STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675205	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Atrium Rehabilitation Center	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)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 26869 Based on interview and record review the facility failed to ensure the resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. The resident has the right to do, and the facility must make prompt efforts to resolve grievances for 1 of 3 (# 2) residents in that: Resident #2's family had a grievance that was not resolved by the ADM from 12/11/202 to current (43) days. ADM did not call family back to discuss the resolve. This could affect all residents and could result in residents/families not having their grievances resolved timely. The Finding included: Record review of Residents #2's family grievance form was dated 12/11/2024 by her family, revealed this concerned was reported to the ADM and stated: Documentation of Grievance/complaint- staff brought food tray into residents' room but informed it was for the roommate. Staff said she would return but continued to ignore resident's food. Then staff said that original tray was for resident. resident and family feel discriminated, and resident had a cold meal. Resident was also not changed/cleaned. Documentation of facility follow-up: blank What other action was taken to resolve concerns? blank Action taken: blank Resolution of Grievance/complaint: was grievance resolved-blank; identify the method used to notify the resident and/or resident representative for the resolution: blank, the signature and date was blank. (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

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 01/24/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 2's Admission record dated 1/24/2025 revealed she was admitted on ,d+[DATE] /2009, readmitted on [DATE] with diagnoses of pneumonia, lack of coordination, pressure ulcer, contractures, diabetes II, major depressive disorder, and seizures. Record review of Resident 2's Quarterly MDS dated [DATE] revealed her BIMs score was 0 of 15, reflecting severely impaired, Resident had a manual wheelchair and had lower extremity impairment on both sides. Record review of Resident 2's was CP dated 6/30/2024 revealed she was a risk for falls, diabetes II, spoke Spanish and had impaired cognitive function/dementia or impaired processes related to Dementia. Record review of Resident #2's grievance dated 12/11/2024 by her family, revealed this concerned was reported to the ADM and stated: Documentation of Grievance/complaint- staff brought food tray into residents' room but informed it was for the roommate. she said she would return but continued to ignore resident's food. Then staff said that original tray was for resident. resident and family feel discriminated, and resident had a cold meal. resident was also not changed/cleaned. Documentation of facility follow-up: The previous DON documented the staff was confused with Resident #2's food tray and roommate. Went back in room is there a problem, how can I help you? she felt discriminated against because the food tray was sent after the fact, insisted it was given last, first name to ensure. What other action was taken to resolve concerns? Was told to give information of complaint to me and gave residents family member full name. Actions taken: discussion -educated staff on customer service, passing trays, assisting resident with dining room and in resident rooms and customer service techniques with resistant, families and other loved ones. Resolution of Grievance/complaint was grievance resolved-blank; identify the method used to notify the resident and/or resident representative for the resolution: blank, the signature and date was blank. Interview on 1/24/2025 at 4:00 PM with the ADM stated he had found the area where the complaints were, this grievance was resolved, but the area of Resolution of Grievance section, the method of notification and signature areas were blank. The ADM stated grievances were resolved within 24 hours. No policy was provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **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 be free from misappropriation of resident property for 1 of 7 residents (Resident #4) reviewed for controlled narcotic medications. Resident #4 was hospitalized from 5/27/2024 to 6/2/2024 and upon admission to the facility, on 6/2/2025, the facility recognized they failed to secure and thereby lost, Resident #4's, 41 pills of hydrocodone acetaminophen 10mg/325mg. This failure could place residents at risk for harm by losing control of their medications. The findings included: A record review of Resident #4's admission record, dated 1/22/2025 revealed an admitted [DATE] with diagnoses which included pain, psychotic disorder with hallucinations due to known physiological condition (Psychotic disorders are severe mental disorders that cause abnormal thinking and perceptions. People with psychoses lose touch with reality.) A record review of Resident #4's quarterly MDS assessment, dated 5/13/2025, revealed Resident #4 was a [AGE] year-old female admitted for long term care and assessed with a BIMS score of 13 which indicated intact cognition. Further review of Resident #4's MDS revealed she was a quadriplegic (paralysis of all four limbs), diagnosed with coronary heart disease and a wound infection. Resident #4 was assessed as receiving scheduled and as needed pain medication for the period reviewed 5/8/2024 through 5/12/2024. The MDS assessment revealed, Ask Resident: have you had pain or hurting at any time in the last 5 days? . Yes . Pain Frequency: Ask Resident: How much of the time have you experienced pain or hurting? . Frequently . Ask Resident Over the past five days, how much of the time has pain made it hard for you to sleep at night? . Occasionally . Pain Intensity: Numeric rating scale 00-10 Ask Resident: Please rate your worst pain over the last 5 days on a 0 to 10 scale, with zero being no pain and 10 as the worst pain you can imagine. Seven . Prognosis: Does the Resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? . no A record review of Resident #4's care plan dated 1/22/2025 revealed, I have chronic pain r/t (related to) polyneuropathy, necrotizing fasciitis Date Initiated: 04/20/2024 Revision on: 01/18/2025 . Anticipate my need for pain relief and respond immediately to any complaint of pain CNA, Date Initiated: 04/20/2024, Revision on: 04/20/2024 .Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Identify previous pain history and management of that pain and impact on function. Identify previous response to analgesia including pain relief, side effects and impact on function. Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. (continued on next page)

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F 0602

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

A record review of Resident #4's physicians orders revealed Resident #4 was prescribed to receive Oxycodone 10mg (according to the United States Drug Enforcement Agency Oxycodone is a semi-synthetic narcotic analgesic and historically has been a popular drug of abuse among the narcotic abusing population) with Acetaminophen 325mg (Tylenol), the physician's instructions were for Resident #4 to receive 1 tablet every 4 hours as needed for moderate to severe pain beginning on 5/9/2024.

A record review of the United States of America's Drug Enforcement Agency's website https://www.dea.gov/sites/default/files/2020-06/Oxycodone-2020_0.pdf accessed 1/31/2025, revealed, WHAT IS OXYCODONE? Oxycodone is a semi-synthetic narcotic analgesic and historically has been a popular drug of abuse among the narcotic abusing population.

WHAT IS ITS ORIGIN?

Oxycodone is synthesized from thebaine, a constituent of the poppy plant.

What are common street names? Common street names include:

o Hillbilly Heroin, [NAME], OC, Ox, Roxy, Perc, and Oxy .

How is it abused?

Oxycodone is abused orally or intravenously. The tablets are crushed and sniffed or dissolved in water and injected. Others heat a tablet that has been placed on a piece of foil then inhale the vapors.

What is its legal status in the United States? Oxycodone products are in Schedule II of the Controlled Substances Act.

A record review of Resident #4's May 2024 Medication Administration Record revealed Resident #4 had received her Oxycodone 10mg / acetaminophen 325mg, as prescribed as Needed 19 times and administered by LVN A, LVN B, LVN C, LVN D, LVN E, and LVN F.

A record review of Resident #4's nursing progress notes revealed Resident #4 was assessed by LVN A on 5/27/2025 at 8:15 PM with 10 out of 10 pain, cold and shivering, and hurting down to her bones. LVN A documented Resident #4 Was transferred to the hospital.

A record review of Resident #4's nursing progress notes revealed the medical director documented on 6/2/2025 at 8:20 PM, seen and examined. Patient returned back from (hospital) after being treated for sepsis with uti (urinary tract infection), along with oral candidiasis (commonly known as oral thrush, is a fungal infection in the mouth caused by an overgrowth of yeast-like organisms called Candida) new orders noted start pt/ot (physical therapy / occupational therapy) pain meds revised discussed with RN.

(continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #4's nursing progress notes revealed LVN B documented on 6/2/2025 at 9:08 PM, resident returned to facility from stay at (name) hospital admitted for severe sepsis d/t uti. Resident transferred to bed from Gernie sic(gurney) with s/s of pain voiced/observed. Resident A&Ox3, able to verbalize all needs/wants, recognized staff as well as location without cues. Resident stated my leg hurts bad they did nothing for it while beginning to cry while voicing discomfort with stay/current s/s. MD pending call back, after hours number with vmail left to return call promptly for review of orders. ADON/Supervisor aware of return arrival, pending MD return call. A record review of the Pharmacist's Medication Audit report dated 6/4/2024 revealed, June 4, 2024 Investigation Report Subject: Possible Drug Diversion at (The Facility) Investigator: (PharmD), RPh, Consultant Pharmacist I. Concern On June 3, 2024, I was contacted by facility that a medication card of Oxycodone/Acetaminophen 10/325mg Tablets for (Resident #4) could not be located. II. Findings On May 27, 2024, resident was noted to have abnormal vital signs and was sent out of the facility to the hospital. On June 2, 2024, resident returned late in the evening. Medication orders were restarted. It was discovered that resident's medication card for Oxycodone/Acetaminophen 10/325 was not with her other medications. Medication carts, locked control boxes, and medication rooms were searched looking for the missing card. Drug destruction areas were reviewed. The medication card was not located. The pink inventory sheet was also missing from control medication notebook. The medication card dispensed from the pharmacy was for a quantity of 60, and review noted that 19 doses had been administered. The lost card had 41 doses of Oxycodone/Acetaminophen 10/325mg tablets. The pharmacy was immediately contacted, and replacement medication was obtained. As resident was out of the facility for six days, it was unclear when the medication was lost or diverted. III. Recommendations The DON noted a new shift change inventory sheet for nurses/medication aides to ensure that medication cards are always inventoried with each change of shift. DON also had obtained a control inventory sheet that would track the number of controlled medications at beginning and end of every shift. This would ensure that if a medication card and the pink inventory sheet were removed, this would cause a discrepancy that could investigated quickly. IV. Conclusion There appears to have been an unexplained loss of a medication card of Oxycodone/Acetaminophen 10/325mg. The resident at no time was without medication. The facility thoroughly searched facility. The facility is instituting new tracking for controlled medication cards. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Updating procedures and the additional step of inventorying the number of controlled medications in the facility will go a long way in helping to catch any discrepancy with missing medication cards. (PharmD), RPh During an interview on 1/22/2025 at 12:13 PM the ADON stated he reported to DON H and Administrator I that Resident #4 was missing her oxycodone drugs. The ADON stated the PharmD came in and investigated the medication loss. The ADON stated the staff involved were not drug tested however, through other actions they were terminated. The ADON stated the local police department were notified and visited the facility and gave a police report number. The ADON stated all the staff had received an in-service for ANE and medication storage to include controlled medications protocols. The ADON stated as a result the facility had provided an enhanced controlled medication accounting to include the addition of a master control log where all controlled medications were recorded when delivered by the pharmacy and the controlled drugs on the medication carts were audited with the master control log daily. The ADON stated upon recognition of the lost oxycodone for Resident #4 all residents who were prescribed controlled narcotics were identified as seven residents to include Resident #4. All residents were reviewed for their physical narcotic and only Resident #4 was missing medications. All 7 residents were assessed for adverse reactions from missing their narcotic medications and none were evidence with any adverse reactions, the ADON stated Resident #4 had received a new prescription from the pharmacy and in the interim she had received medications from the facility's emergency kit provided by the pharmacy. During an interview on 01/23/2025 at 10:00 AM the Administrator and the DON stated some of the staff who were involved with the missing narcotics for Resident #4 were terminated and included: MA F. MA G. LVN B. RN E. and LVN A. The Administrator and the DON stated they were not the DON and or the administrator at the time and date of the lost medication but had reviewed the actions of the previous Administrator I and DON H and continued with the practice of having an enhanced controlled medication accounting to include the addition of a master control log where all controlled medications were recorded when delivered by the pharmacy and the controlled drugs on the medication carts were audited with the master control log daily. During an interview on 1/22/2025 at 2:12 PM MA G stated she usually worked the 8a-8p shift and regarding Resident #4's missing oxycodone, she recalled administering the medication to Resident #4 on 5/27/2024 and counting the medication at end of her shift with the oncoming nurse. MA G stated she did not recall if Resident oxycodone specifically was counted the following day. MAG stated she had not removed the oxycodone medication from cart. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/22/2025 at 2:13 PM LVN B stated she usually worked 12-hour day shifts on the weekends and regarding Resident #4's missing oxycodone, she did not recall if oxycodone specifically was counted at change of shift during the previous weekend. LVN B stated she did not remove Resident #4's oxycodone medication from cart. During an interview on 1/22/2025 at 2:17 PM RN E stated usually worked 12-hour day shifts on the weekends and regarding Resident #4's missing oxycodone, she did not recall if oxycodone specifically was counted at change of shift during the previous weekend. RN E stated she did not remove Resident #4's oxycodone medication from cart. During an interview on 1/22/2025 at 3:25 PM LVN A stated he usually worked the 2p-10p shift and regarding Resident #4's missing oxycodone, he could not recall specifically counting oxycodone during change of shift. [NAME] stated he did not remove medication from cart. LVN A stated he did not remove Resident #4's oxycodone medication from cart. A record review of the facility's Controlled Substances policy dated December 2023 revealed, Policy Statement The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. Policy Interpretation and Implementation: 1. Only authorized licensed nursing and/or pharmacy personnel shall have access to Schedule II controlled drugs maintained on premises. 2. The Director of Nursing Services will identify staff members who are authorized to handle controlled substances. 10. The Director of Nursing Services shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsibility parties and shall give the Administrator a written report of such findings. 11. The Director of Nursing Services shall consult with the provider pharmacy and the Administrator to determine whether any further legal action is indicated. A record review of the facility's master control binder, on-going dates, revealed the facility DON and or ADON audited the narcotics on the medication's carts with the control log daily. A record review of Resident's with narcotics counts sheets, on-going dates, revealed no discrepancies and were signed as the medications were administered. A record review of Resident #4's narcotic count sheet, on-going dates, revealed no discrepancies. During an observation and interview on 1/22/2025 at 6:10 PM revealed Resident #4 in her room dressed groomed seated in her wheelchair. Resident #4 could not recall missing any drugs and stated she did have recurrent pain and the pain was satisfied with her medications administered by the nurses. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the facility's in-service dated 6/4/2024 titled Controlled medications revealed, Objectives 1) controlled substances will be counted on delivery and at the end of each shift. 2) discrepancies will be reported to the DON. 3) detailed narcotic Audit form will be updated and signed for new, discontinued, or completed controlled medications. Further review revealed LVN A, LVN B, LVN C, LVN D, RN E, MA F, and MA G signed the in-service. A record review of the facility's narcotic count sheet for the 100-hall medication cart, dated May 2024, revealed *All Controlled medications need to be counted by the On-coming and Off-going Certified Medication Aide at change of shift [NAME]. *Each Certified Medication Aide/Charge Nurse participating in the count should initial on the appropriate date/time. Further review revealed all shifts except 5/26/2025 2p-10p shift, had documented they counted the narcotics on the cart for the month of May 2024. A record review of the facility's narcotic count sheet for the 100-hall medication cart, dated January 2025, revealed *All Controlled medications need to be counted by the On-coming and Off-going Certified Medication Aide at change of shift [NAME]. *Each Certified Medication Aide/Charge Nurse participating in the count should initial on the appropriate date/time. Further review revealed all shifts had documented they counted the narcotics on the cart for the month of January 2025.

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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 interview and record review the facility failed to ensure the development and comprehensive-centered care plan for each resident, consistent with the resident rights, that measurable objectives and timeframes to meet a residents medical, nursing, and mental and psychological 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 as required under and the resident's goals for admission and desired outcomes for 2 of 3 (#2, #3) residents in that: 1. Resident #2's care plan dated 6/30/2024 was not updated with a manual wheelchair and that the resident had lower extremity impairment. 2. Resident #3 care plan dated 4/10/24 was not updated with several e-signatures or completed. This could affect all residents and could result in staff not providing care to residents. The findings included: 1. Record review of Resident #2's Admission record dated 1/24/2025 revealed she was admitted on [DATE], readmitted on [DATE] with diagnoses of pneumonia, lack of coordination, pressure ulcer, contractures, diabetes II, major depressive disorder, and seizures. Record review of Resident #2's Quarterly MDS dated [DATE] revealed her BIMs score was 0 of 15, severely impaired, had a manual wheelchair and had lower extremity impairment on both sides. Record review of Resident #2's Quarterly MDS dated [DATE] revealed her BIMs score was 0 of 15, severely impaired, had a manual wheelchair and had lower extremity impairment on both sides. Record review of Resident #2's CP dated 6/30/2024 revealed she was at risk for falls, diabetes II, spoke Spanish and had impaired cognitive function/dementia or impaired processes related to Dementia. 2. Record review of Resident #3's Admission Record dated 1/23/2025 revealed she was admitted on [DATE], readmitted on [DATE] with diagnoses of abnormal gait, heart disease without heart failure, major depressive disorder, and repeated falls. Record review of Resident #3's screen shot of Care plans revealed the following dates were waiting for e-signatures: 10/14/2024, 5/7/2024, 12/22/2023 and other previous dates (before the annual recert) and were not completed. Record review of Resident #3's Quarterly MDS dated [DATE] revealed her BIMs score was 15 out of 15, cognitively intact, and used a wheelchair to mobilize. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's care plan dated 4/10/24 revealed she was a risk for falls, attends activities and had bowel incontinence. Interview on 1/24/2025 at 2:09 PM with MDS stated she was new (date of hire 9/30/2024) and was not aware she had to start a new care plan for each resident's MDS. MDS stated she was responsible for updating care plans. Interview on 1/24/2025 at 5:00 PM with the ADM stated this was an individual error and will educate, ADM stated care plans should be up to date. No policy provided prior to exit on 01/24/2025.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews, and record reviews the facility failed to develop, within 7 days after completion of the comprehensive assessment, a care plan and invited, to the extent practicable, the participation of the resident and the resident's representative(s) with an explanation in the resident's medical record if the participation of the resident and their resident representative was determined not practicable for the development of the resident's care plan and reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 2 of 6 (#1, #5) residents reviewed for revised care plans. 1.Resident #1's care plan dated 9/27/2024 was not updated because the CP had current revision dates but did not coincide with the MDS dates. 2. The facility failed to revise Resident #5's care plan on 8/20/2024 with interventions to support Resident #5's hypothyroid diagnosis and hypothyroid medication regime. This failure could place residents at risk for harm by not having a plan of care to support their needs for care. The findings included: 1. Record review of Resident #1's Admission Record dated 9/27/2024, readmitted on [DATE] with dx of unspecified fx, for femur, renal dialysis, pressure sore on sacrum, vit D deficiency, ESRD (end stage renal disease), dysfunction of bladder, Parkinson's (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination.), diabetes II (a chronic, metabolic disease characterized by elevated levels of blood glucose (or blood sugar), which leads over time to serious damage to the heart, blood vessels, eyes, kidneys and nerves) , and dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities. Record review of Resident #1's Quarterly MDS dated [DATE] revealed she had a BIMs score of 3 out of 15, severely impaired, she required set-up for eating and mobilized with a manual wheelchair. Record review of Resident #1's Quarterly MDS dated [DATE] revealed she had a BIMs score was 3 out of 15, severely impaired, required extensive assistance with transfers, supervision with eating and mobilized with a manual wheelchair. Record review of Resident #1's Care plan dated 9/27/2024 revealed she had a risk for falls, a fracture, Diabetes II, and eating was set-up. Resident #1's care plan had current revision dates but did not coincide with the MDS dates. (continued on next page)

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 01/24/2025
NAME OF PROVIDER OR SUPPLIER The Atrium Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7602 Louis Pasteur St San Antonio, TX 78229	

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A record review of Resident #5's admission record revealed an admitted [DATE] with diagnoses which included cerebral infarction (stroke), Hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid stimulating hormone TSH), and Alzheimer's disease (a progressive and irreversible brain disorder that gradually destroys memory, thinking skills, and the ability to carry out everyday tasks.) A record review of Resident #5's quarterly MDS assessment dated [DATE] revealed Resident #5 was an [AGE] year-old female admitted for long term care and assessed with a BIMS score of 2 out of a possible 15 which indicated a severely impaired cognition. Further review revealed a diagnosis of Hypothyroidism. A record review of Resident #5's physicians orders dated 01/22/2025 revealed the physician prescribed Resident #5 to receive levothyroxine 100mcg (a thyroid stimulating hormone) daily for hypothyroidism. Further review revealed the physician prescribed for Resident #5 to have weekly skin assessments, and weekly weights monitoring for Loss under 100 lbs. A record review of Resident #5's care plan dated 1/22/2025 revealed no focus's, goals, nor interventions regarding Resident #5's diagnosis of hypothyroidism. A record review of Resident #5's laboratory physicians order dated 6/13/2024 revealed the physician ordered a TSH Free T4 lab test (a test to reveal how much thyroid stimulating hormone the body is producing.) A record review of Resident #5's laboratory results dated [DATE] revealed a TSH T 4 level as greater than 100mu/L (million per microliter.) A record review of the United States of America's Department of Veterans Affairs website https://www.va.gov/WHOLEHEALTHLIBRARY/tools/hypothyroidism.asp Accessed 1/31/2025, titled Hypothyroidism revealed, In primary hypothyroidism, serum TSH is elevated (typically greater than 4.5mu/L) A record review of Resident #5's physician's orders revealed the physician began a new medication for Resident #5 to receive daily levothyroxine 25mcg for a new diagnosis of hypothyroidism. A record review of Resident #5's medical record from July 2024 through October 2024 revealed the physician continued to monitor Resident #5's TSH blood levels and continued to evidence high levels which indicated hypothyroidism and continued to increase Resident #5's levothyroxine in to reduce the high TSH levels as evidenced by the physician's order on 9/6/2024 when the physician prescribed Resident #5 to receive levothyroxine 100mcg daily. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/22/2025 at 4:53 PM Resident #5's representative stated she had never been invited to a care plan meeting although she visited Resident #5 weekly and may have inadvertently been involved in an informal care plan meeting with the nurses and may not have recognized it was a care plan meeting. Resident #5's representative stated she has hypothyroidism and believed Resident #5 also had hypothyroidism and had been receiving levothyroxine since 2023 prior to being admitted to the facility. Resident #5's representative stated she learned while Resident #5 was admitted to the facility she had not been diagnosed with hypothyroidism until June 2024 when Resident #5 had been diagnosed with hypothyroidism and had begun receiving levothyroxine. Resident #5's representative stated she was not aware Resident #5 had no interventions for monitoring, and or supporting Resident #5's needs for hypothyroidism and at a minimum would like for Resident #5 to be monitored for her TSH blood work regularly. During an observation and interview on 1/23/2025 at 2:00 PM revealed LVN J to review Resident #5's medical record to include Resident #5's care plan. LVN J stated she could not evidence any focus, goal, nor interventions for hypothyroidism. LVN J stated Resident #5 was monitored for her weight and her skin condition and stated hypothyroidism could affect a person's weight and skin condition. During an interview on 1/23/2025 at 2:59 PM the ADON stated there was no interventions for Resident #5's care plan and would review Resident #5's care plan and ensure there would be a focus for hypothyroidism to included goals and interventions to support management of Resident #5's hypothyroidism. Interview on 1/24/2025 at 2:09 PM with MDS stated she was new (date of hire 9/30/2024) and was not aware she had to start a new care plan for each resident MDS. MDS stated she was responsible for updating care plans. Interview on 1/24/2025 at 5:00 PM with the ADM stated this was an individual error and will educate, ADM stated care plans should be up to date. A policy for care plan revisions was requested on 1/23/2025 and as of exit on 1/23/2025 was not provided. A record review of the United states of America's Medicare.gov website accessed 1/31/2025 https://www.medicare.gov/providers-services/original-medicare/nursing-homes/care-plan , titled What's a nursing home care plan? revealed, A care plan says how staff at a nursing home will help manage your care. To prepare your care plan, the nursing home staff will get your health information and review your health condition. You (if you're able), your family (with your permission), or someone acting on your behalf has the right to take part in planning your care with the nursing home staff. The basic care plan included: A health assessment (a review of your health condition) that begins on the day you're admitted and must be completed within 14 days. A health assessment at least every 90 days after your first review, and possibly more often if your medical status changes, with?changes to your care plan as needed. Nursing homes are required to submit this information to the federal government. This information is used for quality measures, nursing home payment, and state inspections. (continued on next page)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675205	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Atrium Rehabilitation Center	7602 Louis Pasteur St San Antonio, TX 78229

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Depending on your needs, your care plan may include: The personal or health care services you need. The type of staff that can give you the services. How often you need the services. The equipment or supplies you need (like a wheelchair or feeding tube). Describe your dietary needs and food preferences. How your care plan will help you reach your goals. If you plan on returning to the community and the plan to?help you meet that goal.