

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675205	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024
NAME OF PROVIDER OR SUPPLIER The Atrium Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7602 Louis Pasteur St 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43889</p> <p>Based on observation, interview, and record review, the facility failed to provide services as outlined by the comprehensive care plan that meet professional standards of quality for 1 of 5 residents (Resident #1) reviewed for (insert type of care plan you were reviewing) in that:</p> <p>The facility failed to ensure Resident #1's care plan addressed his contractures.</p> <p>This failure could place residents at risk for not receiving the care and services to meet their needs.</p> <p>The findings were:</p> <p>Record review of Resident #1's face sheet, dated 4/18/24, revealed Resident #1 was initially admitted to the facility on [DATE] with diagnoses of cerebral infarction [stroke], contracture [a fixed tightening of muscle or tendons], right knee, contracture, left knee, muscle wasting and atrophy [shrinking of muscle or nerve tissue], not elsewhere classified, multiple sites, and pressure ulcer of other site, stage 3.</p> <p>Record review of Resident #1's entry MDS, dated [DATE], revealed Resident #1 had no BIMS score because Resident #1 was rarely/never understood. Further record review of this document revealed Resident #1 had the following Additional Active Diagnosis . contracture, right knee . contracture, left knee . muscle wasting and atrophy.</p> <p>Record review of Resident #1 care plan, dated 4/18/24, revealed Resident #1 did not have a care plan specifically for his contractures.</p> <p>Observation on 4/19/24 at 9:15 a.m., revealed Resident #1 was in bed and in no acute distress. Resident #1 had contractures in both lower extremities, causing his knees to bed.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and record review on 4/19/24 at 11:54 a.m., the MDS Coordinator stated, diagnosis, code status, hospice . whatever applies to the patients, should be on the resident's care plan. The MDS Coordinator confirmed contractures should be on the care plan. The MDS Coordinator stated Resident #1 had contractures and stated she did not create Resident #1's care plan. The MDS Coordinator stated she did not know who created his care plan. Resident #1's care plan was reviewed with the MDS Coordinator and MDS Coordinator confirmed Resident #1's care plan did not have a care plan about his contractures. The MDS Coordinator stated the facility's corporate nurse went through the resident care plans but she (the MDS Coordinator) was not sure how frequently the corporate nurse did this. When asked what sort of negative effects could occur to the residents if their care plans did not include contractures, the MDS Coordinator stated, I couldn't answer that question.</p> <p>Record review of a facility policy titled, Care Plans, Comprehensive, dated December 2023, revealed the following: the comprehensive, person-centered care plan will: .describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being[.]</p> <p>Record review of a facility policy titled, Resident Mobility and Range of Motion, dated December 2023, revealed the following: The care plan will include specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43889</p> <p>Based on observation, interview, and record review, the facility failed to ensure incontinent care was provided in accordance with appropriate treatment and service practices to prevent urinary tract infections and to restore continence to the extent possible for 1 of 5 residents (Resident #2) reviewed for incontinent care and catheter care, in that:</p> <p>The facility failed to ensure Resident #2's urinary catheter tubing was secured.</p> <p>This failure could place residents at risk for infection, pain, and skin break down due to improper care practices.</p> <p>Record review of Resident #2's face sheet, dated 4/19/24, revealed Resident #2 was initially admitted to the facility on [DATE] with diagnoses of other lack of coordination, erythema intertrigo [redness on both sides of a skin fold], acute pyelonephritis [a type of urinary tract infection where one or both kidneys become infected], and obstructive and reflux uropathy [when urine is unable to drain through the urinary tract and causes urine to back up into the kidneys], unspecified.</p> <p>Record review of Resident #2's entry MDS, dated [DATE], revealed no BIMS score.</p> <p>Record review of Resident #2's physician orders, dated 4/18/24, revealed the following order, dated 1/30/24: monitor foley catheter [a flexible tube that is inserted through the urethra and into the bladder to drain urine; a urinary catheter] leg strap for proper placement every shift.</p> <p>Observation of Resident #2's urinary catheter care on 4/18/24 at 11:01 a.m. revealed Resident #2 had a stabilization device placed on her left thigh, which was meant to prevent the urinary catheter tubing from moving and causing discomfort to Resident #2. Resident #2's urinary catheter was not anchored using the stabilization device.</p> <p>During an interview on 4/18/24 at 11:13 a.m., after Resident #2's urinary catheter care, CNA C stated the stabilization device on Resident #2s left thigh was to hold the urinary catheter. CNA C stated Resident #2's urinary catheter was disconnected from the stabilization device because she (CNA C) and another CNA were doing the urinary catheter care. CNA C stated Resident #2's LVN, LVN D, will reconnect the urinary catheter to the stabilization device.</p> <p>During an observation and interview on 4/18/24 at 11:58 a.m., Resident #2's urinary catheter was still not connected to the stabilization device. Resident #2 stated the device had been disconnected prior to the catheter care earlier but the facility staff had not reconnected the urinary catheter to the stabilization device.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/19/24 at 12:17 p.m., the DON stated she was new to the position at this facility. The DON stated she was not sure if the facility had a process to ensure urinary catheters were secured appropriately, but she knew the facility conducted rounds to check a resident's oxygen tubing, foley catheters, and gastrostomy tubes [an artificial opening to the stomach from the abdominal wall.] When asked what sort of negative effects could occur to the residents if their foley catheters were not secured appropriately, the DON stated, it could be pulled or dislodged or cause some kind of trauma.</p> <p>Record review of a facility policy titled, Catheter Care, Urinary, dated 6/18/18, revealed the following: Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh.)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43889</p> <p>Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles in locked compartments and permit only authorized personnel to have access to the keys for 1 of 5 residents (Resident #2) reviewed for storage of drugs, in that:</p> <p>The facility failed to ensure Resident #2's nystatin powder [a medication for fungus] was secured.</p> <p>This failure could place residents at risk of medication misuse and diversion.</p> <p>The findings were:</p> <p>Record review of Resident #2's face sheet, dated 4/19/24, revealed Resident #2 was initially admitted to the facility on [DATE] with diagnoses of other lack of coordination, erythema intertrigo [redness on both sides of a skin fold], acute pyelonephritis [a type of urinary tract infection where one or both kidneys become infected], and obstructive and reflux uropathy [when urine is unable to drain through the urinary tract and causes urine to back up into the kidneys], unspecified.</p> <p>Record review of Resident #2's entry MDS, dated [DATE], revealed no BIMS score.</p> <p>Record review of Resident #2's physician orders, dated 4/18/24, revealed the following order, dated 2/13/24: Clean abdominal folds with wound cleanser, pat dry, sprinkle nystatin powder followed by ABD [abdominal] pad once daily/PRN. as needed for redness.</p> <p>During an observation and interview on 4/18/24 at 11:58 p.m., an unlabeled medication cup with white powder was on Resident #2's bedside table, unsecured and unattended. Resident #2 stated the white powder was a medicated powder for her skin folds. Resident #2 stated someone brought the medication into her room and left it on the bedside table.</p> <p>During an interview on 4/18/24 at 12:06 a.m., LVN D stated he was Resident #2's nurse. LVN D stated he ensured medication security by ensuring a resident took the medication and locking the medication cart. LVN D stated medications should not be in a resident's room unless there was an order for the medication to be in the room. LVN D stated he saw the medication cup of white powder in Resident #2's room earlier and he did not know how the medication got there or who put the medication in there. LVN D stated when he saw the medication cup of white powder earlier he should have removed it from Resident #2's room.</p> <p>During an interview on 4/19/24 at 12:17 p.m., the DON stated she just started in this position at this facility. The DON stated he and the ADON conducted rounds every day to ensure medications were secured appropriately. When asked what sort of negative effects could occur to the residents if medications were left in their rooms, the DON stated, anybody can get them and have access to them.</p> <p>(continued on next page)</p>		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy titled, Storage of Medications, dated December 2023, revealed the following: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner . Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems.		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43889</p> <p>Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 residents (Resident #4) reviewed for infection control in that:</p> <p>During Resident #4's wound care, ADON failed to perform hand hygiene appropriately.</p> <p>This failure could affect residents and place them at risk for infection.</p> <p>The findings were:</p> <p>Record review of Resident #4's face sheet, dated 4/19/24, revealed Resident #4 was initially admitted to the facility on [DATE] with diagnoses of heart failure, unspecified, depression, unspecified, non-pressure chronic ulcer of skin and other sites with unspecified severity, Type 2 Diabetes Mellitus with other diabetic ophthalmic [eye issues due to diabetes] complication, and Type 2 Diabetes Mellitus with foot ulcer.</p> <p>Record review of Resident #4's quarterly MDS, dated [DATE], revealed Resident #4 had a BIMS score of 12, signifying moderate cognitive impairment.</p> <p>Record review of Resident #4's physician order's, dated 4/18/24, revealed the following order dated 4/2/24: Clean open area to left heel with normal saline [a mixture of sodium chloride and water used to cleanse wounds, flush lines, and treat dehydration], pat dry, apply alg. calcium [referring to calcium alginate, a special type of wound dressing that promotes healing and is used for wounds with a lot of drainage], cover with border gauze QD/PRN as needed for open area to left heel for 30 Days.</p> <p>Observation on 4/18/24 at 1:53 p.m., revealed the ADON began Resident #4's wound care. The ADON assured privacy, washed hands, and donned gloves. The ADON removed the heel-lifting boot on Resident #4's left foot, removed his soiled gloves, and did not perform hand hygiene. The ADON removed Resident #4's old wound care dressing. The ADON removed his soiled gloves, washed his hands, and put on a new pair of gloves. The ADON cleansed Resident #4's left heel wound with gauze soaked in normal saline. The ADON removed his soiled gloves, did not perform hand hygiene, and put on a new pair of gloves. The ADON cleansed Resident #4's left heel wound again with gauze soaked in normal saline. The ADON removed his soiled gloves, washed his hands, and put on a new pair of gloves. The ADON used his right hand to pick up gauze and pat dry Resident #4's left heel wound. The ADON removed his soiled right glove, did not perform hand hygiene, and put on a clean glove on his right glove. The ADON did not change his left glove. The ADON placed calcium alginate and a border gauze on Resident #4's left heel wound.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/18/24 at 2:06 p.m., the ADON stated during wound care hand hygiene should be done during the care, before touching anything dirty and moving to a clean area. When asked if hand hygiene should be done between glove changes, the ADON stated, it depends on if you're clean to clean, but typically yes. The ADON stated he felt his hand hygiene during Resident #4's wound care was adequate. The ADON stated he only recalled not performing hand hygiene when he used one hand to pat dry Resident #4's left heel wound. The ADON stated he last received hand hygiene education during his wound care skills check. The ADON stated it was important to do hand hygiene to prevent infection. When asked what sort of negative effects could occur to the residents if hand hygiene was not done appropriately, the ADON stated, Infection, antibiotics.</p> <p>During an interview on 4/19/24 at 12:17 p.m., the DON stated the facility conducted audits as part of their monthly QAPI meeting but she did not know how many hand hygiene audits the facility conducted per month.</p> <p>Record review of a facility policy titled, Hand-Washing/Hand Hygiene, dated December 2021, revealed the following: use an alcohol-based hand rub; or, alternatively, soap . and water for the following situations: .after removing gloves.</p>		