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	05/16/2025

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 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** 34957 Based on interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, are reported immediately but no later than 2 hours after the allegation is made, for 1 of 6 Residents (Resident #1), reviewed for freedom of abuse. The facility did not report to local law enforcement an allegation of sexual abuse involving Resident #1 by a CNA. This failure could result in law enforcement not investigating an allegation of sexual abuse and subjecting residents to other acts of sexual abuse, psychosocial and physical harm, and a diminished quality of life. The findings included: Record review of Resident #1's face sheet, dated 5/14/25, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: dementia (a decline in mental ability), Alzheimer's disease (a progressive disease that destroys memory and other mental functions), and cognitive deficits (difficulties in memory, thinking, and decision making). The RP was listed as: two family members. Record review of Resident#1's quarterly MDS assessment, dated 2/14/25, reflected: BIMS score was 01, which indicated severe impairment in cognition. In the area of toileting (incontinent care) the resident required moderate to extensive assistance by one staff because the resident was incontinent of bowel and bladder. The resident also required moderate assistance in transfer by one staff member. The resident's assistive devise was a wheelchair. Record review of R#1's Hospital Report dated 5/13/25 at 5:52 PM reflected: the RP and a family member alleged sexual abuse of the resident by an unknown provider in the facility. The nature of the sexual abuse was that the resident's breast and vaginal were touched by a CNA. Findings by the hospital were: neck pain, acute pain of left shoulder, history of dementia, and prophylactic for an STD [no finding of sexual abuse]. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of R#1's Police Report dated 5/13/25 at 9:02 PM filed by a community representative reflected, Officer # 1785 responded to an indecent assault report made by the RP and a family member. The case was referred to CID Detective #2364. Record review of Resident #1's Incident Law Enforcement Report was filed by the facility on 5/15/25 at 8:25 PM [after surveyor inquired of the Administrator on 5/14/25 was law enforcement contacted about the alleged sexual abuse of Resident #1]. Record review of facility's internal investigation file dated 5/13/25 reflected: No law enforcement case number. During joint interview with the Administrator and DON on 5/14/25 at 11:15 AM, the Administrator stated the facility made a self-report on 5/13/25 to HHS. The Administrator stated, Resident #1's RP alleged that an agency CNA [A] inappropriately trounced, in the peri-area, of Resident #1, when providing incontinent care on 5/11/25. The Administrator stated, the interventions put in place included: Resident #1 sent to ER for an assessment; and returned 5/14/25 with no negative findings. The Administrator stated the agency CNA [A] was suspended; and in-service started on ANE; and internal investigation initiated. The DON stated that Resident #1 experienced no psychosocial harm and there was no signs and symptoms of sexual abuse. The DON stated, Resident #1 had not withdrawn from activities, accepted treatment, and services, and smiled this morning [5/14/25]. Both the Administrator and the DON stated that law enforcement was not contacted when the initial allegation of sexual abuse was made on 5/13/25 and not immediately contacted when Resident #1's hospital discharge record dated 5/14/25 documented an assessment for an alleged incident of sexual abuse. During an interview on 5/14/25 at 2:00 PM, the Hospital Nurse stated, Resident #1 did not have the capacity to consent to sexual contact. The Hospital Nurse stated, during the assessment (5/13/25), Resident #1 had redness in the genital (vaginal) area and the resident became tense during the assessment; and the assessment was not fully completed. The Hospital Nurse stated the resident was given a prophylactic medication to treat any STD. The Hospital Nurse stated the expectation was when there was an allegation of sexual abuse law enforcement had to be contacted. During an interview on 5/14/25 at 4:05 PM, Admission Supervisor stated: he did not know whether law enforcement was called at the time of the incident or when the grievance was filed on 5/13/25. During an interview on 5/14/25 at 4:41 PM, the SW stated: she did not know whether the Administrator, when alerted on 5/13/25 around 1:30 PM about an alleged abuse of Resident #1 by a CNA [A], called law enforcement. During telephone interview, in Spanish, on 5/14/25 at 3:00 PM the RP stated, the alleged incident of abuse occurred on 5/11/25 around 10:00 PM. The RP stated he alerted the facility on 5/13/25 in the early afternoon and expected that Resident #1 was sent to the ER for an evaluation and law enforcement notified of a possible physical or sexual abuse. The RP stated that Resident #1 alleged the incident of sexual abuse. During telephone interview on 5/15/25 at 9:41 AM, LVN E stated the procedure the facility should follow when there was an allegation of abuse, either physical or sexual, was: immediate assessment of the resident, notification to the MD and RP, call to law enforcement, and call to EMS. (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 5/15/25 at 11:06 AM, LVN H, stated she attended ANE training and the message for staff was to report immediately and contact to the Abuse Coordinator. LVN H stated the contacting of law enforcement for any allegations of abuse was the purview of the Administrator who was the Abuse Coordinator. During a telephone call on 5/15/25 at 11:42 AM, the MD stated he was notified of an alleged sexual abuse incident involving Resident #1 and that the family wanted the resident sent to the ER for an assessment on 5/13/25. The MD stated he had seen the resident the prior week and she was clinical normal; no distress or S/S of abuse. The MD stated that his expectation was that the sooner the better he should be notified when an allegation was made about abuse so that he could issue any new orders. The MD stated the resident was assessed in the ER and no finding of sexual abuse. The MD did not provide a response as to when law enforcement was to be notified; except it was in the arena of the Administrator. During an interview on 5/15/25 at 3:10 PM, the Administrator stated: he was notified of the alleged abuse involving Resident #1 by CNA A on 5/13/25 around 1:30 PM. The Administrator stated, the actions taken by the facility included: head to toe assessment of Resident #1, self -report to HHS within 2 hours of knowing about the allegation of abuse, suspension of CNA A, and initiation of facility investigation, the MD and Medical Director were notified., the SW initiated safe surveys, and skin assessments were completed on non-verbal residents. The Administrator stated, ANE in-service was initiated on 5/13/25. On 5/14/25 at 9:24 AM, the resident returned to facility with the assignment of female CNAs. The Administrator stated he followed the HHS PL 2024-14 (Attachment 2: How to report ANE) and the PL did not require the notification of law enforcement. When asked about compliance with the law involving elder abuse and state laws, the Administrator stated: he had not reported the incident to law enforcement as of today (5/15/25 at 3:34 PM) because he had not established in his investigation that any sexual abuse occurred involving Resident #1 by a CNA. The Administrator stated that he became aware of the alleged sexual abuse from the hospital report received the morning of 5/14/25 around 9:46 AM. The Administrator stated that he was not aware of any law enforcement case opened on an allegation of sexual abuse involving Resident #1. During an interview on 5/15/25 at 5:10 PM, the Administrator stated he called law enforcement on the case involving Resident #1 late in the afternoon to ensure the resident and all residents were safe. The Administrator stated he made the call, after the discussion was held with the surveyor involving elder abuse, hospital documentation of alleged sexual abuse, and requirements for reporting to HHS and state/local agencies, to contact law enforcement. Record review of facility's incident report dated 5/13/25 [prior to surveyor's entrance on 5/14/25] repeated the same information for the above interview with Administrator and DON on 5/14/25 at 11:15 AM. The facility was still in the process of investigating the incident and no finding had been established. Record review of the facility's Abuse, Neglect, Exploitation Prevention Program, dated revised April 2021 read: .Investigate and report any allegations within timeframes required by federal requirements . Assessment Record review of Stage regulations (N3568) on reporting ANE read: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A local or state law enforcement agency must be notified of reports described in subsection (a) of this section, that allege that: (1) a resident's health or safety is in imminent danger. . (3) a resident has been hospitalized or treated in an emergency room because of conduct alleged in the report of abuse or neglect or other complaint. (4) a resident has been a victim of any act or attempted act described in the Texas Penal Code, SS21.02,21. 11, 22.011, or 22.021; or (5) a resident has suffered bodily injury, as that term is defined in the Texas Penal Code, S1.07, because of conduct alleged in the report of abuse or neglect or other complaint.