completed after the incident on elopement. Interview on 03/04/2025 at 2:40 PM, the Regional Corporate Nurse stated that there had not been an elopement at the facility since the incident. Interview on 03/04/2025 at 3:00 PM, the ADM stated he was not working at the facility at the time of the incident, and that he began as Administrator of the facility in December of 2024. The Administrator was notified on 03/05/2024 at 5:25 PM, a past non-compliance IJ situation had been identified due to the above failure. The facility implemented the following interventions. Record review of Resident #1's Care Plan, undated, reflected that the facility enhanced Resident #1's to include transferred to memory care unit 9/24/2024 d/t elopement from facility with interventions to include monitoring wandering patterns and document wandering behavior and attempted diversional interventions in behavior log. Further record review of the facilities provider investigation report reflected that after the incident, the facility reported the incident to the state, implemented frequent monitoring, updated the resident's care plan, and moved the resident to the secured unit in the building with family/RP consent due to wandering behaviors and elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of in-service training documentation, dated 09/25/2024, reflected that 100% of facility staff were in-serviced on elopement, wandering, and responding to alarming doors. All new hires are also in serviced as part of the new hire onboarding process. 10% of staff were interviewed on in-servicing on elopements. Record review of facility Incidents and Accidents report, dated encompassing 03/04/2024 through 03/04/2025 reflected that no other resident had eloped apart from the incident on 09/24/2024. Interview with DON on 03/04/2024 at 2:36 PM, stated everyone's wandering assessments were reviewed to ensure accuracy and stated they have a receptionist at the front door until 5:00 pm and at 5:00 pm the doors automatically lock and staff has to open it for anyone to get in or out and staff were educated on ensuring residents aren't following anyone out of the door. The DON stated that no other resident had eloped prior to or since the incident with Resident #1 on 09/24/2024. Observation on 03/04/2024 at 2:45 PM near the entrance to the facility revealed a sign informing guests not to open the door for anyone outside of their party. Interview on 03/05/2025 at 10:47 AM, RN D stated she is not familiar with the incident but was trained on elopement at the time of hire and has been in-serviced on wandering and elopement since the incident in September of 2024. RN D stated if she saw a resident exhibiting exit seeking behaviors, she would redirect the resident and inform her ADON and/or DON. Interview on 03/05/2024 at 11:24 AM, LVN E stated she had been in-serviced on elopements and wandering after the incident with Resident #1 in September of 2024. LVN E stated that if a resident's wandering behaviors or exit seeking behaviors change from their baseline to inform the ADON or DON and begin more frequent visual checks on the resident. Interview on 03/07/2025 at 10:44 AM, CNA F stated she had been trained on wandering and elopements, particularly after the incident with Resident #1 in September of 2024. CNA F stated that if she saw a resident attempting to leave the facility through any door she would redirect the resident and inform the charge nurse and/or ADON of the behavior of the resident. Facility policy titled, Wandering and Elopements, dated revised March 2022, reflected, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. The Facility Wandering and Elopements Policy then detailed the procedures for identifying residents at risk for elopement, locating a missing resident, and procedure for post-elopement. The noncompliance was identified as PNC . The IJ began on 9/24/2024 and ended on 9/25/2024. The facility had corrected the noncompliance before the survey began 2. Record review of Resident #2's face sheet, dated 03/07/2025, reflected the resident was an [AGE] year-old female and originally admitted to the facility on [DATE] with diagnosis of Alzheimer's disease (destroy memory and thinking skills), type 2 diabetes mellitus (not control blood sugar levels), and heart failure. (continued on next page)

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	03/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #2's quarterly MDS, dated [DATE], reflected the resident's BIMS score was 0 out of 15, which indicated the resident had severe cognitive impairment. Further record review of the MDS revealed the resident was dependent (helper does ALL the effort) sit to lying, bed-to-chair transfer, and tub/shower transfer, and that the resident was not physically able to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed, toilet transfer, or walk 10 feet. Record review of Resident #2's care plan, dated 03/07/2025, reflected Resident #2, requires substantial/dependent assistance by staff to move between surfaces. Assist x 2 with hoyer. with an initiated date of 08/12/2024. Record review of the Facility Provider Investigation Report, dated 08/20/2024, reflected that at approximately 11:00 AM on 08/15/2024, CNA A transferred Resident #2 without a hoyer lift, by himself, by holding the resident under her arms and moving her. During this transfer, Resident #2 sustained an injury to her left foot. Record review of Resident #2's progress note on 08/15/2024 at 11:29 AM reflected, Acetaminophen tablet 500MG given for pain, pain due to left big toe injury results pending further review of progress note reflects that on 08/15/2024 at 1:30 PM an assessment was completed and Resident #2's left big toenail was lifted and bleeding, and there was redness to her hips and ribs. Record review of Resident #2's incident report, dated 8/15/2024 at 1:30 PM reflected that the resident had bleeding to left great toe, which was injured during a transfer, and PRN pain medication was provided. Record review of the facility in-service training report, dated 08/16/2025, reflected the facility provided in-services to all nursing and maintenance staff regarding Transfer Status to include how to find each residents inidvidual transfer status and how to appropriately transfer residents. Interview on 03/05/2025 at 10:47 AM, RN D stated she was trained on transfer status and is familiar with different residents need for different transfer status, to include rechecking transfer status for change in condition. RN D stated staff are frequently observed for competencies on transferring residents appropriately. Interview on 03/05/2024 at 11:24 AM, LVN E stated she had been in-serviced on transfer status and ensuring residents are appropriately transferred based on their plan of care. Interview on 03/07/2025 at 10:44 AM, CNA F stated she had been trained on transfer status and how to find what type of transfer a resident needs. CNA F was able to show the surveyors how to find out a residents transfer status in the EHR of the resident and was able to describe the procedure of different types of transfers to include hoyer transfers. Record review of staff competencies reviewed on transfer status after the incident reflected no concerns with competencies. Record review of the CNA A's employee profile reflected the facility terminated CNA A's employment on 08/15/2024. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Podiatry Visit Notes, dated 08/16/2024, reflected that the podiatrist saw Resident #2 the day after the incident occurred and removed her left big toenail, which was no longer connected to the toe. Observation of transfer on 03/05/2025 at 10:30 AM reflected no concerns for the hoyer transfer of Resident #7 observed. Hoyer transfer was observed with 2 staff members operating the hoyer lift and no injuries to the resident as a result. Record review of Resident #7's Care Plan reflected that Resident #7 needed to be assisted with transfers with 2 staff members using a hoyer lift. Interview on 03/05/2025 at 3:00 PM, the ADM stated he was not working at the facility at the time of the incident, and that he began as Administrator of the facility in December of 2024. Interview on 03/05/2025 at 5:00 PM, with the DON and RNC, the DON stated CNA A had not reported the injury to the nurse, and the family had informed the nurse of the injury when they noticed it within minutes of the injury occurring. The DON stated he believes CNA A did not realize there was an injury but did not know why he would have the resident sit on the edge of the bed to dress her. The DON stated Resident #2 saw podiatry the next morning with no concerns. The DON stated the expectation is that staff transfer residents as is appropriate and on the resident's plan of care. The DON stated the risk to residents could include injury for not being appropriately transferred . The noncompliance was identified as PNC. The noncompliance began on 08/15/2024 and ended on 08/16/2024. The facility had corrected the noncompliance before the survey began

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 of 5 residents (Resident #5 and #6) reviewed for pharmacy services. 1. The facility failed to ensure Resident #5's pain medications were acquired and dispensed per physician's orders. 2. The facility failed to ensure Resident #6's pain medications were acquired and dispensed per physician's orders. This failure could place residents at risk of not receiving their prescribed medications and a decreased quality of life. The findings included: Record review of the facility provider investigation report written by the facility administrator, dated 3/6/25, reflected: A drug diversion has been identified. Review of the facility provider investigation report revealed a medication audit identified Resident #5 and Resident #6 had narcotic medications missing. The report further revealed the residents were assessed for pain with no deviation from baseline noted, no missing doses were noted, and back up medication was used from the facility emergency kit. The facility identified 6 nursing staff responsible for medications administered to Resident #5 and Resident #6 (RN D, RN G, LVN H, LVN K, LVN L and LVN M). 1. Record review of Resident #5's face sheet dated 3/9/25 revealed an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included osteomyelitis (infection of the bone usually caused by bacteria that can cause pain, selling and redness throughout the affected area), peripheral vascular disease (condition in which the blood vessels become narrowed or blocked and affects the blood flow to the legs, feed and sometimes arms), diabetes with neuropathy (condition where high blood sugar levels cause nerve damage), pain in right foot, and chronic ulcer (a long-lasting open wound or sore that does not heal within a typical timeframe due to underlying health conditions, such as diabetes) of the right foot. Record review of Resident #5's most recent quarterly MDS assessment dated [DATE] revealed the resident was moderately cognitively intact for daily decision-making skills, experienced pain occasionally, and received opioid medications. Record review of Resident #5's comprehensive care plan with revision dated 1/30/25 revealed the resident had acute/chronic pain related to surgical incision/wound with interventions that included to administer analgesics as ordered, anticipate the resident's need for pain relief and respond immediately to any complaint of pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #5's MAR (Medication Administration Record) for February 2025 included the following: - HYDROcodone-Acetaminophen Oral Tablet 10-325 MG, Give 1 tablet by mouth every 4 hours as needed for pain with start date 11/4/24 and no stop date. Further review of the MAR revealed the resident received one dose on 2/25/25 at 7:16 p.m. - Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen), Give 2 tablets by mouth every 6 hours as needed for Pain until Hydrocodone comes in, with start date 11/4/24 and no stop date. Further review of the MAR revealed did not receive any does of the Tylenol Extra Strength for the month of February. - MONITOR FOR PAIN EVERY SHIFT, USE 0-10 SCALE (A) FOR ALERT RESIDENTS USE PAIN AD (B) FOR CONFUSED RESIDENTS DOCUENT WHICH PAIN SCALE USED TO ASSESS RESIDENTS PAIN RATING, every shift with order date 2/5/25 and no stop date. Further review of the MAR revealed the resident scored a 0, indicating no pain recorded for every shift, except 2/24/25 with a score of 4 recorded on the evening shift, and 2/26/25-2/27/25 with a score of 3 recorded on the day shift. Record review of Resident #5's MAR for March 2025 included the following: - HYDROcodone-Acetaminophen Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen), Give 1 tablet by mouth every 4 hours as needed for pain with start date 11/4/24 and no end date. Further review of the MAR revealed the resident did not receive any doses of the HYDROcodone-Acetaminophen. - MONITOR FOR PAIN EVERY SHIFT, USE 0-10 SCALE (A) FOR ALERT RESIDENTS USE PAIN AD (B) FOR CONFUSED RESIDENTS DOCUENT WHICH PAIN SCALE USED TO ASSESS RESIDENTS PAIN RATING, every shift with start date 2/5/25 and no stop date. Further review of the MAR revealed the resident rated 0 for pain level during all three shifts for the month. -Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen), Give 2 tablet by mouth every 6 hours as needed for Pain until Hydrocodone comes in, with start date 11/4/24 and no end date. Further review of the MAR revealed the resident received the Tylenol Extra Strength on 3/5/25 at 12:00 a.m., and again on 3/6/25 at 12:27p.m. 2. Record review of Resident #6's face sheet dated 3/9/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (symptoms associated with a decline in memory, reasoning and other cognitive abilities severe enough to interfere with daily life), bipolar disorder (mental health condition characterized by extreme mood swings), primary osteoarthritis of knee (degenerative joint disease that affects the same joints on both sides of the body), and age-related osteoporosis (condition characterized by a gradual decrease in bone mineral density and mas leading to weakened bones that are more susceptible to fractures) without current pathological fracture. Record review of Resident #6's most recent quarterly MDS assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills and did not receive antipsychotic or opioid medications. (continued on next page)

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	455824	A. Building B. Wing	03/09/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #6's comprehensive care plan with revision date 11/18/24 revealed the resident had osteoporosis with a history of fractures and interventions that included to give analgesics as needed for pain and medications as ordered. Record review of Resident #6's MAR for February 2025 included the following: - Tramadol HCL Oral Tablet 50 mg, Give 1 tablet by mouth every 6 hours as needed for pain, with start date 11/7/24 and no end date - HYDROcodone-Acetaminophen Oral Tablet 10-300 MG, Give 1 tablet by mouth every 6 hours as needed for pain with start dated 11/7/24 and discontinue date 2/14/25. Further review of the MAR revealed the resident was not given any HYDROcodone-Acetaminophen during that timeframe. - MONITOR FOR PAIN EVERY SHIFT, USE 0-10 SCALE (A) FOR ALEFT RESIDENTS USE PAIN AD (B) FOR CONFUSED RESIDENTS DOCUMENT WHICH PAIN SCALE USED TO ASSESS RESIDENTS PAIN RATING, every shift with start date 2/5/25 and no end date. Further review of the MAR revealed the resident rated a pain level of 6 on 2/19/25 during the day shift and was administered Tramadol 50 mg used as needed for pain. Record review of Resident #6's MAR for March 2025 included the following: - Tramadol HCL Oral Tablet 50 mg, Give 1 tablet by mouth every 6 hours as needed for pain, with start date 11/7/24 and no end date. Further review of the MAR revealed the resident did not receive any doses of Tramadol up until the investigation on 3/9/25. - MONITOR FOR PAIN EVERY SHIFT, USE 0-10 SCALE (A) FOR ALEFT RESIDENTS USE PAIN AD (B) FOR CONFUSED RESIDENTS DOCUMENT WHICH PAIN SCALE USED TO ASSESS RESIDENTS PAIN RATING, every shift with start date 2/5/25 and no end date. Further review of the MAR revealed the resident rated a pain level of 0 from 3/1/25 up until the investigation on 3/9/25. During an interview on 3/8/25 at 8:26 a.m., RN I stated the process for avoiding a drug diversion required for nursing staff to count the narcotics in the medication cart with the next shift to ensure the medications were accounted for. RN I further stated, if there was a discrepancy with the narcotic count, the incoming nurse would not accept the keys to the medication cart and report to the DON for an investigation. RN I stated, a (narcotic) count is done every time (at shift change). During an interview on 3/8/25 at 9:05 a.m., Med Aide J stated, the process for avoiding a drug diversion required for the nursing staff to count the narcotics in the medication cart with the next shift to ensure the medications were accounted for. Med Aide J stated, I would never accept the keys (to the medication cart) from somebody who did not count (narcotics) with me, you never know what they did. Not acceptable. Med Aide J stated she was not allowed to given pain medications when needed because only a nurse can make the assessment but was allowed to administer scheduled pain medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/8/25 at 9:31 a.m., the DON stated, our policy, when narcotics are delivered, two nurses must sign for it (the narcotic delivery). The DON further stated, the delivery sheet/manifest (a detailed list of the items delivered) had to be signed by two nurses and then the delivery sheet/manifest would be filed in the medical records box after the medications were received. The DON acknowledged the facility identified a drug diversion on 3/5/25 in which Resident #5's and Resident #6's pain medications for HYDROcodone-Acetaminophen were missing from the medication cart. The DON acknowledged the facility did not have a process for checking to ensure the delivery sheet/manifest had two nurse signatures. During an interview on 3/8/25 at 1:06 p.m., RN G stated the facility policy, when receiving medication deliveries, including narcotics, was for two nurses to sign the delivery sheet/manifest, place the narcotic log associated with the medication prescribed to the resident in the narcotic log, and place the medications in the medication cart. RN G further stated the delivery sheet/manifest was filed in a folder that used to be at the nurse's station. RN G stated the file for the delivery sheet/manifest had been gone for a while and (the delivery sheet/manifest) have been going to the shredder. I can't say if that was a good idea. RN G stated, the DON had only been employed since last year, so it's not like everybody has been doing that (checking for the delivery sheet/manifest), we used to file all that stuff, but then they (the file) disappeared. During a telephone interview on 3/8/25 at 1:45 p.m., LVN F stated protocol for accepting a medication delivery, including narcotics would be to sign for the delivery on the pharmacy delivery driver's phone and then she would sign the delivery sheet/manifest. LVN F stated, the delivery sheet/manifest were supposed to be filed and it was a reference to show the medications were delivered. LVN F stated, the narcotic log once completed or the delivery sheet/manifest were never placed in the shredder, that is not protocol. During an interview on 3/8/25 at 2:00 p.m., LVN H stated, once the pharmacy delivered medications, including narcotics, the receiving nurse signed electronically for the delivery on the pharmacy delivery driver's phone, and then the delivery sheet/manifest was supposed to be signed by two nurses confirming the order of medication was received. LVN H stated, the delivery sheet/manifest was filed in a binder that was at the nurse's station. LVN H stated, we have always had that binder, it has never gone away. LVN H stated, then the narcotic log was supposed to be signed by two nurses and placed in the narcotic log and the medication was stored in the locked box in the medication cart. LVN H stated it was not acceptable for one person to sign the narcotic sheet because a second person was needed to witness the medication was received. LVN H stated, once the narcotic log was zeroed out (completed) and the narcotic log was marked zero, I would take the narcotic log and place it in the medical records box and then throw the empty med card/blister pack away but tear the resident's information and put in the shredder and the empty blister pack was thrown in the trash. LVN H further stated, I would say the packing slips (delivery sheet/manifest) need to be saved, but the pharmacy has proof when we signed their phone that the product was delivered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/8/25 at 3:44 p.m., the ADON stated it was facility protocol, when the pharmacy delivered medications, including narcotics, the delivery sheet/manifest was supposed to be signed by one nurse for regular medications and two nurses for the narcotics. The ADON stated, once the delivery sheet/manifest was signed by two nurses, it was supposed to be delivered to the ADON to audit for signatures. The ADON stated, we do know we lost medications. I think part of the failure of the process was when the nurses stopped being accountable for the packing slips. But when you are no longer held accountable for what you receive that could be a very big problem. If the resident did not receive their medications when they needed them because they were unavailable their pain could not have been controlled and that is a serious problem. During a telephone interview on 3/9/25 at 4:12 p.m., RN D stated, protocol for receiving medications, including narcotics were for the nurse receiving the medications to electronically sign for them on the pharmacy driver's phone. RN D stated, then the medication packets were opened, check what was delivered and then double check the delivery with a second nurse. RN D stated the count sheets (narcotic logs) were supposed to be signed by two nurses and placed in the narcotic log with the medication cart and place the narcotics in the lock box inside the medication cart. RN D stated she typically took the delivery sheet/manifest and placed it in the shred box. RN D stated, I was never told what to do with it (the delivery sheet/manifest) so I just put it in the shred box, whether it was a narcotic or regular medication. I've never worked like that before, so it was pretty much I didn't know what to do with it, had never been told what to do with it and just put it in the shredder box. Once the count sheets are zeroed out, we wrap the empty blister pack with the zeroed-out count sheet and put it back in the cart. Record review of the facility policy and procedure titled Policies and Procedures for Pharmacy Services, undated revealed in part, .Delivery, Receipt and Storage of Medication .Upon delivery by the pharmacy, the facility nurse or designee will sign the electronic delivery receipt device and assume responsibility for the receipt, proper storage, and distribution of the medications .The facility staff should notify the pharmacy immediately of any discrepancy of the medications received (damage, erroneous, or missing items) .The pharmacy will send scheduled medications sign off of sheets for each scheduled medication. The scheduled medication inventory sheet should be completed for each dose administration. The scheduled medication inventory sheet should be archived upon completion of the medication supply .Drug Diversion .The facility will comply with all federal, state, and local laws as it pertains to controlled substances .The facility must have a system that records receipt, usage, and disposition of all controlled substances in sufficient detail that permits for an accurate reconciliation .