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	06/03/2022

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957 Based on interview and record review, the facility failed to allow the resident's representative the right to exercise the resident's rights to the extent those rights are delegated to the representative for 1 resident (Resident #1) of 6 residents reviewed for resident rights. The facility failed to ensure only female aides were assigned to Resident #1 after the RP requested that only female aides provide ADL care to the resident. On 05/30/22, CNA A (a male CNA) was about to dress Resident # 1 when she fell off the bed. This failure could place residents at risk of violating their resident rights and decrease of quality of life. The findings were: Record review of Resident #1's face sheet dated 06/02/22, and EMR (electronic medical record) revealed, the resident was [AGE] year-old female admitted on ,d+[DATE] and readmitted on [DATE]. Her diagnoses included: Alzheimer's disease (primary), dementia, age related osteoporosis (brittle and fragile bones), muscular degeneration, and muscle wasting with atrophy. RP (responsible party) was listed as a family member who was the residents Power of Attorney and the legal RP for the resident. Record review of Resident #1's Annual MDS , dated 4/20/22, revealed: o BIMS Score was 0 indicating severe impairment. o ADLs B/B incontinent of both. Transfer extensive 2 person. Bed Mobility (Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture) extensive 2 person assistance . Dressing: total dependence with one person assistance. ROM upper extremity-impairment on one side; lower extremity-impairment on both sides. Record review of Resident #1's Care Plan, undated, revealed: the resident required extensive assistance for ADLs. For the ADL of dressing, the intervention read, DRESSING: The resident requires extensive/total assistance by staff to dress. Dress resident in their own clothes. Allow resident to participate with choice of clothes as able. Allow sufficient time for dressing and undressing. The care plan also addressed the resident's risk for falls and her diagnosis of osteoporosis. Record review of facility's initial investigation report started 5/31/22 revealed: (continued on next page)

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

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The incident occurred on 5/30/22 at 7:00 AM. Description of Incident: 5/30/(22): CNA A delivering care (dressing) turned to get clothes from closet & resident slipped from bed. CNA A attempted to catch & protect torso but contracted feet hit floor. Accident, observed, did not report. 5/31(22) Ombudsman called to discuss neglect allegation. Reported a neglect allegation Written statement completed by Administrator of follow-up interview with CNA A, undated, revealed: CNA A raised Resident #1's bed, he turned to get clothes from the closet (and) heard her vocalize 'aye, aye' .she turned herself and started to fall from the bed. I reached for her (and) caught her by the torso & head, lowered her (to) the floor .her lower extremities hit the floor .called (CNA D) & (LVN F) for help . Record review of Resident #1's Nurse Note, dated 5/30/22, authored by LVN F, read: Assessment: Resident was receiving morning ADLs by CNA (A). When CNA (A) went to her closet to get her belongings resident slid out of the bed due to her contractures and being on a reduced pressure air mattress and not having the proper body mechanics to prevent from leaning towards gravity. Resident contacted the ground with both feet CNA was able to assist resident to floor without injuring upper body and preventing her from further injuries from landing on the floor. Nurse was then called to assess resident and noticed 4x abrasions to the left foot and above the ankle on the right leg had edema to the site. Resident was assisted back in bed by staff x2 for further assessment and scrap/abrasion was noted to the back of her left elbow. Resident is unable to verbalize what happen, but nurse noticed facial grimacing. MD called and gave order to send to (hospital) for further evaluation, family RP . was notified and stated she will meet her at hospital, and . ambulance notified and gave ETA (estimated time of arrival) of 30 minutes. DON and ADON notified. Will continue to monitor resident. Record review of resident #1's ER record, dated 5/30/22, revealed: Chief Complaint: Swelling and pain to the right lower calf. She was seen and evaluated by (MD C) and a pathologic fracture of the right tibia and fibula were noted between the middle and distal thirds. Additional fractures were noted to the proximal phalanx of the fifth toe and to the next of the second and third metatarsals. The left foot has a decubitus ulcer stage IV, down to the bone, treated with daily wound care with Silvadene with limited success. Her contractures make her decubitus potential extremely high and turning on in bed, no doubt carries a risk of a fracture again, but fall out of bed remains a mystery, unwitnessed . Record review of Resident #1's Fall Risk Score, dated 5/30/22, revealed a score of 10 (high risk for falls). [only fall risk assessment in the Resident's medical record. No mention as to what made the resident a risk for falls except that resident was bedbound and had contractures of both legs]. Record review of Resident #1's ADL sheet for the Month of May 2022 revealed, she was a one person assist for dressing and two persons for mechanical lift. On 5/30/22 there was no mechanical lift documented in the morning shift (6 AM -2 PM); no documentation for bed mobility that included dressing; coded as 97 meaning not applicable. (continued on next page)

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's incident report revealed no falls in the past 90 days 9 (March, April, May 2022). Record review of Nursing Staffing sheet for 5/30/22 revealed: (morning shift 6AM-2PM) 1 RN, 3 LVN, CNA 9, Medication Aide 2; total nursing staffing of 15. During a confidential interview on 6/2/22 at 9:00 AM, it was stated, the (Resident #1) experienced an injury, a fibula fracture, that might have happened from a forceful turn .the resident is contracted and bed bound and could not have fallen by herself .the family wanted the resident evaluated at the ER because of the injury to the resident's leg and right elbow .the resident is alert, not oriented and not verbal . [Location of confidential interview not disclosed by the surveyor]. Observation on 6/2/22 at 9:30 AM, Resident #1 was in a hospital bed, contracted in the right arm and both legs. The resident did not reveal bruises on the face, arms or legs. The resident had an inch skin tear to the right elbow that had healed. The resident's left foot revealed a pressure ulcer or wound. The resident was alert and not oriented; and could not answer any direct questions. During an interview on 6/22/22 at 9:37 AM, Resident #1's RP (was present in the hospital room with Resident #1) and revealed, she was concern about how the resident could had fallen given the resident was bedbound and had contractures of both legs. The RP felt the CNA A dropped the resident during a mechanical lift. Also, the RP was concerned that a male nurse aide dressed Resident #1 on the day of the incident 5/30/22. During an interview on 6/2/22 at 12;15 PM, Ombudsman revealed, she had suggested to the Administrator to assign a male nurse aide to Resident #1 after the incident of alleged sexual abuse a year ago. During an interview on 6/2/22 at 2PM, CNA A, revealed, he was not aware of the past sexual abuse allegation involving Resident #1 and the DON or Administrator had not told him he could not work with Resident #1 given she was a female. Also, CNA A revealed, that the RP had never objected to him working with Resident #1. mini after the allegation of sexual abuse . During an interview on 6/2/22 at 2:27 PM, the Administrator revealed, that the RP had requested that only a female nurse aide work with Resident #1 after the alleged incident of sexual abuse. During an interview on 6/2/22 at 4:00 PM LVN F revealed that she was not aware that only female nurse aides worked with Resident #1 per request of the RP. During an interview on 6/2/22 at 4:21 PM, the DON revealed that, she was aware the RP had made a request about a year ago after the alleged incident of sexual abuse that only female nurse aides worked with Resident #1. , Record review of CNA A's competency checklist, dated, 4/10/22, revealed, CNA A was checked for mechanical lift and gait belt with demonstration signed by LVN H. [No disciplinary action was taken against CNA A except providing him with more education.] [The competency checklist did not cover dressing of residents]. (continued on next page)

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 6/2/22 at 3:47 PM, CNA D, revealed, there was no mechanical lift in the room and CNA A (a male) was alone with the resident. Resident #1 was on the floor. During an interview on 6/2/22 at 4:00 PM, LVN F stated, on 5/30/22 in the morning around 6:40 PM, CNA D called me to help CNA A because Resident #1 was injured .when I entered the resident room she was totally on the floor .I assessed her and asked (CNA A) what happened .he said he was getting her a dress and heard her groaning for help and he held her upper body and he assisted her to the floor because of her contractures .the resident was on an air mattress .she was contracted and cannot pull back from falling .she might have slid form the mattress .she got injured by hitting the floor .he was only able to save her head and torso from hitting the floor .he lost sight of her .he was educated to first get her belongings or get a second person in the room so as to maintain 360 degree visibility .I notified the MD and RP and then the DON. The MD told me to send her out based on the injuries observed, the injuries observed were: right leg above ankle had edema and her left foot had abrasions to it, the resident was non-verbal and had a scrape to an elbow . we immediately started an in-service on fall prevention . During an interview on 6/2/22 at 4:21 PM, the DON revealed, on 5/30/22, she was informed by LNV (F) through a call that resident (#1) had fallen from the bed and (CNA A (a male) while he went to get her a dress and heard her falling and the resident's foot was dangling ; and he caught her torso and head and lowered to the floor and never left her alone. The resident was on the floor and he called another aide to get a nurse. DON stated, I cannot say why he lost sight of her .the usual procedure was to get the resident's clothing first .we started training on fall prevention .she could not move .we are about 80 %; on the training on fall prevention which started on 5/31/22 .the injury was known and it was a witnessed fall .and it was an accident .we have reported it to HHS because the Ombudsman expressed a concern . [The incident was reported on 6/1/22] During an interview on 6/2/22 at 4:40 PM, the Administrator revealed, he reported the incident to HHS because the Ombudsman had expressed a concern on 5/31/22 about Resident #1 falling The Administrator stated, it was an unfortunate accident .he (CNA A) turned to get a dress and took his eyes from her (Resident #1) and the accident occurred .gravity pulled her from the air mattress .resident might have re-positioned herself based on the CNA (A) statement .although she is contracted . The Administrator revealed that he recalled that the RP made a request about a year ago, after the alleged incident of sexual abuse, that only female nurse aides work with the resident. The Administrator revealed he would accommodate the RP's request based on staffing schedules by could not assure the RP that at all times only female nurse aides would work with the resident. During a telephone interview on 6/3/22 at 9:00AM, MD G revealed, Resident #1 was elderly and fragile and contracted. The MD stated, I cannot explain how she had a fall given she was bedbound, contracted, and basically non-mobile . [MD was not aware of the RP's request regarding the gender of the nurse aide] Record review of Resident #1's Admission Packet, dated 02/06/19, signed by the RP, read, page 12, .The facility must encourage and assist you to fully exercise your rights . Record review of Resident #1's Welcome to Nursing and Rehabilitation hand out, undated, read, .You have a right: .2. To safe, decent and clean conditions .10. To participate in developing a plan of care .

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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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957 Based on observation, interview, and record review the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 6 residents (Resident #1) reviewed for adequate supervision. CNA A failed to supervise Resident #1 while she was in bed resulting in Resident #1 falling off the bed resulting in fractures of the right tibia (the inner large bone between the ankle and knee) and fibula (the outer smaller bone between the ankle and knee) between the middle and distal thirds. Additional fractures were noted by the ER to the proximal phalanx (bone in the toe) of the fifth toe and to the next of the second and third metatarsals (bones of the foot). This failure could result in residents experiencing accidents, injuries and/or a diminished quality of life. The findings included: Record review of Resident #1's face sheet dated 06/02/22, and EMR (electronic medical record) revealed, the resident was a [AGE] year old female admitted on [DATE] and readmitted on [DATE] with diagnoses that included: Alzheimer's disease (primary), dementia, age related osteoporosis (brittle and fragile bones), muscular degeneration, and muscle wasting with atrophy. Record review of Resident #1's Annual MDS , dated 4/20/22, revealed: o BIMS Score was 0 indicating severe impairment. o ADLs B/B incontinent of both. Transfer extensive 2 person. Bed Mobility (Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture) extensive 2 person assistance . Dressing: total dependence with one person assistance. ROM upper extremity-impairment on one side; lower extremity-impairment on both sides. Record review of Resident #1's Care Plan, undated, revealed: the resident required extensive assistance for ADLs. For the ADL of dressing, the intervention read, DRESSING: The resident requires extensive/total assistance by staff to dress. Dress resident in their own clothes. Allow resident to participate with choice of clothes as able. Allow sufficient time for dressing and undressing. The care plan also addressed the resident's risk for falls and her diagnosis of osteoporosis. Record review of facility's initial investigation report started 5/31/22 revealed: The incident occurred on 5/30/22 at 7:00 AM. Description of Incident: 5/30/(22): CNA A delivering care (dressing) turned to get clothes from closet & resident slipped from bed. CNA A attempted to catch & protect torso but contracted feet hit floor. Accident, observed, did not report. 5/31(22) Ombudsman called to discuss neglect allegation. Reported a neglect allegation (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Written statement completed by Administrator of follow-up interview with CNA A, undated, revealed: CNA A raised Resident #1's bed, he turned to get clothes from the closet (and) heard her vocalize 'aye, aye' .she turned herself and started to fall from the bed. I reached for her (and) caught her by the torso & head, lowered her (to) the floor .her lower extremities hit the floor .called (CNA D) & (LVN F) for help . Record review of Resident #1's Nurse Note, dated 5/30/22, authored by LVN F, read: Assessment: Resident was receiving morning ADLs by can (A). When can (A) went to her closet to get her belongings resident slid out of the bed due to her contractures and being on a reduced pressure air mattress and not having the proper body mechanics to prevent from leaning towards gravity. Resident contacted the ground with both feet CNA was able to assist resident to floor without injuring upper body and preventing her from further injuries from landing on the floor. Nurse was then called to assess resident and noticed 4x abrasions to the left foot and above the ankle on the right leg had edema to the site. Resident was assisted back in bed by staff x2 for further assessment and scrap/abrasion was noted to the back of her left elbow. Resident is unable to verbalize what happen, but nurse noticed facial grimacing. MD called and gave order to send to (hospital) for further evaluation, family RP . was notified and stated she will meet her at hospital, and . ambulance notified and gave ETA (estimated time of arrival) of 30 minutes. DON and ADON notified. Will continue to monitor resident. Record review of resident #1's ER record, dated 5/30/22, revealed: Chief Complaint: Swelling and pain to the right lower calf. She was seen and evaluated by (MD C) and a pathologic fracture of the right tibia and fibula were noted between the middle and distal thirds. Additional fractures were noted to the proximal phalanx of the fifth toe and to the next of the second and third metatarsals. The left foot has a decubitus ulcer stage IV, down to the bone, treated with daily wound care with Silvadene with limited success. Her contractures make her decubitus potential extremely high and turning on in bed, no doubt carries a risk of a fracture again, but fall out of bed remains a mystery, unwitnessed . Record review of Resident #1's Fall Risk Score, dated 5/30/22, revealed a score of 10 (high risk for falls). [only fall risk assessment in the Resident's medical record. No mention as to what made the resident a risk for falls except that resident was bedbound and had contractures of both legs]. Record review of Resident #1's ADL sheet for the Month of May 2022 revealed, she was a one person assist for dressing and two persons for mechanical lift. On 5/30/22 there was no mechanical lift documented in the morning shift (6 AM -2 PM); no documentation for bed mobility that included dressing; coded as 97 meaning not applicable. Record review of Resident #1's incident report revealed no falls in the past 90 days 9 (March, April, May 2022). Record review of Nursing Staffing sheet for 5/30/22 revealed: (morning shift 6AM-2PM) 1 RN, 3 LVN, CNA 9, Medication Aide 2; total nursing staffing of 15. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a confidential interview on 6/2/22 at 9:00 AM, it was stated, the (Resident #1) experienced an injury, a fibula fracture, that might have happened from a forceful turn .the resident is contracted and bed bound and could not have fallen by herself .the family wanted the resident evaluated at the ER because of the injury to the resident's leg and right elbow .the resident is alert, not oriented and not verbal . [Location of confidential interview not disclosed by the surveyor]. Observation on 6/2/22 at 9:30 AM, Resident #1 was in a hospital bed, contracted in the right arm and both legs. The resident did not reveal bruises on the face, arms or legs. The resident had an inch skin tear to the right elbow that had healed. The resident's left foot revealed a pressure ulcer or wound. The resident was alert and not oriented; and could not answer any direct questions. During an interview on 6/22/22 at 9:37 AM, Resident #1's RP (was present in the hospital room with Resident #1) and revealed, she was concern about how the resident could had fallen given the resident was bedbound and had contractures of both legs. The RP felt the CNA A dropped the resident during a mechanical lift. During an interview on 6/2/22 at 12:15 PM, the Ombudsman stated, the resident (Resident #1) is bedbound and not mobile and has contractures; I saw her last week .she could not have fallen by herself . The Ombudsman revealed she did not express the latter concerns to the Administrator. During an interview on 6/2/22 at 2:00 PM, CNA A, stated, on 5/30/22 Resident #1 was his first resident and explained he would dress her. He had previously worked with the resident providing ADL services. The special training CNA A received was mechanical lift for the transfer of the resident. CNA A stated that only one person was needed to dress Resident #1 and two staff for transfer. He said he raised the bed up (provided no explanation for raising the bed) and then turned to select a dress then he heard her say, 'Aye Aye', she was off the bed and before she was flat on the bed. CNA A said he saw her feet off the bed and he went and pushed her back so that she would not fall. He said the feet were both dragging on the floor and might have hit the floor, and she had a contracted leg and one dressing to the right foot. There were no witnesses present. CNA said he called his co-worker (CNA D) and told her to call the nurse (LVN F).LVN F assessed the resident then we dressed the resident on the bed He said the family and the DON were called and the doctor was called. He said Resident #1 cannot move, but she can move her cradle feet. CNA A stated he did not transfer her and does not know how she was injured. CNA A stated he was competent on transfers and mechanical lifts and could not explain what happened. He said maybe the air mattress swallowed her and she turned and hit her legs and she fell on the floor only the feet. He said he held half her body, the feet hit the floor. Record review of CNA A's competency checklist, dated, 4/10/22, revealed, CNA A was checked for mechanical lift and gait belt with demonstration signed by LVN H. [No disciplinary action was taken against CNA A except providing him with more education.] [The competency checklist did not cover dressing of residents]. During a telephone interview on 6/2/22 at 3:47 PM, CNA D, revealed, there was no mechanical lift in the room and CNA A was alone with the resident. Resident #1 was on the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/2/22 at 4:00 PM, LVN F stated, on 5/30/22 in the morning around 6:40 PM, CNA D called me to help CNA A because Resident #1 was injured .when I entered the resident room she was totally on the floor .I assessed her and asked (CNA A) what happened .he said he was getting her a dress and heard her groaning for help and he held her upper body and he assisted her to the floor because of her contractures .the resident was on an air mattress .she was contracted and cannot pull back from falling .she might have slid form the mattress .she got injured by hitting the floor .he was only able to save her head and torso from hitting the floor .he lost sight of her .he was educated to first get her belongings or get a second person in the room so as to maintain 360 degree visibility .I notified the MD and RP and then the DON. The MD told me to send her out based on the injuries observed, the injuries observed were: right leg above ankle had edema and her left foot had abrasions to it, the resident was non-verbal and had a scrape to an elbow . we immediately started an in-service on fall prevention . During an interview on 6/2/22 at 4:21 PM, the DON revealed, on 5/30/22, she was informed by LNV (F) through a call that resident (#1) had fallen from the bed and (CNA A) while he went to get her a dress and heard her falling and the resident's foot was dangling ; and he caught her torso and head and lowered to the floor and never left her alone. The resident was on the floor and he called another aide to get a nurse. DON stated, I cannot say why he lost sight of her .the usual procedure was to get the resident's clothing first .we started training on fall prevention .she could not move .we are about 80 %; on the training on fall prevention which started on 5/31/22 .the injury was known and it was a witnessed fall .and it was an accident .we have reported it to HHS because the Ombudsman expressed a concern . [The incident was reported on 6/1/22] During an interview on 6/2/22 at 4:40 PM, the Administrator revealed, he reported the incident to HHS because the Ombudsman had expressed a concern on 5/31/22 about Resident #1 falling The Administrator stated, it was an unfortunate accident .he (CNA A) turned to get a dress and took his eyes from her (Resident #1) and the accident occurred .gravity pulled her from the air mattress .resident might have re-positioned herself based on the CNA (A) statement .although she is contracted . During a telephone interview on 6/3/22 at 9:00AM, MD G revealed, Resident #1 was elderly and fragile and contracted. The MD stated, I cannot explain how she had a fall given she was bedbound, contracted, and basically non-mobile . Record review of facility's Falls and Fall Risk, Managing policy, dated revised April 2022) read, .Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications of falling . Record review of in-service sign in-sheet on Fall Prevention, dated 6/1/22, conducted by DON revealed (% of the nursing staff completed the training at time of exit (6/2/22). Total nursing staff was 41.