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	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wurzbach Nursing and Rehabilitation	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to ensure the resident environment remains as free of accident hazards as is possible for residents for 4 of 5 residents (Resident #1, Resident #2, Resident #3, and Resident #5) reviewed for accidents and hazards. The facility failed to ensure Resident #1 did not have body wash/shampoo/conditioner in his bathroom. The facility failed to ensure Resident #2 did not have perineal/skin cleanser and shave cream in his bedroom and bathroom. The facility failed to ensure Resident #3 did not have mouthwash in her room. The facility failed to ensure Resident #5 did not have shampoo/body wash, peri-wash, and lotion in her room and peri-wash in her bathroom. This deficient practice could result in residents having diminished health and/or quality of life. Findings included: 1. Record review of Resident #1's admission Record, dated 6/30/26, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Severe Dementia (group of thinking and social symptoms that interferes with daily functioning), Aphasia (disorder that affects a person's ability to communicate) , and Schizophrenia (A disorder that affects a person's ability to think, feel, and behave clearly) . Record review of Resident #1's quarterly MDS assessment, dated 6/9/26, revealed the resident's cognitive skills for daily decision making was severely impaired. During observation and interview on 6/30/26 at 11:07 am of Resident #1's room with Housekeeper I revealed store-bought body wash/shampoo/conditioner in the resident's bathroom labeled .WARNING: FOR EXTERNAL USE ONLY. Housekeeper I said this item was not supposed to be in the resident's room. During an interview on 7/1/26 at 11:56 am, Resident #1 nodded when asked if he knew what the body wash/shampoo/conditioner in his bathroom was used for and said, In mouth, I don't know. 2. Record review of Resident #2's admission Record, dated 6/30/26, revealed the resident was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included: Vascular Dementia (Brain damage caused by multiple strokes) and Cognitive Communication Deficit (difficulty with thinking and language). Record review of Resident #2's quarterly MDS, dated [DATE], revealed the resident's BIMS score 00, suggesting the resident's cognition was severely impaired. During observation and interview on 6/30/26 at 12:06 pm of Resident #2's room with Housekeeper I revealed medical-surgical supply brand perineal/skin cleanser, labeled .CAUTION: For external use only. and medical-surgical supply brand shaving cream, labeled .WARNING: Contents under pressure.Keep out of reach of children. and store bought shaving cream on the resident's side table labeled .WARNING: Contents under pressure.Intentional misuse by deliberately concentrating and inhaling the contents can be harmful or fatal.KEEP OUT OF REACH OF CHILDREN. Housekeeper I said those items were not supposed to be in the resident's room. During an interview on 7/1/26 at 11:56 am, Resident #2 said he knew what the shaving cream was for and he knew how to use it. 3. Record review of Resident #3's admission Record, dated 6/30/26, revealed the resident was re-admitted to the facility on [DATE] with diagnoses which included: Severe Dementia (group of thinking and social symptoms that interferes with daily functioning), Alzheimer's Disease (disease affecting memory and other important mental functions) , and Cognitive Communication Deficit (difficulty with thinking and language). Record review of Resident #3's quarterly MDS, dated (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE], revealed the resident's BIMS score 07, suggesting the resident's cognition was severely impaired. During an observation and interview on 6/30/26 at 11:48 am of Resident #3's room with Housekeeper I revealed medical-surgical supply brand mouthwash, labeled .CAUTION: Keep out of reach of children. In case of accidental ingestion, seek professional assistance or contact a poison control center immediately. Housekeeper I said this item was not supposed to be in the resident's room. During an interview on 7/1/26 at 11:49 am, Resident #3 said she had mouthwash that stayed in her room. Resident #3 further stated that she knew how to use it and did not have small children. 4. Record review of Resident #5's admission Record, dated 7/2/26, revealed the resident was re-admitted to the facility on [DATE] with diagnoses which included: Senile Degeneration of the Brain (Dementia - group of thinking and social symptoms that interferes with daily functioning). Record review of Resident #5's comprehensive MDS, dated [DATE], revealed the resident's BIMS score 00, suggesting the resident's cognition was severely impaired. During observation and interview on 6/30/26 at 12:52 pm of Resident #5's room revealed medical-surgical supply brand shampoo/body wash, labeled .CAUTION: For external use only., medical-surgical supply brand perineal/skin cleanser, labeled .CAUTION: For external use only., and medical-surgical supply brand lotion, labeled .CAUTION: For external use only. on her side table and medical-surgical supply brand perineal/skin cleanser, labeled .CAUTION: For external use only. in her bathroom. Housekeeper I said these items were not supposed to be in the resident's room. During an interview on 7/2/26 at 8:39 am, Resident #5 said she knew how to use the hygiene items in her room. Resident #5 proceeded to motion showering and applying lotion to her body and said, I just don't know. During an interview on 6/30/26 at 12:09 pm, Housekeeper I said lotion, shampoo and conditioners the family brought were supposed to be locked up. Housekeeper I said that the nurses were responsible for ensuring these items were not in the residents' rooms just in case another resident went in the room and took it. Housekeeper I further stated that some residents may try to eat or drink it the personal hygiene items, such as mouthwash. Housekeeper I said that the residents got confused, they had good days and bad days. Housekeeper I further stated that if a resident was having a bad day, there was a possibility that they may drink personal hygiene items and get sick. During an interview on 7/1/26 at 8:42 am, CNA A said Resident #3 used mouthwash and it was usually put in a drawer or in the restroom. CNA A further stated that Resident #3 was not ambulatory, but her roommate was, and her roommate also had Dementia; adding that when she was confused, these items could be a danger to her. CNA A said that she knew that staff were not supposed to leave personal hygiene items in the residents' rooms, especially for residents with dementia because some of the residents that were ambulatory can grab things. CNA A said that the residents did not know what they were doing and the staff knew that. CNA A further stated that residents could drink personal hygiene items and get sick. CNA A said that usually the nurse will tell the staff not to leave personal hygiene items in the residents' rooms. CNA A said that she did not leave the personal hygiene items in the residents' rooms after she provided care on 6/30/26 and did not know who did. A telephone interview was attempted on 7/1/26 at 8:56 am and 7:01 pm with CNA E (regarding personal hygiene items in resident rooms), without success. A telephone interview was attempted on 7/1/26 at 8:59 am with CNA F (regarding personal hygiene items in resident rooms), without success. During interview and observation on 7/1/26 at 12:14 pm of Resident #1, Resident #2, Resident #3, and Resident #5's rooms with ADON G, ADON G confirmed the store-bought body wash/shampoo/conditioner, medical-surgical supply brand perineal/skin cleanser, medical-surgical supply brand shaving cream, and store bought shaving cream, medical-surgical supply brand mouthwash, medical-surgical supply brand shampoo/body wash, and medical-surgical supply brand lotion were in the residents' rooms. ADON G said the nurses used the perineal/skin wash and must have forgotten it in the resident rooms. ADON G further stated shaving cream should be locked up as well and that sometimes the CNA forgot. ADON G said the residents' mind sometimes come and go, and sometimes they forgot. ADON G further stated that there was a possibility that residents may ingest the hygiene items. ADON G said, for the most part, the majority of the residents (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on the Memory Care Unit were alert, but they got confused. During an interview on 7/1/26 at 2:05 pm, CNA B said the staff were not supposed to keep shampoo or perineal wash in the residents' room because residents could drink them. CNA B said that the residents on the Memory Care Unit got confused. CNA B said if she saw personal hygiene items in the resident rooms, she removed them and put them in the shower room. CNA B said the CNAs were responsible for ensuring that personal hygiene items were not left in the residents' rooms. CNA B further stated that the person that did round and any staff that went into the resident rooms and saw these items were also responsible for removing them. CNA B said residents could become sick if the personal hygiene items were ingested or they may be allergic to the ingredients. CNA B said all the items had chemicals in them and could be dangerous to the residents. During an interview on 7/1/26 at 3:11 pm, CNA C said the personal hygiene items were not supposed to be in the resident rooms because they had chemicals and some had alcohol. CNA C further stated the residents could ingest the personal hygiene items. CNA C said if a resident ingested personal hygiene items they may need to go to the hospital. CNA C said all staff were responsible for ensuring that personal hygiene items were not in the resident rooms. CNA C said somebody might have forgotten the personal hygiene items in Resident #3's room because those items were usually not in her room. CNA C said that he did not know that there were personal hygiene items in Resident #1, Resident #2, Resident #3, or Resident #5's rooms because he did not work with them on 6/30/26. During a telephone interview on 7/1/26 at 6:21 pm, MR said she was assigned to complete room rounds for Resident #2. MR said that she completed room rounds on 6/30/26 around 6:30 am, and there wasn't any shaving cream in Resident #2's room because Resident #2 was not allowed to have shaving cream in his room because he resided in memory care and the staff did not want the resident to ingest it and cause harm. MR said that Resident #2 may have brought shaving cream from home after a pass. During an interview on 7/2/26 at 9:17 am, ADON H said she had read the labels on the personal hygiene items. ADON H said that the medical-surgical supply brand perineal/skin cleanser was okay to be in the resident rooms and so was the medical-surgical supply brand lotion. ADON H said she was not aware that the store-bought personal hygiene items were in the rooms. ADON H further stated that some of the families brought personal hygiene items and left them in the residents' rooms. ADON H said that she was not aware of the store-bought shave cream in Resident 2's room was a new one because sometimes his family would bring items in, but they were usually snacks. ADON H said that she preferred that the medical-surgical supply brand shave cream was not in the room. ADON H further stated she was not sure what the facility's policy was regarding personal hygiene items but said shaving cream was aerosolized and was potentially flammable. ADON H said she was not sure if the medical-surgical supply brand shave cream was aerosolized, but if they were, they were not to be left in the residents' rooms. ADON H said that all staff were responsible for ensuring the shave cream was not in resident rooms. ADON H said that most of the personal hygiene items the facility bought were from medical-surgical supply brand which were not toxic. During an interview on 7/2/26 at 10:42 am, the DON said she did know that there was perineal/skin cleanser, lotion shave cream or mouthwash in the residents' rooms. The DON said that the facility assigned staff to complete room rounds, but anyone that saw these items should remove them because the items were toxic. The DON said the residents were allowed to have non-toxic items in their rooms. The DON further stated that if the items said keep out of reach of children it would be a safety concern in case it was used incorrectly. The DON said having the personal hygiene items in the residents' rooms was a safety concern because they could be ingested or used incorrectly. The DON said the facility had not had any residents ingest personal hygiene items in the past. Record review of the facility's policy titled Personal Property, revised August 2022, revealed: .Residents are permitted to retain and use personal possessions, including furniture and clothing, as space permits, unless doing so would infringe on the rights or health and safety of other residents. Record review of the facility's policy titled Homelike Environment, revised February 2021, revealed: .Residents are provided with a safe, clean, comfortable and homelike environment . Record review of the facility's admission (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	packet revealed: .15. ITEMS PROHIBITED IN RESIDENT ROOMS. State and Federal laws prohibit many items from resident [sic] rooms. The following list is meant to be a guide only and not an exhaustive list.The decision to prohibit items from resident rooms is based upon governing laws, regulations and the need to maintain a safe living environment.No aerosol cans of any products as they are combustible. Further review of the facility's admission packet revealed it did not reference items with KEEP AWAY FROM CHILDREN, POISONOUS, or EXTERNAL USE ONLY warning labels.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure, in accordance withˆstate andˆfederal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access for 1 of 4 residents (Resident #4) reviewed for medication storage.^^ ^^ The facilityˆfailed toˆensure Resident #4 did not have the medication Mupirocin in her room on the Memory Care Unit on 6/30/26. ^^ This failure could place residents at risk of medication misuse and drug diversion.^^ Findings included:^^ Record review of Resident #4's admission Record, dated 6/30/26, revealed the resident was re-admitted to the facility on [DATE] with diagnoses which included: Alzheimer's Disease (disease affecting memory and other important mental functions), Vascular Dementia (Brain damage caused by multiple strokes), and Cognitive Communication Deficit (difficulty with thinking and language). Record review of Resident #4's quarterly MDS, dated [DATE], revealed the resident's BIMS score 00, suggesting the resident's cognition was severely impaired. ^^ Observation and interview onˆ6/30/26 at 11:42 am, revealed a tube of Mupirocin (prescription antibiotic ointment) in Resident #4's dresser draw. ADON G said she did not know that medication was in Resident #4's drawer and it was not supposed to be in there. ADON G further stated the facility had staff that did room rounds, but did not know who was assigned to Resident #4's room. ADON G said there should not be any medications in the residents' rooms because residents could ingest the medications and could die. ADON G further stated that residents in Memory Care did not self-administer medications. ADON G said all staff were responsible for ensuring there were not any medications in the residents' rooms, especially the staff that were assigned to that resident's room. During an interview on 7/2/26 at 9:17 am, ADON H said her expectation was that no medications were left in resident rooms, especially in the Memory Care Unit. ADON H further stated that she did not know that Resident #4 had the tube of Mupirocin in her room. ADON H said that Resident #4 did not have an order for Mupirocin and she did. ADON H further stated she did not know how the medication got there. ADON H said that the tubes of medication were always labeled by the pharmacy. ADON H said she did not know if Resident #4's family brought the Mupirocin for the resident. ADON H said that although The residents' drawers were not part of the routine rounds, she checked the drawers once or twice a week, but she did not like to invade the residents' privacy. ADON H said it was all of the staff's responsibility to ensure that medications were not in resident rooms. ADON H said that on 6/29/26, during her inspection, she went through the resident's drawer and did not see the Mupirocin in Resident #4's drawer. ADON H further stated that if she had seen the Mupirocin in Resident #4's drawer, she would have taken it out. ADON H said that she did not know that she had any resident that would open and try to use the Mupirocin, but the possibility of misuse was always there causing a possible allergic reaction or illness from ingestion. ADON H said that Resident #4 had Dementia and was ambulatory. ADOON B further stated that the majority of the residents on the unit were ambulatory. ADON H said that even though most of the residents did wander into other resident rooms, all of the residents had Dementia, Alzheimer's or other cognitive impairment that impeded their safety awareness. During an interview on 7/2/26 at 9:55 am, Resident #4's family member said that Resident #4 may have picked up the medication at her house during a pass because the resident had free [NAME] of her house when she was there. During an interview on 7/2/26 at 10:42 am, the DON said she did not know there was an ointment in Resident #4's room. The DON said that the staff usually did not go in the residents' drawers, where they had their personal belongings stored unless there was a concern. The DON further stated that all staff that entered resident rooms were responsible for ensuring there were no items that were not supposed to be in the resident's room. The DON said having medications in resident rooms put them at (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	risk of taking medication that was not theirs, and they could have a (negative) reaction to that medication. ^^ Record review of the facility's policy titled, 6. Delivery, Receipt and Storage of Medicationˆundated, revealed: .6.3. Storage of Medication The facility should ensure that only authorized facility staff should have access to the medication storage areas. authorized facility staff should include nursing staff and those authorized to administer medications.ˆ