STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455824	A. Building B. Wing	03/03/2023

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21939 Based on observation, interview, and record review the facility failed to ensure 1 of 46 (Resident #67) sampled residents was treated with dignity during dining room observation. CNA A prevented Resident #67 to move freely by locking his wheelchair after he was finished with his breakfast. This failure could affect all residents in the facility and could result in residents not being treated with dignity. The findings were: Record review of Resident #67's Admission Record (03/03/2023) revealed an admitted [DATE] with diagnoses of Hemiplegia and Hemiparesis following cerebral infarction, Cerebral Infarction, unspecified, and Irritable Bowel Syndrome with Diarrhea. Record review of Resident #67's care plan (02/14/2023) revealed he was at risk for falls due poor safety awareness and needed extensive assistance with activities of daily living with the assistance of two staff when combative. Further record review revealed Resident #67 propels short distances with his wheelchair. Record review of Resident #67's MDS (02/21/2023) revealed a Brief Interview for Mental Status (BIMS) score of 99 (resident was unable to complete the interview). Further review revealed Resident #67 had no potential for indicators of psychosis and exhibited no physical or verbal behavioral symptoms towards others. During an observation on 02/27/23 12:16 p.m., Resident #67 was observed eating his meal. After Resident #67 had finished at 12:20 p.m., he started to reverse-propel himself away from the dining table. Further observation revealed CNA A pushed his wheelchair back under his dining table and proceeded to lock his wheel. CNA A was observed telling Resident #67 to stay there until she can help him get to his bed after she's done with her task. Resident #67 was observed in the same position until 12:40 p.m., when he was assisted out of the dining area. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/28/23 at 09:37 a.m., CNA A stated I wanted to leave the patient in the dining room to monitor him until she can put him in bed because he was a fall risk. Further interview revealed CNA A didn't realized she wasn't supposed to lock Resident #67's wheelchair. During an interview on 03/01/2023 at 04:10 p.m., the Administrator stated locking a resident's wheelchair was part of CNA training and depended on safety, transfer, or if a resident was standing. Further interview with the Administrator revealed it wouldn't be a practice for a CNA to lock their wheelchair after a resident was done eating (and wanting to leave the table) or locking the wheelchair until the CNA can put patient to bed. Further interview with the Administrator revealed patients were free to roam unless they were a danger to self or others. Observation on 3/2/2023 at 12:15 p.m. revealed Resident #67 was able to release his wheelchair brakes on his own. Record review of the agency's policy titled Resident Rights (2001), read in part, .Employees shall treat all residents with kindness, respect, and dignity .I. Exercise his or her rights without interference, coercion, discrimination or reprisal from the facility .

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews and record reviews the facility failed to ensure residents had the right to and the facility had made prompt to resolve grievances the residents may have had, in accordance with identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; for 2 of 5 residents(Resident #6 and Resident #17) reviewed for grievances, in that: 1. Resident #6 family made a grievance in reference to the bruise to Resident #6's chest, under arm, and back, were not consistent with her planned quality of care; for which the facility did not initiate a grievance process. 2. Resident #17 made a grievance regarding her need for a back brace; for which the facility did not initiate a grievance process. These failures could place residents at risk for a diminished quality of life by their grievances not being processed. The findings included: 1. A record review of Resident #6's Admission Record, dated 02/28/2023, revealed an admitted [DATE], with diagnoses which included Alzheimer's disease [causes the brain to shrink and brain cells to eventually die] and dementia [a range of conditions that affect the brain's ability to think, remember, and function normally]. Further review revealed Resident #6 was represented by a Guardian [Guardian Q]. A record review of Resident #6 quarterly MDS, dated [DATE], revealed Resident #6 was an [AGE] year-old female who could usually understand some conversations, could usually make herself understood, given time; however, Resident #6 was assessed to have severe cognitive impairment with short- and long-term memory problem. A record review of Resident #6's medical records revealed a Weekly Skin Observation Tool, dated 01/27/2023, Observations; does Resident have any observed skin issues? No. A record review of Resident #6's medical records revealed a Progress Note, dated 01/30/2023, authored by LVN G, c/o [complaint of] pain to RT [right] shoulder. PRN [as needed] tramadol and muscle pain cream applied. Notified [Nurse Practitioner P] Xray ordered to RT. Shoulder claim #XXXXXXXX. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #6's medical records revealed a Progress Note, dated 01/30/2023, authored by LVN G, [Resident #6 Family Member] on premises to visit [Resident #6] this nurse notified him of some bruising to RT [right] shoulder and c/o [complaint of] pain and Xray was ordered [Resident #6 Family Member] got upset and stated the reason why she is here is to protect her and her [Resident #6 Family Member] kept asking her what happened she said I don't know then [Resident #6 Family Member] asked who hurt you [?] and she responded no one hurt her she does not know what happened. Call placed to [Guardian] mailbox full. During an interview on 02/28/2023 at 02:15 PM LVN G stated she had assessed Resident #6 with a bruise to her right under arm and chest and reported the bruise to [Resident #6 Family Member] when they visited. LVN stated she wrote a progress note in Resident #6's medical record. LVN G stated the bruise was of unknown origin and [Resident #6 Family Member] became upset when they were told about the injury. LVN G stated she had reported the bruise to the next on-coming nurse and reported the bruise to [Nurse Practitioner P] but had not reported [Resident #6 Family Member]'s complaint as a grievance. LVN G stated she had not considered [Resident #6 Family Member] being upset as a grievance. LVN G stated she had been trained to assist residents and families to provide the grievance forms and to assist with reporting grievances to the facility's Administrator. LVN G stated she was not aware where grievance forms are kept and after a search of the nurses' station could not produce a grievance form. LVN G stated she can now understand she could have further assisted [Resident #6 Family Member] by asking [ADON D] for a grievance form. During an interview on 03/02/2023 at 07:56 AM, Resident #6's Family Member stated they spoke with LVN G and stated, it's not right she [Resident #6] had a bruise. Resident #6's Family Member stated they had a concern, no one could explain how this happened [bruise]. Resident #6's Family Member stated Resident #6 claimed, I don't know how the bruise came to be. Resident #6's Family Member stated no one has reported to him the results of how this [bruise] happened. Resident #6's Family Member stated he had no education on the facility's grievance policy, had not been offered a grievance form, and or been supported to file a grievance on behalf of Resident #6. 2. A record review of Resident #17's admission record, dated 03/01/2023, revealed an admitted [DATE], with diagnoses which included wedge compression fracture of T11-T12 vertebra [thoracic area of the spine], age-related osteoporosis [a silent disease that weakens your bones and makes them break easily], spinal stenosis [can cause pressure on your spinal cord or the nerves that go from your spinal cord to your muscles], lumbar region with neurogenic claudication [spinal nerves get compressed in the lower spine, causing intermittent leg pain], and kyphosis [a spinal disorder in which an excessive curve of the spine results in an abnormal rounding of the upper back]. A record review of Resident #17's care plan dated 03/01/2023, revealed, The Resident has osteoporosis . the Resident has pain related to vertebrae compression fractures and muscle pain .interventions . monitor/document report as needed signs and symptoms or complications related to osteoporosis: acute fracture, compression fractures, loss of height, kyphosis, pian, especially back pain. A record review of Resident #17's quarterly MDS, dated [DATE], revealed Resident #17 was an [AGE] year-old female with needs for assistance with activities of daily life complicated by back pain, spine curvature, and porous bones. Resident #17's assessment revealed a BIMS of 14 out of 15 which indicated no mental cognition impairment. Resident #17 could be understood and could understand others. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #17's medical records revealed a progress note, dated 10/7/2023, authored by Resident #17's neurosurgeon, Medical Doctor L, . this is an [AGE] year-old female with osteoporosis and T12, L2 compression fractures with ongoing axial low back pain issues status post kyphoplasty [after a surgery to fix broken vertebrae caused by compression fractures, which can cause pain and deformity] at T12 and L2, 3 weeks ago. Patient no longer has the back brace. We will refer her to orthotics clinic for a TLSO [NAME] extension brace [a unique tool for limiting motion of the spine and reducing pressure on its tissues]. Brace should be worn at all times. A record review of Resident #17's medical records revealed an Encounter Summary, dated 10/12/2022, encounter type, after this visit, October 7th 2022 .reason for referral . orthotics, diagnosis, compression fracture of T12 vertebrae . comments: needs new TLSO [NAME] extension brace for T12 compression fracture with worsening kyphosis status post kyphoplasty . electronically signed by [Medical Doctor L]. During an observation and interview on 02/28/2023 beginning at 02:00 PM, Resident #17 presented in her wheelchair self-ambulating to the dining room. Resident #17 was asked the question, are your needs being met here at the facility?, Resident #17 replied her needs were not being met. Resident #17 stated she had a painful curved spine, had recent spine surgery, and had a need for a back brace, which the neurosurgeon [Medical Doctor L] ordered for her. Resident #17 stated she had a back brace prior to her admission to the facility but somehow it has gone missing. Resident #17 stated she had been to the neurosurgeon [Medical Doctor L] in November [2022] and was prescribed a new back brace but has not received the brace. Resident #17 stated she has complained and asked for a status on the back brace often and has been told the hold-up is insurance paperwork. Resident #17 stated she has no money to pay for the back brace and the facility has reported to her they are attempting to have the neurosurgeon doctor's office fill out paperwork to have Medicaid pay for the brace. Resident stated she has been waiting for the brace since November of 2022. She stated she had had chronic pain and wishes to have the back brace, so my spine will not get worse. Resident #1 stated she has been strong and has not asked for much pain medication and stated she manages her pain by finding a comfortable position while sitting and or laying and only moves when she needs to due to the pain. Resident #17 stated she has asked for the status of her receiving the back brace from many staff members without resolve. Resident #17 stated she had not been offered a grievance form, stated she had not specifically requested a grievance form but had continued to complain and ask about the status of her back brace. Resident #17 stated the situation made her feel, angry and neglected. During an interview on 02/28/2023 at 10:00 AM, LVN E stated Resident #17 needed a back brace. LVN E stated Resident #17 has seen the neurosurgeon [Medical Doctor L] and has been fitted for the [TLSO] back brace, however the brace will not be supplied by the shop until the neurosurgeon's office has had the doctor sign and return 2 documents. LVN E stated she, the ADON, and the DON, have been working with the doctor's office since December [2022] and have not been able to have the doctor's office return the 2 documents needed to pay for the brace. LVN E stated Resident #17 was aware of the situation due to LVN E gives her a report when Resident #17 asks about her back brace. LVN E stated she had not generated a grievance for Resident #17 because Resident #17 was not complaining about her back brace but was asking about her back brace. LVN E stated she was actively attempting to secure Resident #17's back brace. LVN E could not give details to exact dates and times Resident #17 inquired about her back brace. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/01/2023 at 04:10 PM ADON D stated the grievance forms were kept in a binder which was kept on a table by the facility's entrance. When asked if there were grievance forms in other places like the nurses' station ADON D stated she did not know but believed the forms were only kept in the binder by the facility's entrance. ADON D stated she had not generated a grievance form on behalf of Resident #17 since Resident #17 did not complain about her back brace but was only asking about her back brace and she and staff were actively attempting to secure the back brace. ADON D could not give details to exact dates and times Resident #17 inquired about her back brace. During an observation and record review on 03/02/2023 beginning at 04:20 PM revealed a small 2 shelved rectangular table located by the facility's front entrance upon which a 1 white 3 ringed binder was shelved on the tables lower shelf. The binder was labeled concerns and compliments. Record review of the contents of the binder revealed blank grievance forms. During an interview on 03/03/2023 at 08:30 AM, the Administrator stated the grievance forms were kept in a binder which was kept on a table by the facility's entrance. The Administrator stated grievances, on behalf of residents, can be made by anyone to include staff, residents' visitors and / or family members. The Administrator stated no one had reported a grievance to him regarding Resident #6's bruising but he was aware of Resident #17's inquiries for her back brace. The administrator stated the facility was actively working with the physicians' offices to secure the back brace and Resident #17 had made inquiries which were not complaints therefore no grievance reports were generated. The Administrator stated the monthly Resident council meeting is not only a forum for grievances but can also be a positive / compliment comments forum. The Administrator stated if grievances are made the staff are trained to provide the complainant a grievance form and the grievance would be directed to the appropriate department for investigation and resolution. A facility grievance policy was requested and provided on 03/02/2023 but was not secured by the surveyor.

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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** 41937 Based on interviews and record reviews the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source are reported immediately to the administrator of the facility and to other officials, including to the State Survey Agency in accordance with State law through established procedures, for 1 of 5 Residents (Resident #6) reviewed for injuries of unknown origin reporting, in that: Resident #6 was assessed with a large bruise from her chest to her under arm and continued to her back, which was not investigated and not reported to the state agency and Resident #6's Guardian as an injury of unknown origin. This failure could place Resident(s) at risk for harm by further exposure to injuries without proper investigation and reporting. The findings included: A record review of Resident #6's Admission Record, dated 02/28/2023, revealed an admitted [DATE], with diagnoses which included Alzheimer's disease [causes the brain to shrink and brain cells to eventually die] and dementia [a range of conditions that affect the brain's ability to think, remember, and function normally]. Further review revealed Resident #6 was represented by a Guardian [Guardian Q]. A record review of Resident #6 quarterly MDS, dated [DATE], revealed Resident #6 was an [AGE] year-old female who could usually understand some conversations, could usually make herself understood, given time; however, Resident #6 was assessed to have severe cognitive impairment with short- and long-term memory problems. A record review of Resident #6's medical records revealed a Weekly Skin Observation Tool, dated 01/27/2023, Observations; does Resident have any observed skin issues? No. A record review of Resident #6's medical records revealed a Progress Note, dated 01/30/2023, authored by LVN G, c/o [complaint of] pain to RT [right] shoulder. PRN [as needed] tramadol and muscle pain cream applied. Notified [Nurse Practitioner P] Xray ordered to RT. Shoulder claim #XXXXXXXX. A record review of Resident #6's Weekly Skin Observation Tool, dated 01/30/2023, revealed, Observations; does Resident have any observed skin issues? Yes .site: right shoulder bruising . A record review of Resident #6's medical records revealed a Progress Note, dated 01/30/2023, authored by LVN G, [Resident #6 Family Member] on premises to visit [Resident #6] this nurse notified him of some bruising to RT [right] shoulder and c/o [complaint of] pain and Xray was ordered [Resident #6 Family Member] got upset and stated the reason why she is here is to protect her and her [Resident #6 Family Member] kept asking her what happened she said I don't know then [Resident #6 Family Member] asked who hurt you [?] and she responded no one hurt her she does not know what happened. Call placed to [Guardian Q] mailbox full. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #6's medical records revealed a Progress Note, dated 01/30/2023, authored by LVN R, Resident is day 2/3 bruise to R [right] axilla site [arm pit]. Site is c [with] swelling, warmth and discoloration. Localized inflammation to site. Noted to grimace upon assessment c [with] Tylenol regiment offered per this nurse and resident refusing x2 [twice] attempts. Allow this nurse to slightly prop arm on pillow. Resident observed to touch site often. Pleasantly confused to baseline. Receptive to staff assessment. Routine X-ray results in with right shoulder demonstrating no acute fracture. No joint discoloration. mild Bony demineralization. unremarkable soft tissues. there is severe AC joint [shoulder joint] and mild glenohumeral [the joint that connects the body to the arm] arthritis manifested by joint space narrowing, subchondral sclerosis, and degenerative spurring. will follow up with team health as indicated. A record review of Resident #6's medical records revealed a Nurse Practitioner's Progress Note, dated 01/31/2023, authored by Nurse Practitioner P, revealed, Chief complaint / nature of presenting problem: follow up done on large bruising to chest and underarm area reported by nursing today. patient is unable to recall events. She can verbalize needs and report concerns to nurses. Patient is not currently on blood thinners. no falls reported. Have met with director of nursing / administrator to discuss further. Plan: hematoma / ecchymosis [bruising] to chest yellowish in color. Patient is unable to recall how she got it. No falls or trauma reported by nursing. Marking may be associated with gait belt for transfers as it goes around chest and underarms. Patient denied pain at this time. Will monitor for now. During an interview and record review on 02/28/2022 at 01:25 PM Resident #6's Guardian, Guardian Q, stated she was not aware Resident #6 had an injury of unknow origin. Guardian Q stated she would have expected the facility to have reported any injury, especially a large bruise of unknown origin to her and possibly to the police. Guardian Q stated she could be contacted by cell phone, text message, and or her email. Guardian Q and surveyor confirmed contact information held by the facility as accurate. Guardian Q stated if by chance she missed a cell call she could have been contacted by email and or text message. During an interview on 02/28/2023 at 02:15 PM LVN G stated she had assessed Resident #6 with a bruise to her right under arm and chest and reported the bruise to Nurse Practitioner P and RN F. LVN stated she wrote a progress note in Resident #6's medical record. LVN G stated the bruise was of unknown origin and Resident #6 could not state how she developed the bruise. LVN G stated she had not considered Resident #6's bruise a reportable event. LVN G stated she now understands, due to reflection of the incident, Resident #6's injury of unknown origin was a reportable event she should have reported to the Administrator. During an interview on 03/02/2023 at 07:56 AM, Resident #6's Family Member stated they spoke with LVN G and stated, it's not right she [Resident #6] had a bruise. Resident #6's Family Member stated they had a concern, no one could explain how this happened [bruise]. Resident #6's Family Member stated Resident #6 claimed, I don't know how the bruise came to be. Resident #6's Family Member stated no one has reported to him the results of how this [bruise] happened. During an interview on 03/03/2023 at 08:30 AM, the Administrator stated he did not believe Resident #6's injury of unknown origin was not a reportable incident due to Resident #6's own report that no one hurt her, even though the surveyor reminded the Administrator of a record review of Resident #6's diagnoses of Alzheimer's disease and dementia. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility's Recognizing Signs and Symptoms of Abuse / Neglect policy, dated April 2021, revealed, All types of resident abuse, neglect, exploitation, or misappropriation of resident property are strictly prohibited. All personnel are expected to report any signs and symptoms of abuse / neglect to their supervisor or to the director of nursing services immediately. Policy interpretation and implementation: The following are signs and symptoms of abuse / neglect there should be promptly reported. this listing is not all inclusive. other signs and symptoms are actual abuse /neglect may be apparent . signs of physical abuse: injuries that are non-accidental or unexplained . bruises, including those found in unusual locations such as the head neck lateral locations on the arms or posterior trunk and torso . signs of sexual abuse: bruises around the breast, general area or inner thighs . A record review of the facility's Abuse, neglect, exploitation and misappropriation prevention program policy, 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 residents' symptoms. Policy interpretation and implementation . the resident abuse, neglect and exploitation prevention program consists of a facility wide commitment and resource allocation to support the following objectives: protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: staff; other residents . identify and investigate all possible incidents of abuse neglect, mistreatment for misappropriation of resident property .investigate and report any allegations within time frames required by federal requirement .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on interviews and record reviews the facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following, The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 8 (#47) residents in the secured memory care unit in that: Resident #47 did not have a care plan for care in the secure memory care unit. This could affect residents in the secure unit and could result in residents not provided care while in the memory care unit. The findings included: Record review of Resident #47's Admission Record dated March 2. 2023 revealed she was admitted to the facility on [DATE] with diagnoses of dementia, schizoaffective, adult failure to thrive, major depressive disorder, convulsions, diabetes and muscle wasting/atrophy with hospice services. Record review of Resident #47's care plan dated completed date 2/25/2023 revealed Resident #47 had potential to be physically/verbally aggressive related to difficulty with adjustments to change of facility and when re-directed, previously threw a chair at a window, impaired cognition related to dementia, hallucinations/delusions; at risk for falls related to decreased cognition, medications and history of falls, and under hospice services (start date 8/18/2022). Resident #47 did not have a care plan for the memory care unit. Record review of Resident #47 Quarterly MDS dated [DATE] revealed her BIMs score was 99, her cognition was severely impaired. Record review of Resident #47's memory care unit continued stay review assessment dated [DATE] and completed on this date 3/1/23 after surveyor intervention. Record review of Resident #47 consolidated physicians' orders for March 2023 revealed she lived in the secured memory care unit start date 10/12/2021. Observation on 2/28/2023 at 9:35 AM revealed Resident #47 was in her room, in the secure unit. Interview on 2/28/2023 at 9:38 AM with LVN B stated Resident #47 was an elopement risk and she had a history of COVID (residents with COVID-19 were moved to the secured memory care unit. (continued on next page)

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	455824	A. Building B. Wing	03/03/2023

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/02/23 at 3:14 PM with SW stated she was responsible for residents' memory care assessments, but not the initials. The SW stated she took over the memory care assessments around May 2022. The SW stated she should keep track of assessments in memory care, but she relied on the PCC alerts and those are not always accurate. The SW stated the memory care unit continued stay review assessment should be completed quarterly. The SW confirmed Resident #47 did not have memory care unit continued stay review assessments for 2022. Interview on 3/02/2023 at 3:47 PM with RN MDS C stated she did not see Resident #47's secured memory care unit in her care plan. RN MDS stated she missed inputting Resident #47's memory care unit care and will fix. The RN MDS stated during morning meetings they review resident admissions, re-admission and any change of conditions to include in a resident's care plan. Record review of the facility Care Plan Comprehensive Person -Centered policy dated 2001 revealed A comprehensive, person-centered cater plan that includes measurable objective and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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F 0684 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observations, interviews, and record reviews the facility failed to ensure the rights of residents to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents, for 1 of 5 residents reviewed (Resident #17) for accommodation of orthotic support devices, in that: The facility failed to report to Resident #17's physician's the inability to fulfill Resident #17's order for a back brace, ordered by a neurologist [a medical doctor who specializes in diagnosing and treating diseases of the brain, spinal cord, and nerves]. Resident #17 had a compression fracture of vertebra and kyphosis. Resident #17had spinal surgery and an order for a back brace from November 2022 that she did not receive. Resident revealed she was in [NAME] pain. This failure could place residents at risk for denial of their rights to have reasonable accommodations. The findings included: A record review of Resident #17's admission record, dated 03/01/2023, revealed an admitted [DATE], with diagnoses which included wedge compression fracture of T11-T12 vertebra [thoracic area of the spine], age-related osteoporosis [a silent disease that weakens your bones and makes them break easily], spinal stenosis [can cause pressure on your spinal cord or the nerves that go from your spinal cord to your muscles], lumbar region with neurogenic claudication [spinal nerves get compressed in the lower spine, causing intermittent leg pain], and kyphosis [a spinal disorder in which an excessive curve of the spine results in an abnormal rounding of the upper back]. A record review of Resident #17's care plan dated 03/01/2023, revealed, The Resident has osteoporosis . the Resident has pain related to vertebrae compression fractures and muscle pain .interventions; . monitor/document report as needed signs and symptoms or complications related to osteoporosis: acute fracture, compression fractures, loss of height, kyphosis, pian, especially back pain. A record review of Resident #17's quarterly MDS, dated [DATE], revealed Resident #17 was an [AGE] year-old female with needs for assistance with activities of daily life complicated by back pain, spine curvature, and porous bones. Resident #17's assessment revealed a BIMS of 14 out of 15 which indicated no mental cognition impairment. Resident #17 could be understood and could understand others. A record review of Resident #17's medical records revealed a progress note, dated 10/7/2023, authored by Resident #17's neurosurgeon, Medical Doctor L, . this is an [AGE] year-old female with osteoporosis and T12, L2 compression fractures with ongoing axial low back pain issues status post kyphoplasty [after a surgery to fix broken vertebrae caused by compression fractures, which can cause pain and deformity] at T12 and L2, 3 weeks ago. Patient no longer has the back brace. We will refer her to orthotics clinic for a TLSO [NAME] extension brace [a unique tool for limiting motion of the spine and reducing pressure on its tissues]. Brace should be worn at all times. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	A record review of Resident #17's medical records revealed an Encounter Summary, dated 10/12/2022, encounter type, after this visit, October 7th 2022 .reason for referral . orthotics, diagnosis, compression fracture of T12 vertebrae . comments: needs new TLSO [NAME] extension brace for T12 compression fracture with worsening kyphosis status post kyphoplasty . electronically signed by [Medical Doctor L]. During an observation and interview on 02/28/2023 at 02:00 PM, Resident #17 presented in her wheelchair self-ambulating to the dining room. Resident #17 was asked the question, are your needs being met here at the facility?, Resident #17 replied her needs were not being met. Resident #17 stated she had a painful curved spine, had recent spine surgery, and had a need for a back brace, which the neurosurgeon [Medical Doctor L] ordered for her. Resident #17 stated she had a back brace prior to her admission to the facility but somehow it has gone missing. Resident #17 stated she had been to the neurosurgeon [Medical Doctor L] in November [2022] and was prescribed a new back brace but has not received the brace. Resident #17 stated she has complained and asked for a status on the back brace often and has been told the hold-up is insurance paperwork. Resident #17 stated she has no money to pay for the back brace and the facility has reported to her they are attempting to have the neurosurgeon doctor's office fill out paperwork to have Medicaid pay for the brace. Resident stated she has been waiting for the brace since November of 2022. She stated she had had chronic pain and wishes to have the back brace, so my spine will not get worse. Resident #1 stated she has been strong and has not asked for much pain medication and stated she manages her pain by finding a comfortable position while sitting and or laying and only moves when she needs to due to the pain. Resident #17 stated the situation made her feel, angry and neglected. During an interview on 02/28/2023 at 10:00 AM, LVN E stated Resident #17 needed a back brace. LVN E stated Resident #17 has seen the neurosurgeon [Medical Doctor L] and has been fitted for the [TLSO] back brace, however the brace will not be supplied by the shop until the neurosurgeon's office has had the doctor sign and return 2 documents. LVN E stated she, the ADON, and the DON, have been working with the doctor's office since December [2022] and have not been able to have the doctor's office return the 2 documents needed to pay for the brace. LVN E stated Resident #17's attending physician at the facility is Medical Doctor N and is seen by Medical Doctor N's Nurse Practitioner O. LVN E stated she had not given Medical Director N nor Nurse Practitioner O a report about Resident #17 needed a back brace and did not have one. LVN E stated they know [Medical Director N nor Nurse Practitioner O] because they can read the notes and the Resident [#17] can tell them. A record review of Resident #17's medical record revealed a progress note authored by LVN E, dated 01/31/2021, detailing the most recent attempted call to neurosurgeon Medical Doctor L. The note revealed, Call placed to [name] orthotics clinic to follow up on [Resident #17's] TLSO Brace. Spoke to [M orthotics clinic personnel] who stated they have now sent SWO and title 19 forms to [Medical Doctor L's] office three times, since my last call. Forms have not been returned and the orthotics has called and emailed [Medical Doctor L] regarding the forms several times. Last attempt was 01/27/2023. Writer called [Medical Doctor L's] office to follow-up on forms. Message left for Dr. that Resident [#17] does not have brace and cannot attend his desired follow-up with brace due to forms not being faxed back to orthotics clinic. Expecting return phone call from [Medical Doctor L]. will continue to follow up. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	During an interview on 02/28/2023 at 10:20 AM, ADON D stated she was aware of Resident #17's need of a back brace and stated she and her staff have been attempting to have the appropriate paperwork supplied to the orthotics shop for payment of Resident #17 back brace. ADON D stated the facility and Resident #17 were waiting for the doctor's office [Medical Doctor L] to fill out the paper-work for Resident #17. ADON D stated she had not given Medical Director N nor Nurse Practitioner O a report about Resident #17 needed a back brace and did not have one. ADON D stated she believed everyone knew about Resident #17 back brace situation. ADON D stated there were many progress notes in Resident #17's chart. During an interview on 03/01/2023 at 11:10 AM, the SW stated she was aware Resident #17 needed a back brace but was not able to receive the back brace for unknown reasons. The SW stated she was not asked to intervene and advocate for Resident #17 by anyone at the facility. The SW stated she understood it was being resolved by the nursing staff. The surveyor asked the SW what could she have done if someone had asked her to intervene and advocate for Resident #17? The SW stated, Maybe, I would have called the doctor or doctors. During an interview on 03/01/2023 at 04:48 PM the Medical Director stated he was the medical Director for the facility and Resident #17. Medical Director stated Medical Doctor N was a peer and attended to Resident #17. The Medical Director stated no one has reported to him Resident #17 needed a back brace. The Medical Director stated Resident #17 had a kyphosis diagnosis and understood she was being seen by a neurosurgeon but did not know about the neurosurgeon's order for a back brace and the lack of the brace for Resident #17. The Medical Director stated he could not state what effect the lack of the brace could have on Resident #17 and Resident #17 should be re-assessed by the neurosurgeon due to the prolonged time Resident #17 has been without the brace. When asked if the facility had given the Medical Director a report what could you have done? The Medical Director replied, well, there are many interventions .but I could have intervened by calling the neurosurgeon [Medical Doctor L] .a physician-to-physician call surveyor asked, an intervention. The Medical Doctor replied, Yes. During an interview on 03/01/2023 at 05:48 PM Nurse Practitioner O stated no one has reported to him, nor Medical Doctor N, Resident #17 needed a back brace. NP O stated Resident #17 had a kyphosis diagnosis and understood she was being seen by a neurosurgeon but did not know about the neurosurgeon's order for a back brace and the lack of the brace for Resident #17. Nurse Practitioner O could not state what effect the lack of the brace could have on Resident #17 and Resident #17 should be re-assessed due to the prolonged time Resident #17 has been without the brace. Nurse Practitioner O stated he would give Medical Doctor N a report. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	During an interview on 03/02/2023 at 10:05 AM the DON stated she was aware and very involved in the situation of Resident #17's back brace. The DON stated she and her staff have been trying to work with Medical Doctor L's office to secure the 2 documents needed to secure Resident #17 back brace and have had no success with Medical Doctor L's office. The DON stated, we have done all we could, they have not returned the documents needed. When asked if the Medical Director, Resident #17's attending Medical Doctor N, or Nurse Practitioner O have been given a report the DON stated, yes they know, when asked for documentation to support the medical doctors knew; the DON stated there was not any documentation other than the progress notes which detail all the requests for the brace and/or paper-work needed from the doctor's office [Medical Doctor L's office]. When the DON was asked who was responsible for the failure to secure Resident #17's back brace; the DON replied, the doctor's office [Medical Doctor L's office] who would not supply the signed forms needed by the orthotics clinic. When the DON was asked how this failure could affect Resident #17; the DON stated the surveyor could ask the doctor. An accommodation of needs policy regarding Resident #17's back brace orthotics equipment was requested from the DON; the DON replied she did not believe there would be a specific policy for the situation due to the facility was not responsible to pay for items such as back braces. A record review of the facility's personal property policy did not adequately address the facility's response to Resident #17's reasonable accommodation of need for a back brace.

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F 0696 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care/assistance for a resident with a prosthesis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews, and record reviews the facility failed to ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the residents' goals and preferences, to wear and be able to use the prosthetic device for 1 of 5 (Resident #17) residents reviewed for orthotic devices, in that: Resident #17 needed a back brace as ordered by her neurosurgeon, and the facility failed to escalate their efforts to secure the back brace for Resident # 17. This failure could place residents at risk for health status decline without the support and therapeutic effects of prostheses devices. The findings included: A record review of Resident #17's admission record, dated 03/01/2023, revealed an admitted [DATE], with diagnoses which included wedge compression fracture of T11-T12 vertebra [thoracic area of the spine], age-related osteoporosis [a silent disease that weakens your bones and makes them break easily], spinal stenosis [can cause pressure on your spinal cord or the nerves that go from your spinal cord to your muscles], lumbar region with neurogenic claudication [spinal nerves get compressed in the lower spine, causing intermittent leg pain], and kyphosis [a spinal disorder in which an excessive curve of the spine results in an abnormal rounding of the upper back]. A record review of Resident #17's care plan dated 03/01/2023, revealed, The Resident has osteoporosis . the Resident has pain related to vertebrae compression fractures and muscle pain .interventions; . monitor/document report as needed signs and symptoms or complications related to osteoporosis: acute fracture, compression fractures, loss of height, kyphosis, pian, especially back pain. A record review of Resident #17's quarterly MDS , dated 12/14/2022, revealed Resident #17 was an [AGE] year-old female with needs for assistance with activities of daily life complicated by back pain, spine curvature, and porous bones. Resident #17's assessment revealed a BIMS of 14 out of 15 which indicated no mental cognition impairment. Resident #17 could be understood and could understand others. A record review of Resident #17's medical records revealed a progress note , dated 10/7/2023, authored by Resident #17's neurosurgeon, Medical Doctor L, . this is an [AGE] year-old female with osteoporosis and T12, L2 compression fractures with ongoing axial low back pain issues status post kyphoplasty [after a surgery to fix broken vertebrae caused by compression fractures, which can cause pain and deformity] at T12 and L2, 3 weeks ago. Patient no longer has the back brace. We will refer her to orthotics clinic for a TLSO [NAME] extension brace [a unique tool for limiting motion of the spine and reducing pressure on its tissues]. Brace should be worn at all times. (continued on next page)

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F 0696 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #17's medical records revealed an Encounter Summary [an office visit to the neurosurgeon], dated 10/12/2022, encounter type, after this visit, October 7th, 2022 .reason for referral . orthotics, diagnosis, compression fracture of T12 vertebrae . comments: needs new TLSO [NAME] extension brace for T12 compression fracture with worsening kyphosis status post kyphoplasty . electronically signed by [Medical Doctor L]. During an interview on 02/28/2023 at 10:00 AM, LVN E stated Resident #17 needed a back brace. LVN E stated Resident #17 has seen the neurosurgeon [Medical Doctor L] and has been fitted for the [TLSO] back brace, however the brace will not be supplied by the shop until the neurosurgeon's office has had the doctor sign and return 2 documents. LVN E stated she, the ADON, and the DON, have been working with the doctor's office since December [2022] and have not been able to have the doctor's office return the 2 documents needed to pay for the brace. LVN E stated Resident #17's attending physician at the facility is Medical Doctor N and is seen by Medical Doctor N's Nurse Practitioner O. LVN E stated she had not given Medical Director N nor Nurse Practitioner O a report about Resident #17 needed a back brace and did not have one. LVN E stated they know [Medical Director N nor Nurse Practitioner O] because they can read the notes and the Resident [#17] can tell them. During an observation and interview on 02/28/2023 at 02:00 PM, Resident #17 presented in her wheelchair self-ambulating to the dining room. Resident #17 was asked the question, are your needs being met here at the facility?, Resident #17 replied her needs were not being met. Resident #17 stated she had a painful curved spine, had recent spine surgery, and had a need for a back brace, which the neurosurgeon [Medical Doctor L] ordered for her. Resident #17 stated she had a back brace prior to her admission to the facility but somehow it has gone missing. Resident #17 stated she had been to the neurosurgeon [Medical Doctor L] in November [2022] and was prescribed a new back brace but has not received the brace. Resident #17 stated she has complained and asked for a status on the back brace often and has been told the hold-up is insurance paperwork. Resident #17 stated she has no money to pay for the back brace and the facility has reported to her they are attempting to have the neurosurgeon doctor's office fill out paperwork to have Medicaid pay for the brace. Resident stated she has been waiting for the brace since November of 2022. She stated she had had chronic pain and wishes to have the back brace, so my spine will not get worse. Resident #1 stated she has been strong and has not asked for much pain medication and stated she manages her pain by finding a comfortable position while sitting and or laying and only moves when she needs to due to the pain. Resident #17 stated the situation made her feel, angry and neglected. A record review of Resident #17's medical record revealed a progress note authored by LVN E, dated 01/31/2021 , detailing the most recent attempted call to neurosurgeon Medical Doctor L. The note revealed, Call placed to [name] orthotics clinic to follow up on [Resident #17's] TLSO Brace. Spoke to [M orthotics clinic personnel] who stated they have now sent SWO and title 19 forms to [Medical Doctor L's] office three times, since my last call. Forms have not been returned and the orthotics has called and emailed [Medical Doctor L] regarding the forms several times. Last attempt was 01/27/2023. Writer called [Medical Doctor L's] office to follow-up on forms. Message left for Dr. that Resident [#17] does not have brace and cannot attend his desired follow-up with brace due to forms not being faxed back to orthotics clinic. Expecting return phone call from [Medical Doctor L]. will continue to follow up. (continued on next page)

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F 0696 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/28/2023 at 10:20 AM, ADON D stated she was aware of Resident #17's need of a back brace and stated she and her staff have been attempting to have the appropriate paperwork supplied to the orthotics shop for payment of Resident #17 back brace. ADON D stated the facility and Resident #17 were waiting for the doctor's office [Medical Doctor L] to fill out the paperwork for Resident #17. ADON D stated she had not given Medical Director N nor Nurse Practitioner O a report about Resident #17 needed a back brace and did not have one. ADON D stated she believed everyone knew about Resident #17 back brace situation. ADON D stated there were many progress notes in Resident #17's chart. During an interview on 03/01/2023 at 11:10 AM, the SW stated she was aware Resident #17 needed a back brace but was not able to receive the back brace for unknown reasons. The SW stated she was not asked to intervene and advocate for Resident #17 by anyone at the facility. The SW stated she understood it was being resolved by the nursing staff. The surveyor asked the SW what could she have done if someone had asked her to intervene and advocate for Resident #17? The SW stated, Maybe, I would have called the doctor or doctors. During an interview on 03/01/2023 at 04:48 PM the Medical Director stated he was the medical Director for the facility and Resident #17. Medical Director stated Medical Doctor N was a peer and attended to Resident #17. The Medical Director stated no one has reported to him Resident #17 needed a back brace. The Medical Director stated Resident #17 had a kyphosis diagnosis and understood she was being seen by a neurosurgeon but did not know about the neurosurgeon's order for a back brace and the lack of the brace for Resident #17. The Medical Director stated he could not state what effect the lack of the brace could have on Resident #17 and Resident #17 should be re-assessed by the neurosurgeon due to the prolonged time Resident #17 has been without the brace. When asked if the facility had given the Medical Director a report what could you have done? The Medical Director replied, well, there are many interventions .but I could have intervened by calling the neurosurgeon [Medical Doctor L] .a physician-to-physician call surveyor asked, an intervention. The Medical Doctor replied, Yes. During an interview on 03/01/2023 at 05:48 PM Nurse Practitioner O stated no one has reported to him, nor Medical Doctor N, Resident #17 needed a back brace. NP O stated Resident #17 had a kyphosis diagnosis and understood she was being seen by a neurosurgeon but did not know about the neurosurgeon's order for a back brace and the lack of the brace for Resident #17. Nurse Practitioner O could not state what effect the lack of the brace could have on Resident #17 and Resident #17 should be re-assessed due to the prolonged time Resident #17 has been without the brace. Nurse Practitioner O stated he would give Medical Doctor N a report. (continued on next page)

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F 0696 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/02/2023 at 10:05 AM the DON stated she was aware and very involved in the situation of Resident #17's back brace. The DON stated she and her staff have been trying to work with Medical Doctor L's office to secure the 2 documents needed to secure Resident #17 back brace and have had no success with Medical Doctor L's office. The DON stated, we have done all we could, they have not returned the documents needed. When asked if the Medical Director, Resident #17's attending Medical Doctor N, or Nurse Practitioner O have been given a report the DON stated, yes they know, when asked for documentation to support the medical doctors knew; the DON stated there was not any documentation other than the progress notes which detail all the requests for the brace and/or paper-work needed from the doctor's office [Medical Doctor L's office]. When the DON was asked who was responsible for the failure to secure Resident #17's back brace; the DON replied, the doctor's office [Medical Doctor L's office] who would not supply the signed forms needed by the orthotics clinic. When the DON was asked how this failure could affect Resident #17; the DON stated the surveyor could ask the doctor. An accommodation of needs policy regarding Resident #17's back brace orthotics equipment was requested from the DON; the DON replied she did not believe there would be a specific policy for the situation due to the facility was not responsible to pay for items such as back braces . A record review of the facility's personal property policy did not adequately address the facility's response to Resident #17's reasonable accommodation of need for a back brace.

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	455824	A. Building B. Wing	03/03/2023

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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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observations, interviews, and record reviews the facility failed to provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, for 1 of 5 residents (Resident #238) reviewed for laboratory services, in that: Resident #238 was ordered a urinalysis which was not sent to the laboratory for 7 days. This failure placed residents at risk for health status decline related to denying the physician a prompt result from the ordered urinalysis. The findings included: A record review of Resident #238's Admission Record, dated 2/28/2023, revealed an admitted [DATE] with diagnoses which included encephalopathy [a term for any disease of the brain that alters brain function or structure] and seizures [a seizure is a sudden, uncontrolled burst of electrical activity in the brain]. A record review of Resident #238's care plan, dated 03/01/2023, revealed, The Resident [Resident #238] uses mood stabilizers, anticonvulsive medications related to seizures .Interventions: . obtain and monitor lab diagnostic work as ordered. Report results to MD [medical doctor] and follow up as indicated. A record review of Resident #238's admission MDS, dated [DATE], revealed Resident #238 was a [AGE] year-old female who was admitted from the hospital. Resident #238 was assessed as a 12 out of 15 for the Brief Mental Interview Status which indicated mild cognitive impairment and is occasionally incontinent of bladder. A record review of Resident #238's physicians orders, dated 02/21/2023, revealed Doctor S ordered for Resident #17 a urinalysis, with a culture and sensitivity, to rule out urinary tract infection. A record review of the facility's unit A 24hr reports for the dates 02/21/2023 through 02/28/2023 revealed on 02/2021 RN F documented [Resident #238] has new orders UA [urinalysis] , labs and LVN G documented UA to be obtained. Record review of the 24-hr. report dated 02/22/2023, revealed RN F documented, UA needed did not collect. Record review of the 24-hr. report dated 02/23/2023, revealed UA collected and RN F documented pending urine PU [pick-up]. Record review of the 24-hr. reports dated 02/24/2023 and 02/25/2023, revealed, pending UA results. Record review of the 24-hr. report dated 02/26/2023, revealed LVN U and LVN T documented Resident #238 *Needs UA*. Record review of the 24-hr. report dated 02/27/2023, revealed LVN U, RN F and LVN G documented Resident #238 *Needs UA*, unable to collect. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation, interview, and record review on 02/28/2023 beginning at 10:02 AM, revealed the facility's contracted laboratory's representative was asking RN F for the sample to be sent to the laboratory. A record review of the sample and documentation paperwork revealed the sample was ordered on 02/21/2023. When RN F was asked why the sample was being sent out to the laboratory seven days later than ordered, RN F replied there were some difficulties collecting the urine sample and was collected twice and the current sample was collected yesterday [02/27/2023] and was the most recent. RN F stated the laboratory picked up samples from the facility three times a week Monday, Tuesdays, and Thursdays. RN F stated she, LVN U, and LVN G recognized the UA sample for Resident #238 collected on 02/23/2023 was not picked up from the facility on 02/23/2023 and by 02/24/2023 the nurses [LVN G, LVN T, LVN U, and RN F] gave report to each other to collect a new sample and send the new sample to the laboratory. RN F stated the sample was older than 48 hours and a new sample was required. RN F stated LVN G collected the new sample on the evening of 02/27/2023. RN F stated the facility recently upgraded their laboratory services plan to include the use of the laboratory contractor's website to enter laboratory orders for residents. RN F stated she recognized this morning [02/28/2021] no one had entered the urinary analysis order for Resident #238, and she entered the order into the system. RN F stated she had not reported to Doctor S his 02/21/2023 was not collected until 02/23/2023 and not picked up by the laboratory until 02/28/2023. RN F stated Resident #238 was fine, as evidenced by Resident #238's vital signs, and did not see any problem not reporting to Doctor S his 02/21/2023 was not collected until 02/23/2023 and not picked up by the laboratory until 02/28/2023. During an observation, interview, and record review on 02/28/2023 beginning at 04:02, LVN G stated on 02/27/2023, she received report from RN F, the urine sample collected on 02/23/2023, for Resident #238, was not picked up by the laboratory and a new sample was needed. LVN G stated she collected a urine sample from Resident #238 on her shift on the evening of 02/27/2023. LVN G stated she had not reported to Doctor S the late collection of the UA. LVN G stated she had not considered she needed to report the late collection of the urine sample and believed RN F would have reported the late collection since RN F worked the day shift. During an interview on 03/01/2023 at 10:00 AM the facility's Medical Director stated he was responsible for all residents in the facility to include Resident #238. The Medical Director stated a urinalysis ordered on 02/21/2023 and sent to the lab seven days later [02/28/2023] would have been too long. The Medical Director stated a regularly ordered urinalysis would be reasonable for the sample to be sent the next business day to include a couple of days. The Medical Director stated it would be reasonable for the laboratory to pick up samples from the facility three times a week. The Medical Director stated no one contacted him to report Resident #238's urine sample was not sent to the lab until seven days later. The Medical Director stated he could not give comment on what Doctor S would have done if he had been given a report of the difficulty collecting and sending the urine sample to the laboratory; but an option could have been to intervene with a plan of care dependent on the resident's assessment. An unsuccessful interview was attempted with Doctor S on 03/01/2023 at 01:46 PM. During an interview on 03/01/2023 at 4:05 PM, Resident #238 stated she was asked several times by nursing staff to alert them when she needed to urinate and was provided a hat to pee in when she needed to urinate. Resident stated this occurred last week and again this weekend. Resident #238 could not recall the exact dates and times. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/02/2023 at 04:38 PM the DON stated she was not given a report of the 02/21/2023 UA order for Resident #238 which was sent to the lab om 02/28/2023. The DON stated the urine sample could have been picked up, by the laboratory, on 02/23/2023 when it was collected. The DON stated the order could have been put into the laboratory's web-based portal on the day the order was given [02/23/2023]. The DON could not comment on the details surrounding the incident, due to the nurses involved did not give her a report. The DON stated the nurses involved should have given Doctor S a report to the delay in sending the urine sample. A policy regarding reporting to a physician a delay in following laboratory orders was requested. A record review of the facility's policy regarding reporting to a physician a delay in following laboratory orders was not reviewed due to the policy provided by the facility did not address the facility not sending Resident #238's urine sample to the laboratory until seven days later. The policy provided addressed medication orders; how to receive and record medication orders.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21939 Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment, and to help prevent the development and transmission of communicable disease and infections for 2 of 2 (Residents #12 and #67) observed for care in that: 1. CNA A failed to remove her gloves and perform hand hygiene before moving from a contaminated-body site to a clean-body site during care for Resident #12. 2. CNA A failed to remove her gloves and perform hand hygiene before moving from a contaminated-body site to a clean-body site during care for Resident #67. This failure can affect residents in the facility who received incontinent care and could result in spread of infections. The findings were: 1. Record review of Resident #12's Admission Record (03/03/2023) revealed an admitted [DATE] with diagnoses of Irritable bowel syndrome (disorder that affects the stomach and intestines, also called the gastrointestinal tract) with Diarrhea and Cerebral Infarction, unspecified. Record review of Resident #12's careplan (01/17/2023) revealed activities of daily care deficit due to immobility and required one person assist for toileting. Record review of Resident #12's MDS (01/31/2023) revealed she was always incontinent and was total dependent with toileting. Further record review revealed she required one person assistance. During observation on 02/28/2023 beginning at 08:53 a.m., CNA A provided incontinent care for Resident # 12. Further observation revealed Resident #12 had a bowel movement. CNA A washed her hands and donned a pair of gloves. CNA A wipe Resident #12's perineal area. After CNA a wiped Resident #12's perineal area, CNA A with the same gloves, touched Resident # 12's pillow and placed it at the Resident # 12's foot of bed. Resident #12 was repositioned to the left side, CNA A wiped Resident #12's bottom and removed the patient's briefs. CNA A removed her gloves, sanitized her hands, and donned another pair of gloves. Resident #12's pillow was placed back under her left arm. 2 Record review of Resident #67's facesheet (03/03/2023) revealed an admitted [DATE] and diagnoses of Disturbance, Neuromuscular Dysfunction of the Bladder, Benign Prostatic Hyperplasia with lower urinary tract symptoms, and Chronic Kidney Disease. Record review of Resident #67's careplan revealed self-care performance deficit in activities of daily living tasks and required extensive assistance by staff. Record review of Resident #67's MDS revealed he required extensive assistance with one person assist for toileting. Further review revealed Resident #67 had an indwelling catheter and frequently incontinent of bowel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of CNA A's last peri-care/incontinence care skill assessment (male and female) was on 12/22/2022. Further review revealed proficiency criteria included taking off the gloves, putting them in the trash bag and washing hands and putting on new gloves. During an observation on 02/28/2023 at 09:15 a.m., CNA A Provided cath care for Resident #12. CNA A washed hands/gloved, anchor in place, wiped patients cath 3 to inches down, and around cath tubing, after, CNA A wiped head of penis and down and around and down, after, with same gloves CNA A left hip and blanket, to roll pt. to right side wiped bottom, touched clean brief, added brief, then removed gloves. During an interview on 02/28/23 at 09:37 a.m., CNA A indicated she should've removed her gloves after cleaning Resident # 12's peri area, before touching Resident #12's pillow, and after wiping Resident #67's indwelling catheter and perineal area. Further interview with CNA A revealed she didn't pay attention to that because she's in a rush to care for other residents. During an interview on 03/01/2023 at 4:10 p.m., the Administrator stated competency on incontinent care were done on hire and annually. Record review of the facility's policy and procedure titled Stand Precautions (2001), read in part, Standard Precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status .2. Gloves: d. Gloves are changed and hand hygiene performed before moving from a contaminated-body site to a clean-body site during resident care.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews, and record reviews the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside, for 2 of 5 Residents (Resident #15 and Resident #18) reviewed for the ability to call for staff, in that: Resident #15 and Resident #18 presented with their call light on the floor away from their reach. This failure could place residents at risk for injury and diminished self-esteem, due to the inability to call for assistance. The findings included: A record review of Resident #15's admission record, dated 03/03/2023, revealed an admitted [DATE] with diagnoses which included Parkinson's disease [a chronic and progressive movement disorder that initially causes tremor in one hand, stiffness or slowing of movement], and severe intellectual disabilities. A record review of Resident #15's care plan, dated 03/03/2023, revealed, The Resident has an activity of daily life self-care performance deficit related to severe intellectual disabilities. Needs extensive assistance for all activities of daily life. non-ambulatory [cannot walk or self-propel] .the resident has stiffness in bilateral upper lower extremities .the resident requires extensive total assistance by staff for toileting .the resident is at risk for falls related to intellectual disabilities, poor impulse control, decrease functional status, and leans . interventions . be sure the Resident's call light is within reach and encourage the resident to use it for assistance as needed. The Resident needs prompt response to all requests for assistance. A record review of Resident #15's quarterly MDS, dated [DATE], revealed Resident #15 was a [AGE] year-old male with severe mental disabilities and needed assistance with all activities of daily life to include eating, drinking, and toileting. During an observation and interview on 02/27/2023 beginning at 11:08 AM, revealed Resident #15 in his bedroom, dressed, and seated in his wheelchair. Resident #15 was seated by his bed facing the television and his call light was resting on the floor between the bed and the wall out of Resident #15's reach. During an interview with Resident #15 revealed Resident #15 communicated with body gestures. Resident #15 was asked where his call light was, Resident #15 replied with a shoulder shrug as if communicating I don't know. Surveyor identified to Resident #15 his call light was on the floor and asked Resident #15 if he could reach it, Resident #15 nodded his head from left to right to communicate a no response. A record review of Resident #18's admission record revealed an admitted [DATE], with diagnoses which included dementia [a term for a range of conditions that affect the brain's ability to think, remember, and function normally], and schizoaffective disorder [a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms]. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #18's care plan, dated 03/03/2023, revealed, The Resident is at risk for falls related to confusion, gate balance problems, incontinence, psychoactive drug use, unawareness of safety needs . interventions . be sure the residents call light is within reach and encourage the resident to use it for assistance as needed. The Resident needs prompt response to all requests for assistance. A record review of Resident #18's quarterly MDS, dated [DATE], revealed Resident #18 was a [AGE] year-old female who was assessed with moderate intellectual impairment and required limited assistance with personal hygiene, and locomotion in and out of her room. During an observation and interview on 02/27/2023 beginning at 11:12 AM, revealed Resident #18 in her bedroom, dressed, and laying in her bed. The call light presented behind the bed on the floor in between the bed and the wall, out of Resident #18's reach. During an interview Resident #18 was asked by surveyor can you call for help, Resident #18 stated yes by nodding her head in an up and down motion. When asked where her call light was? Resident #18 responded with a shoulder and outward hand gestures. When surveyor identified the call light as being behind the bed and on the floor; Resident #18 nodded her head in a left to right motion to answer the question, if she could reach the call light? During an interview and observation on 02/27/2023 beginning at 11:27 AM, CNA H stated she was the CNA responsible for residents on A hall to include Residents #15 and #18. CNA H confirmed the observations of the call lights located on the floor and out of reach for residents #15 and #18. CNA stated she had placed the call lights on the residents within their reach and they must have thrown the call lights down. CNA H promptly repositioned the call lights off the floor and within reach of residents #15 and #18. CNA H stated residents #15 and #18 could use their call lights and should always have their call lights within their reach. CNA stated if residents are not able to call for assistance, they may suffer a fall or incontinence. During an interview on 02/27/2023 at 11:30 AM, RN F stated she was the charge nurse for A hall to include CNA H and Residents #15 and #18. RN F stated she would provide reinforced delegation of duties for CNA H to include call lights should be attached to Residents' reachable area, such as their robes, clothes, and / or blankets and it is unacceptable for call lights to be out of Residents' reach. RN F stated residents could have a fall if denied the ability to call for assistance. A call light policy was requested on 03/03/2023 and the policy was provided, and the surveyor failed to secure the policy.