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	04/17/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 4 residents (Resident #1) reviewed for medical records accuracy, in that: The facility failed to ensure Resident #1's medical record was free of medication administration time entry errors on 3/12/2026, 3/13/2026, 3/16/2026, 3/17/2026 and 3/31/2026 as documented on the MAR by LVNs A, C, D, and F. This failure could place residents at risk for an inaccurate clinical picture and errors in care and treatment. The findings were: Record review of Resident #1's face sheet, dated 4/17/2026, revealed a [AGE] year-old male admitted on [DATE] under hospice care with diagnoses which included: malignant neoplasm of middle third of esophagus (cancer of the esophagus), dysphagia (difficulty and/or discomfort with swallowing) and anemia. Record review of Resident #1's Care Plan, dated 3/17/2026, indicated he had acute and chronic pain with interventions to administer analgesia as per orders. The care plan also indicated the resident was on hospice services with interventions which included: administer pain medications as ordered. Record review of Resident #1's admission MDS assessment, dated 3/23/2026, revealed a BIMS of 10 which indicated a moderate cognitive impairment. Record review of Resident #1's Order Summary dated for March 2026 revealed the following orders:Lorazepam oral concentrate 2 mg/ml, give 0.5 mg by mouth every 2 hours for anxiety with a start date of 3/30/2036. Morphine Sulfate oral solution 20 mg/5 ml, give 0.5 ml every 2 hours for pain with a start date of 3/30/2026. Methadone HCL oral solution 10 mg/5ml, give 2.5 ml every 8 hours for pain by mouth with a start date of 3/12/2026. Record review of Resident #1's Medication Audit Report for March 2026 revealed the following meds were documented as administered late (later than one hour after the schedule administration time) with no corrections in time. -3/12/2026 Methadone 10 mg/5 ml, give 2.5 ml by mouth every 8 hours for pain, scheduled for 5:00 pm and documented as given at 7:20 pm by LVN A.-3/13/2026 Methadone 10 mg/5 ml, give 2.5 ml by mouth every 8 hours for pain, scheduled for 1:00 a.m. and documented as given at 4:38 a.m. LVN F.-3/16/2026 Methadone 10 mg/5 ml, give 2.5 ml by mouth every 8 hours for pain, scheduled for 9:00 am and documented as given at 11:17 am by LVN C. -3/16/2026 Methadone10 mg/5 ml, give 2.5 ml by mouth every 8 hours for pain, scheduled for 1:00 a.m. and documented as given at 4:24 a.m. by LVN D. -3/17/2026 Methadone 10 mg/5 ml, give 2.5 ml by mouth every 8 hours for pain, scheduled for 1:00 a.m. and documented as given at 3:41 a.m. by LVN F.-3/31/2026 Morphine 20 mg/5 ml, give 0.5 ml by mouth every 2 hours for pain scheduled at 4:00 a.m. and documented as given at 7:33 a.m. by LVN F.-3/31/2026 Lorazepam 2 mg/ml, give 0.5 ml by mouth every 2 hours for anxiety scheduled at 4:00 a.m. and documented as given at 7:33 am by LVN F. -3/31/2026 Morphine 20 mg/5 ml, give 0.5 ml by mouth every 2 hours for pain scheduled at 6:00 am and documented as given at 7:33 pm by LVN F.-3/31/2026 Lorazepam 2 mg/ml, give 0.5 ml by mouth every 2 hours for anxiety scheduled at 6:00 a.m. and documented as given at 7:33 a.m. by LVN F. During an interview on 4/17/2026 at 2:46 p.m., LVN A stated she administered Resident #1's Methadone as scheduled. She stated she was not sure why it was documented as administered late. She stated for the 5:00 p.m. scheduled dose was right in (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the middle of shift change. She stated she has one hour before and one hour after the scheduled dose to administer the medication per policy. She stated she prioritized insulin and pain medication administration and may have documented late after she was finished other change of shift tasks. She stated she was the only nurse working in the building due to low census at the time and was trying to prioritize tasks. During an Interview on 4/17/2026 at 3:16 p.m., LVN C stated she administered Resident #1's Methadone as scheduled on 3/16/2026. She stated she clicked it off (entered it into PCC) late. She stated the facility policy was to document medication as soon as the medication was given. She stated she did not know why she clicked it off late. During an interview on 4/17/2026 at 3:23 p.m., LVN F stated she administered Resident #1's scheduled medication on time. She stated she did not know why it was documented as late except that she clicked it off later during her shift when she was not busy. She stated she gave the medications on time but if she was busy, she would not document until later in the shift. LVN F stated she would get easily distracted with other tasks and have to go back later. She stated the facility policy indicated she should document or click off the medication as it was given. During an interview on 4/17/2026 at 3:35 p.m. LVN D stated she worked night shift. She stated at times during the night Resident #1 would refuse his methadone. She stated he had the right to refuse. She stated she would go back later and ask him if he was sure he did not want it and he would take it or he would ask for it and she would give it. She stated she did not correct the time entry to reflect the actual time she gave it. She would just click off the time it was scheduled (which did not reflect the actual time it was given). LVN D stated she did not make any notes in the medical record to indicate the medication was given late. She stated at other times, she just did not click it off at the same time she gave it because things happened. During an interview on 4/17/2026 at 4:22 p.m., the ADON stated his expectation was that the nurses should sign of medication administration on the electronic MAR immediately after the medication was given. He stated this was best practice to not get sidetracked. He stated someone else could accidentally administer the same medications if the medication had not been signed off when it was given. He stated he would expect staff to make a note in the MAR to indicate the correct time the medication was given. Record review of the facility's policy, titled Administering Oral Medications dated December 2025 revealed: Documentation: Follow guidelines in the procedure entitled Documentation of Medication Administration. Record review of the facility's policy, titled Documentation of Medication Administration dated December 2025 revealed: 2. Administration of medication must be documented immediately after (never before) it is given.