

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455824	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Wurzbach Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 8300 Wurzbach Rd San Antonio, TX 78229	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 26869 Based on interview and record review the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 of 5 (CNA E) CNAs in that: CNA E did not have a current EMR/NAR check. This could place residents at risk of abuse, neglect, and exploitation. The Findings: Record review of the staff list dated 4/23/2024 revealed that CNA E was hired on 4/21/2024. Record review of CNA E's personnel file revealed there was not a current EMR/NAR. CNA E's last EMR/NAR check was on 3/17/2023. Interview on 4/26/2024 at 12:33 PM the Administrator stated she would search for the EMR/NAR for CNA E. The Administrator did not provide evidence before exit. ADM stated they did not have HR (Human Resources) staff in the building. ADM searched and provided the information for licensure. ADM stated she was not able find CAN E's EMR/NAR. Record review of policy Abuse, Neglect and Exploitation Program, dated April 2021 revealed Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. 4. Conduct employee background checks and not knowingly employ or otherwise engage any individual who has: b. had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property.		

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	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** 47564 Based on observation, interview, and record review, the facility failed to ensure that all allegations involving abuse, neglect, and misappropriation were reported immediately, but no later than 2 hours after the allegation was made to the State Survey Agency for 1 of 8 residents (Resident #56) reviewed for abuse and neglect. The facility did not report to the State Survey Agency (HHSC) an incident in which Resident #56 had an unwitnessed fall a skin tear and a hematoma to her head. This failure could place residents at risk for abuse/neglect and could lead to a diminished quality of life and psychosocial harm. The findings included: Record review of Resident #56's Face Sheet, dated 4/26/2024, reflected an [AGE] year-old female resident with an initial admitted [DATE], with diagnoses including Alzheimer's disease (progressive disease that destroys memory and other important mental functions), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and that the resident was discharged on [DATE]. Record review of Resident #56's Quarterly MDS Assessment, dated 3/4/2024, reflected the resident had a BIMS of 00, reflecting the resident had severe cognitive impairment. The MDS Assessment further reflected that the resident had not had any falls since their prior assessment. Record review of Resident #56's Comprehensive Person-Centered Care Plan, dated 4/26/2024, reflected, The resident is risk for falls d/t dementia .Unsteady gait leans forward when ambulating . with interventions including, attempt to keep in sight of staff, when agitated and attempting to rise without assistance:. Record review of a Nurse's Note, dated 3/29/2024 and created by LVN B, reflected, Resident found sitting on the bedroom floor holding napkin to head. Resident confused, denies pain but unable to verbalize how she hit her head. Skin tear noted to R forearm upon assessment. VS baseline. Resident assisted to bed by staff. DON, [Hospice], RP notified. Per [Hospice Physician] ice forehead and monitor neuros. Dressing cover for skin tear to forearm. Record review of the fall incident report regarding Resident #26, dated 3/29/2024, reflected an incident description of Resident found sitting on the bedroom floor holding napkins to head. Resident confused, denies pain, unable to describe how she hit her head. The incident report also reflected, under the subsection, Witness, reflected No Witnesses found. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/26/2024 at 9:41 AM, LVN B stated that Resident #56 fell and there were not any witnesses. LVN B stated hospice had just been in to visit the resident and the resident had been found on the ground. LVN B stated she and the hospice nurse assessed Resident #56 together, and that the resident was unable to tell them how she fell . LVN B stated she informed the DON, RP, and residents' physician . LVN B stated the resident had a skin tear and a hematoma to her head. Interview on 4/26/2024 at 10:19 AM, the DON stated she believed Resident #56's fall was witnessed but was unable to inform the surveyor of who witnessed the fall. Interview on 4/26/2024 at 11:15 AM, the DON stated she believed a housekeeper witnessed Resident #56's fall and was attempting to look for the witness statement. Interview on 4/26/2024 at 12:16 PM, the DON stated that she had not been able to find the witness statement but was calling the CNA staff member she believed was the witness. After requesting the DON's investigation of the fall, the DON stated she did not have it but would write it. Interview on 4/26/2024 at 12:23 PM, the Administrator stated that the provided incident report should be the complete investigation of the incident. The Administrator stated that any injury in a suspicious area such as the inner thigh would be reported if it was not witnessed. The Administrator stated that the incident was not reported as Resident #56 was found on the floor with a bruise on her head, so it was deduced that the resident fell . Interview and record review on 4/26/2024 at 2:30 PM, the DON stated the Admissions Coordinator saw Resident #56 fall. Record review of a handwritten document , untitled, dated 3/29/2024, reflected Resident #56 fell forward out of her wheelchair hitting her face on the wheelchair and LVN B was told of the resident's fall. Record review of hand typed document provided by the facility, untitled, dated 4/2/2024, reflected Resident #56 fell out of bed, witnessed by the Admissions Coordinator, who then reported the residents fall to LVN B. Record review of facility policy titled , Abuse, Neglect, Exploitation and Misappropriation Prevention Program, undated, reflected, Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property, and Investigate and report any allegations within timeframes required by federal requirements.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564 Based on record review and interview, the facility failed to thoroughly investigate all alleged violations of resident abuse, neglect, exploitation, or mistreatment for 1 of 6 (Resident #56) residents assessed for reporting allegations. The facility failed to thoroughly investigate an incident in which a resident was found on the floor of their room with a skin tear to the right forearm and a hematoma to the top of the resident's scalp. This deficient practice placed residents at risk of abuse, neglect, exploitation, or mistreatment. The findings included: Record review of Resident #56's Face Sheet, dated 4/26/2024, reflected an [AGE] year-old female resident with an initial admitted [DATE], with diagnoses including Alzheimer's disease (progressive disease that destroys memory and other important mental functions), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and that the resident was discharged on [DATE]. Record review of Resident #56's Quarterly MDS Assessment, dated 3/4/2024, reflected the resident had a BIMS of 00, reflecting the resident had severe cognitive impairment. The MDS Assessment further reflected that the resident had not had any falls since their prior assessment. Record review of Resident #56's Comprehensive Person-Centered Care Plan, dated 4/26/2024, reflected, The resident is risk for falls d/t dementia .Unsteady gait leans forward when ambulating . with interventions including, attempt to keep in sight of staff, when agitated and attempting to rise without assistance:. Record review of a Nurse's Note, dated 3/29/2024 and created by LVN B, reflected, Resident found sitting on the bedroom floor holding napkin to head. Resident confused, denies pain but unable to verbalize how she hit her head. Skin tear noted to R forearm upon assessment. VS baseline. Resident assisted to bed by staff. DON, [Hospice], RP notified. Per [Hospice Physician] ice forehead and monitor neuros. Dressing cover for skin tear to forearm. Record review of the fall incident report regarding Resident #26, dated 3/29/2024, reflected an incident description of Resident found sitting on the bedroom floor holding napkins to head. Resident confused, denies pain, unable to describe how she hit her head. The incident report also reflected, under the subsection, Witness, reflected No Witnesses found. Interview on 4/26/2024 at 9:41 AM, LVN B stated that Resident #56 fell and there were not any witnesses. LVN B stated hospice had just been in to visit the resident and the resident had been found on the ground. LVN B stated she and the hospice nurse assessed Resident #56 together, and that the resident was unable to tell them how she fell . LVN B stated she informed the DON, RP, and residents' physician. LVN B stated the resident had a skin tear and a hematoma to her head. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/26/2024 at 10:19 AM, the DON stated she believed Resident #56's fall was witnessed but was unable to inform the surveyor of who witnessed the fall. Interview on 4/26/2024 at 11:15 AM, the DON stated she believed a housekeeper witnessed Resident #56's fall and was attempting to look for the witness statement. Interview on 4/26/2024 at 12:16 PM, the DON stated that she had not been able to find the witness statement but was calling the CNA staff member she believed was the witness. After requesting the DON's investigation of the fall, the DON stated she did not have it but would write it. Interview on 4/26/2024 at 12:23 PM, the Administrator stated that the provided incident report should be the complete investigation of the incident. Interview on 4/26/2024 at 2:30 PM, the DON stated she investigated incidents such as falls at the facility. When asked for the investigation report, the DON stated she would write one. Record review of hand typed document provided by the facility, untitled, dated 4/2/2024, reflected Resident #56 fell out of bed, witnessed by the Admissions Coordinator, who then reported the residents fall to LVN B. Record review of facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, undated, reflected, Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property.		

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41480 Based on interview and record review the facility failed to ensure, before a resident was transferred to a hospital or the resident went on therapeutic leave, provided written information to the resident or the resident representative that specified the duration of the bed-hold policy, if any, during which the resident was permitted to return and resume residence in the nursing facility for 1 of 1 residents (Residents #89) reviewed for transfers, in that: The facility did not provide Resident #89 with a written bed-hold policy when the resident was transferred out to the hospital. This failure could place residents at risk for not receiving notice of the facility's bed hold policy before being transferred and at risk for of being improperly discharged and placed in unsafe conditions. The findings were: Record review of Resident #89's face sheet, undated, revealed an [AGE] year-old-female was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include respiratory failure, COPD (lung disease), heart failure, hypertension (high blood pressure), and diabetes (high blood sugar). Record review of Resident #89's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Brief Interview for Mental Status score revealed a score of 15, which indicated the resident's cognition was intact. Record Review of Resident #89's census from the EMR revealed that on 03/11/24 billing was stopped. The discharge MDS dated [DATE] revealed Resident #89 was discharged to short-term general hospital with return anticipated . Resident #89 returned to facility on 03/12/24. Record review of Resident #89's admission record indicated that she received the bed-hold policy [NAME] admission indicating that the facility procedure was upon transfer or discharge, a signed bed hold agreement was required on all residents who discharged to the community and wished to return to the same bed when admitted . During an interview on 04/26/24 09:45 AM with the Admin Coor., he stated Resident #89 did not sign a bed hold when she went out to the hospital. He stated the facility did not do bed holds when residents were transferred out to the hospital. He stated the facility would hold the resident's bed because the facility wanted them to return to the facility. (continued on next page)		

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/26/24 at 09:50 AM with the ADM, she stated they do not give residents or family members a bed hold when the resident was discharged to the hospital. She stated they hold the bed until the resident returns. She stated the purpose of the bed hold was in the event a resident wanted to hold the bed to ensure they have the same room. She stated they have no system in place to ensure bed hold are given to residents when they are discharged from the facility and plan to return. She stated if the facility was at full capacity and a resident was private pay and went out to the hospital, they would notify the responsible party by phone and give them the option to pay for a bed hold. She stated residents applied income paid to the facility was what they consider payment for bed holds. She stated the BOM and Admission Coord. were responsible for obtaining a resident bed hold when they find out a resident went out to hospital. During an interview on 04/26/24 at 10:09 AM with BOM, she stated bed holds were used to guarantee the resident will be readmitted to same room. The BOM stated she had been trained on bed hold policy. She stated there would be no negative outcome of not giving a resident a bed hold, because they hold the residents bed until they return. She stated the facility had never given any bed holds since she had been here for the past 6 years. Record review of the facility policy titled Bed Hold (undated) revealed: I. Bed Hold Policy is governed by the Texas Administrative Code 40 TAC S19.503 and all other State and Federal requirements for participation of a Texas Skilled Nursing Facility. II. Signed bed hold agreements are required on all Residents who discharge the Community and wish to return to the same bed when readmitted . This signed agreement should be obtained at the time of discharge. If the Resident or Resident's Representative is unable to come to the Community location to sign, a verbal agreement can be obtained and is required to be documented. Contact for, and documentation of, the verbal bed hold agreement will be completed by the Business Office Manager, or their appointed representative, during routine business hours of 8am - 5pm, Monday through Friday. Contact for, and documentation of, the verbal bed hold agreement for after-hours discharge is completed by the nurse on duty, or their appointed representative, in the form of a clinical note in the electronic medical record system, detailing the date, time and name of the person verbally approving the bed hold. After hours is generally considered nights and weekends but is expected to cover holidays and anytime other than the routine business hours stated above. The bed hold agreement must be scanned, emailed, or faxed to be signed by the Resident or Resident Representative. The signed agreement must be returned within five (5) Business Days of discharge, but no later than the 2nd business day following the end of the month. The bed hold agreement will be provided to the Resident and/or Resident Representative (RR) by the Business Office Manager, or appointed representative. (continued on next page)		

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In the event of an after- hours discharge, the Business Office Manager, or appointed representative will provide the agreement to the Resident and/or RR the next business day. Without a proper signature on the bed hold form by the 2nd business day of the following month, the Resident will be discharged from the Community back to the date the Resident transferred out of the Community . Bed hold Authorization & Agreement Forms must be filled out and signed by the Resident or Resident Representative and designated to either execute the bed hold or not .		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on interview and record review the facility failed to ensure that each resident receives an accurate assessment for 1 of 9 (#77) that were reviewed in that: Resident #77 was discharged on [DATE] and a discharge MDS was not completed. This could affect all residents and could result in residents' information not being accurate. The Findings: Record review of Resident #77's Admission Record revealed she was admitted on [DATE], [AGE] year old female, and her diagnoses were Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs.), chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), adult failure to thrive, osteoporosis (a bone disease that develops when bone mineral density and bone mass decreases, or when the structure and strength of bone changes),)and osteoarthritis (degenerative joint disease. The record revealed Resident #77 was discharged on [DATE]. Record review of Resident #77's chart revealed she did not have a discharge MDS. Record review of Resident #77's care plan dated 3/11/2023 revealed the resident wished to remain in long term care, no discharge at this time. Record review of Resident #77's progress note dated 1/25/2024 reflected Resident # 77 went to hospital due to critical labs and never returned. Interview on 4/25/24 at 12:35 PM RN/MDS A stated she had completed Resident #77's last MDS assessments, and she missed the discharge MDS at the time of discharge on 1/25/2024 . MDS stated should be done soon after resident was discharged and SNF knew they would not be back to facility. Interview on 4/25/2204 at 2:40 PM LVN B stated Resident #77's had critical labs. She stated Resident #77 was refusing medications. So, Resident #77 was sent to hospital via physician. Interview on 4/25/2024 at 3:43 PM MDS C stated she missed the discharge MDS and would mess up the MDS system and resident monitoring. Record review of the Discharge Process policy, no date, revealed 5. communicate with staff about the residents' upcoming discharge date and time, d. The following people should be notified of planned discharge, vii MDS nurse. Record review of MDS RAI 3.0 was documented 09. Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days. o Must be completed within 14 days after the discharge date . o Must be submitted within 14 days after the MDS completion date.		

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on interview and record review the facility failed to ensure when the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, a recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results, a final summary of the resident's status to include items in paragraph, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative; reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter) for 1 of 3 (Resident #77) resident reviewed for discharge in that: Resident #77 was discharged on [DATE] and a discharge summary was not completed. This could affect all residents and could result in residents' information not being accurate. The Findings: Record review of Resident #77's Admission Record revealed she was admitted on [DATE] and her diagnoses were Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs.), chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), adult failure to thrive, osteoporosis (a bone disease that develops when bone mineral density and bone mass decreases, or when the structure and strength of bone changes),)and osteopathic (degenerative joint disease. The record revealed Resident #77 was discharged on [DATE]. Record review of Resident #77's chart revealed she did not have a discharge MDS. Record review of Resident #77's chart revealed there was not a discharge summary report. Record review of Resident #77's care plan dated 3/11/2023 revealed resident wishes to remain in long term care, pre-discharge care plan. Record review of Resident #77's progress note dated 1/25/2024 reflected Resident #77 went to hospital due to critical labs and never returned. Interview on 4/26/24 at 11:48 AM the DON stated she would look for Resident #77's discharge summary report. No evidence was provided before exit . (continued on next page)		

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Policy Transfer or Discharge, Facility-Initiated, dated October 2022, revealed Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy. Documentation of Facility-Initiated Transfer or Discharge, 1. When a resident is transferred or discharged from the facility, the following information is documented in the medical record: f. A summary of the resident's overall medical, physical, and mental condition; g. Disposition of personal effects; and h. Disposition of medications.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41480 Based on observation, interview and record review, the facility failed to ensure that a resident, who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals, and preferences for 1 of 20 residents reviewed for respiratory care. (Resident #240) The facility did not ensure Resident #240 had orders for the administration of oxygen. This failure could place the residents at risk of not receiving the care and services to maintain their highest level of well-being. Findings included: Record review Resident #240's face sheet dated 04/24/24 reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included hypertension (high blood pressure), atrial fibrillation (irregular heart beat), COPD (lung disease) and falls. Record review of Resident #240's EMR reflected he did not have a complete MDS assessment. Record review of care plan dated 04/22/24 reflected Resident #240 had cardiac disease with intervention to administer oxygen as ordered per physician. Resident #240 had altered respiratory status/difficulty breathing with interventions oxygen settings: O2 via (specify: nasal prongs/mask) at (specify) L (specify freq.) Humidified (specify). During observations Resident #240 had oxygen in progress as follows: 04/23/24 at 10:15 AM O2 on via oxygen concentrator at 4lpm via nasal cannula 04/24/24 at 09:00 AM O2 on via oxygen concentrator at 4lpm via nasal cannula 04/25/24 at 10:00 AM O2 on via oxygen concentrator at 4lpm via nasal cannula During an interview on 04/23/24 at 10:15 AM with Resident #240, he stated he was admitted with oxygen and wears it all the time. He stated he was not sure how many liters it was to be set on. Record review of Resident #240's physician's order listing report dated 04/23/24 reflected no order of oxygen. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/25/24 at 02:00 PM with the DON, she stated any resident using oxygen must have a physician order. She stated all nursing staff had been trained to obtain orders and put them in the EMR. She stated the nurses was responsible for physician orders and she was responsible for monitoring orders. She stated nurses can place oxygen in emergency situations using nursing judgement but would need to get a physician order once the resident was stable. She stated Resident #240 did not have any orders for oxygen. She stated she was not sure why it was missed. She stated the oxygen orders should have been entered on day of admission. She stated the potential negative outcome could be a resident hyperventilated or had breathing difficulties. During an interview on 04/25/24 at 04:00 PM with the ADM, she stated residents on oxygen does require an order. She stated the charge nurse, admission nurse and DON was responsible for obtaining the order. She stated staff had been trained on obtaining orders. She stated she was not sure why it was missed. She stated they review all new admissions during stand-up morning meeting to go over all orders and concerns. She stated the potential negative outcome could be a resident not getting what they need as for as oxygen was concerned. Record review facility policy title Oxygen administration dated October 2010 reflected the following: Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration .		

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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** 26869 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 1 of 8 (Resident #64) in that: Resident #64 was not administered her Tylenol and Senexon . This could affect all residents and could result in residents not administered medications can increase pain and constipation. The Findings: Record review of Resident #64's Admission Record dated April 3, 2004 revealed she was admitted on [DATE], readmitted on [DATE], she was [AGE] years old, with diagnoses of dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), diabetes II (a disease that occurs when your blood glucose, also called blood sugar, is too high.), chronic pain, and osteoporosis (a medical condition in which the bones become brittle and fragile from loss of tissue, typically as a result of hormonal changes, or deficiency of calcium or vitamin D). Record review of Resident #64's Quarterly MDS dated [DATE] revealed Section C- Cognition Patterns BIMS score was 8/15 (moderate cognitive impairment), Section H Bladder and Bowel, bowel was frequently incontinent and Section J Health Conditions she received scheduled pain medications and no pain. Record review of Resident #64's care plan revealed The resident has impaired cognitive cognition and thought processes related to dementia. Interventions were Administrator medications as ordered. Monitor/document side effects and effectiveness. Record review of Resident #64's consolidated orders) lower extremities pain and Senexon-S oral tablet 8/6-50 mg (sennosides-docusate sodium), give 2 tablets by mouth at bedtime for constipation. Record review of Resident #64's MAR for April 2024 revealed the order for Tylenol Extra Strength oral tablet 500 mg, give 1 tablet by mouth three times a day for bilateral lower extremities pain was not administered on 4/9/2024. Also, Senexon-S oral tablet 8/6-50 mg (sennosides-docusate sodium), give 2 tablets by mouth at bedtime for constipation was not administered on 4/9/2024 and 4/12/2024 by LVN D. Interview on 4/26/2024 at 11:48 PM the DON stated medications Tylenol Extra Strength and Senexon-S oral tablet 8/6-50 mg were available in central supply and they could also get it at the store, they are viable OTC. The DON stated LVN D did not notify her of any medications that were out of stock. The DON stated the risk to residents would be increased pain and constipation. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/26/2024 at 12:25 PM LVN D stated Resident #64 did not have medications Tylenol or Senexon in the medication cart and there was no central supply at that time. LVN D stated the Tylenol and Senexon were out of stock and was not administered on 4/9/2024 and 4/12/2024. LVN D stated Resident #64 did not complain of pain or constipation. She stated she notified the DON and Administrator. LVN D stated Resident #64 had other orders for medication that was scheduled. Interview on 04/26/24 12:33 PM the Administrator stated LVN D had not discussed any medications she withheld. The Administrator stated the Tylenol and Senexon were always available in central supply closet. Record review of the policy Administering Medications, dated April 2019 revealed Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in a safe and timely manner, and as prescribed.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564 Based on observations, interviews, and record reviews the facility failed to ensure residents were free of any significant medication errors for 1 of 8 residents (Resident #28) reviewed for medication administration. Resident #28 was provided a medication, Midodrine, outside of physician parameters. This failure could place residents at risk for not receiving the therapeutic effects of their prescribed medications. The findings included: Record review of Resident #28's face sheet, dated 4/25/2024, reflected a [AGE] year-old female resident with an initial admitted [DATE] and diagnosis including Huntington's disease (an inherited condition in which nerve cells in the brain break down over time). A record review of resident #28's quarterly MDS assessment, dated 2/8/2024, revealed Resident #28 was assessed with a BIMS score of 2 out of a possible 15 which indicated severe cognitive impairment. A record review of resident #28's Care Plan dated 3/1/2024, revealed the resident had hypotension with interventions including giving the resident their medications as ordered and monitoring vital signs. A record review of Resident #28's Physician's orders, undated, revealed Resident #28 was prescribed Midodrine HCl Oral Tablet 5 MG for orthostatic hypotension (positional change in blood pressure) hold for SBP>120, indicating the medication should not be provided to the resident if their systolic blood pressure (the top number, which measures the pressure in your arteries when your heart beats) is over 120. A record review of Resident #28's April 2024 medication administration record dated 4/25/2024 revealed Resident #28 could have been administered Midodrine Hcl 63 times from 04/01/2024 to 04/25/2024 and was administered Midodrine HCl out of physician parameters as follows: 1. On 4/6/2024, LVN F administered Midodrine to Resident #28 while her Systolic Blood Pressure was 124 at 7:00 PM. 2. On 4/7/2024, LVN F administered Midodrine to Resident #28 while her Systolic Blood Pressure was 122 at 10:00 AM. 3. On 4/9/2024, LVN F administered Midodrine to Resident #28 while her Systolic Blood Pressure was 128 at 2:00 PM. 4. On 4/9/2024, LVN G administered Midodrine to Resident #28 while her Systolic Blood Pressure was at 7:00 PM. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 4/13/2024, LVN F administered Midodrine to Resident #28 while her Systolic Blood Pressure was 124 at 10:00 AM. 6. On 4/13/2024, LVN F administered Midodrine to Resident #28 while her Systolic Blood Pressure was 126 at 7:00 PM. 7. On 4/20/2024, LVN G administered Midodrine to Resident #28 while her Systolic Blood Pressure was 122 at 7:00 PM. 8. On 4/21/2024, LVN H did not administer Midodrine to Resident #28 while her Systolic Blood Pressure was 105 at 2:00 PM. During an interview on 04/25/2024 at 9:41 AM, LVN B stated staff who administer Midodrine or any medications with parameters such as Midodrine take the vitals immediately before administering the medication. LVN B also stated that if a resident was given medications out of parameters, the nurse would need to call the doctor immediately, and notify the DON and RP. During an interview on 04/25/2024 at 10:45 AM the DON stated the expectation for nurses was to take the residents vitals when a medication had parameters that require knowing a vital sign. The DON stated if a nurse makes a medication error such as providing medications out of parameters, they should inform the DON, physician, and RP. The DON stated the risk of the resident receiving medications out of parameters included not properly managing the residents' conditions. During an interview on 04/26/2024 at 12:35 PM the Administrator stated she was not a clinician and referred to the DON's supervision and stated the expectation would be for a nurse to notify the DON and physician of the medication error. A record review of the facility's Policy Interpretation and Implementation, dated April 2019, revealed, Medications are administered in accordance with prescriber orders.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41480 Based on observations, interviews, and record review the facility failed to, in accordance with State and Federal laws, ensure all drugs and biologicals were stored properly in the medication cart for 1 (Station A) of 3 medication treatment carts observed for drug storage. The facility failed to ensure 5 insulin pens were dated when opened. This failure could result in harm due to resident received expired medications. The findings were: Record review Resident #4's face sheet dated 04/24/24 revealed an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included dementia (cognitive loss), diabetes (high blood sugar), and major depressive disorder (mental illness, feeling of sadness). Record review of Resident #4's quarterly MDS assessment, dated 02/22/24 revealed a BIMS score of 12, which indicated cognition was moderately impaired. Section N - medications reflected Resident #4 had received insulin injections during the last 7 days. Record review of Resident #4's care plan dated 03/07/24 reflected a focus area Resident #4 had diabetes with intervention for diabetes mediations as ordered by doctor. Record review of Resident #4's physician order listing report dated 04/24/24 reflected an order for Basaglar Kwik pen solution pen-injection 100 unit/ml - inject 40 units subcutaneously in the evening for uncontrolled DM dated 2/27/24 and 40 units subcutaneously in the morning for uncontrolled DM dated 4/10/24. An order for NovoLog Flex Pen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale dated 01/25/24 . Record review Resident #4's treatment administration record dated 04/24/24 reflected Resident #4 received Basaglar 40 units in the morning on 4/1/24 through 4/24/24 and Basaglar 40 units in the evening on 04/01/24 through 04/23/24. Resident #4 received Novolog per sliding scale on 04/01/24 through 04/24/24. Observation on 04/24/24 at 09:30 AM during the medication cart inspection on Station A revealed Basaglar Kwik Pen and NovoLog Flex pen with Resident #4's name on the label and no open date on the pens. Record review Resident #31s face sheet dated 04/24/24 revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included dementia (cognitive loss), diabetes (high blood sugar), COPD (lung disease) and major depressive disorder (mental illness, feeling of sadness). (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #31's comprehensive MDS assessment, dated 02/08/24 revealed a BIMS score of 00, which indicated cognition was severely impaired. Section N - medications reflected Resident #31 had received insulin injections during the last 7 days. Record review of Resident #31's care plan dated 03/01/24 reflected a focus area Resident #31 had diabetes with intervention for diabetes medications as ordered by doctor. Record review of Resident #31's physician order listing report dated 04/24/24 reflected an order for Humulin N Kwik Pen Subcutaneous Suspension Pen-injector 100 UNIT/ML (Insulin NPH (Human) (Isophane)) Inject 50 unit subcutaneously in the morning for uncontrolled DM dated 3/9/24 and 15 units subcutaneously in the evening for uncontrolled DM dated 03/25/24. Record Review of Resident #31's treatment administration record dated 04/24/24 reflected Resident #31 received Humulin N 50 units in the morning on 04/01/24 through 04/24/24 and Humulin N 15 units in the evening on 04/01/24 through 04/23/24. Observation on 04/24/24 at 09:30 AM during the medication cart inspection on Station A revealed Humulin N Kwik pen with Resident #31's name on the label and no open date on the pen. Record review Resident #53's face sheet dated 04/24/24 revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included dementia (cognitive loss), heart failure, diabetes (high blood sugar), hypertension (high blood pressure) and major depressive disorder (mental illness, feeling of sadness). Record review of Resident #53's quarterly MDS assessment, dated 03/05/24 revealed a BIMS score of 14, which indicated cognition was intact. Section N - medications reflected Resident #4 had received insulin injections during the last 7 days. Record review of Resident #53's care plan dated 03/05/24 reflected a focus area Resident #53 had diabetes with intervention for diabetes medications as ordered by doctor. Record review of Resident #53's physician order listing report dated 04/24/24 reflected an order for Lantus pen injector - inject 20 units subcutaneously at bedtime for diabetes dated 2/13/24 and Lantus pen injector - inject 50 units subcutaneously one time a day for diabetes dated 3/30/24 . Record review of Resident #53's treatment administration record dated 04/24/24 reflected Resident #53 received Lantus 20 units at bedtime on 04/01/24 through 04/23/24 and Lantus 50 units in the morning on 04/01/24 through 04/24/24. Observation on 04/24/24 at 09:30 AM during the medication cart inspection on Station A revealed Lantus pen injector with Resident #53's name on the label and no open date on the pen. Record review Resident #82's face sheet dated 04/24/24 revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included diabetes (high blood sugar), hypertension (high blood pressure, heart failure, and Alzheimer's disease (cognitive loss). (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #82's quarterly MDS assessment, dated 03/08/24 revealed no BIMS score, but indicated cognition was severely impaired. Section N - medications reflected Resident #4 had received insulin injections during the last 7 days. Record review of Resident #82's care plan dated 04/04/24 reflected a focus area Resident #4 had diabetes with intervention for diabetes medications as ordered by doctor. Record review of Resident #82's physician order listing report dated 04/24/24 reflected an order for insulin glargine subcutaneous solution 100unit/ml - inject 10 units subcutaneously at bedtime for diabetes dated 2/27/24 . Record review of Resident #82 treatment administration record dated 04/24/24 reflected Resident #82 received insulin glargine 10 units at bedtime on 04/01/24 through 04/23/24. Observation on 04/24/24 at 09:30 AM during the medication cart inspection on Station A revealed insulin glargine pen with Resident #82's name on the label and no open date on the pens. During an interview on 04/24/24 at 09:50 AM with the ADON, he stated all insulin pens should be dated when opened. He stated it was the nurse's responsibility to date the pen when opened. He stated he did not know why the pens were not dated. He stated the potential negative outcome could be given a resident insulin past the expiration date. He stated he was trained to date insulin pens on the day it was opened. During an interview on 04/25/24 at 02:00 PM with the DON, she stated all insulin pens should have a date on them when opened. She stated all staff have been trained to date multiuse pens when opened. She stated the nurses, ADON and DON were responsible to monitoring the medication carts and medication dates. She stated the potential negative outcome could be administering old or expired medications. During an interview on 04/25/24 at 04:15 PM with the ADM , she stated insulin pens should be dated when opened. She stated all nurses had been trained. She stated the nurse, medication aide, ADON and DON were responsible for making sure medications were dated. She stated the potential negative outcome could be giving a resident a medication that was expired or past date it can be given. Record review of facility policy titled Administering Medications dated April 2019 reflected the following: Policy Statement - medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 12. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container . Record review of facility policy titled Medication and Preparation Administration, undated reflected the following: 9.1 Prior to Medication Administration . (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The following general recommendations should be utilized during preparation of medication: . Facility staff should plan an opened-on date on the medication label for medications with limited expiration date upon opening .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41480 Based on observation, interview and record review, the facility failed to maintain an infection control program designed to provide a safe, comfortable, and sanitary environment to help prevent the development and transmission of diseases for 1 of 3 (Residents #82) and 1 of 1 (LVN B) staff reviewed for infection control. LVN B failed to change gloves after removing a soiled dressing and failed to wash her hands or use ABHR after glove change. LVN B failed to wear proper PPE. These failures could place residents at risk for spread of infection and cross contamination. Findings include: Record review Resident #82's face sheet dated 04/24/24 revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included diabetes (high blood sugar), hypertension (high blood pressure, heart failure, and Alzheimer's disease (cognitive loss). Record review of Resident #82's quarterly MDS assessment, dated 03/08/24 reflected no BIMS score, but indicated cognition was severely impaired. Section M - Skin conditions reflected the resident had 4 venous and arterial ulcers (leg ulcer caused by problems with blood flow in leg veins) present and infection of the foot. Record review of Resident #82's care plan dated 04/04/24 reflected a focus area that Resident #82 had wound to the right third toe, left third toe, left lateral (outer edge of the foot) foot and right great toe with interventions to treat wound as ordered and monitor the extremities for s/sx of injury, infection or ulcers. During an observation on 04/25/24 10:23 AM revealed wound care was provided by LVN B. LVN B entered Resident #82's room and placed supplies on the bedside table. LVN B washed her hands and donned gloves. LVN B removed the soiled dressing from left 3rd toe and placed it in the trash can. LVN B cleaned the wound with wound cleaner and gauze. LVN B applied Medi-honey to left 3rd toe wound and covered with alginate. LVN B picked up a dressing and stated, I forgot to date it. LVN B removed the glove from her right hand and took a marker out of her shirt pocket. LVN B wrote the date on the dressing. LVN B donned a new glove on her right hand and placed the dressing over the alginate. LVN B cleaned 3 other toes with a betadine swab using a new swab for each toe. LVN B removed her gloves and gathered the trash. LVN B donned a glove on her right hand and picked up the used glove off the floor. LVN B removed glove from right and placed it in the trash bag. LVN B washed her hands and exited room. Observation reflected there were no glove changes when going from dirty to clean and no hand washing or ABHR when LVN B removed her right glove. Observation also reflected LVN B did not wear a gown. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/25/24 at 11:00 AM with LVN B, she stated I should have changed my gloves after removing the old dressing. She stated she should have washed her hands or used ABHR between glove changes. She stated she should have worn a gown during wound care as part of the new enhanced barrier protection. She stated she did not have any reason to not change gloves or wear a gown. She stated, I just did not think about it. She stated the potential negative outcome could be spread infection or make it worse. She stated she had training on infection control, wound care, and handwashing. During an interview on 04/25/24 at 02:00 PM with the DON, she stated gloves should be changed after removing the soiled dressing and cleaning the wound. She stated hands should be washed if gloves were visibly soiled or could use ABHR between glove changes. She stated all nurses had been trained on wound care, infection control and handwashing. She stated RN A, ADON and DON were responsible to monitoring the staff for compliance with infection control. She stated the potential negative outcome could be spread of microorganisms. She stated RN A was the infection preventionist nurse and did all the training on infection control. During an interview on 04/25/24 at 03:14 PM with RN A, she stated she was responsible for monitoring infection control practices and education related to infection control. She stated all staff had been trained on infection control, handwashing, and enhanced barrier protection. She stated they need to wear a gown during wound care related to the new enhanced barrier protection . She stated enhanced barrier protection was to help prevent multidrug resistant bacteria spread. She stated hands should be washed between glove changes. She stated the potential negative outcome could be cross contamination between resident and objects. During an interview on 04/25/24 at 04:15 PM with the ADM, she stated staff should wash hands between glove changes. She stated LVN B should have changed her gloves after removing the soiled dressing. She stated any staff providing direct patient care with a wound or infection should be wearing a gown as it is part of the new enhanced barrier protection. She stated the DON was responsible for monitoring for compliance with infection control. She stated the DON would show staff the steps and then they do a return demonstration of the steps. She stated the potential negative outcome could spread bacteria and cross contamination between residents and staff. Record review Handwashing Skill assessment dated [DATE] reflected LVN B passed the assessment. Record review Donning on and doffing off protective patient equipment (PPE) skill assessment dated [DATE] reflected LVN B passed the assessment. Record review the facility in-service attendance sheet titled Handwashing/PPE dated February 2024 reflected LVN B signature and printed Name. Record review facility Inservice attendance sheet titled Handwashing/PPE dated March 2024 reflected LVN B signature and printed name. Record review facility Inservice attendance sheet titled Enhanced Barrier Precautions dated April 2024 reflected LVN B signature and printed name. Record review facility policy titled Enhanced Barrier Precautions dated August 2022 reflected the following: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455824	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Wurzbach Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 8300 Wurzbach Rd San Antonio, TX 78229	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Statement - Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Policy Interpretation and Implementation 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). b. Personal protective equipment (PPE) is changed before caring for another resident. 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: . h. wound care (any skin opening requiring a dressing) . 5. EBPs are indicated (when contact precautions does not otherwise apply) for residents with wounds and or indwelling medical devices regardless of MDRO colonization. 6. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk . Record review facility policy titled Handwashing/Hand Hygiene dated August 2019 reflected the following: Policy Statement - This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation . 6. Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations: a. When hands are visibly soiled; and . 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: . b. before and after direct contact with resident; . g. before handling clean or soiled dressings, gauze pads, etc.; h. before moving from a contaminated body site to a clean body site during resident care; i. after contact with a resident's intact skin; (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455824	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Wurzbach Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 8300 Wurzbach Rd San Antonio, TX 78229	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	j. after contact with blood or bodily fluids; k. after handling used dressings, contaminated equipment, etc; . m. after removing gloves; . 9. The use of gloves does not replace handwashing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections . Record review facility policy title Wound Care dated October 2010 reflected the following: Policy statement - The purpose of this procedure is to provide guidelines for the care of wounds to promote healing . Equipment and Supplies The following equipment and supplies will be necessary when performing this procedure. 1. Dressing material, as indicated (i.e., gauze, tape, scissors, etc.); 2. Disposable cloths, as indicated; 3. Antiseptic (as ordered); and 4. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed). Steps in the Procedure . 4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 6. Put on gloves .		