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	04/05/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observation, interview and record review the facility failed to ensure when the facility transfers or discharges a resident under any of the circumstances, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider for 1 of 3 (Resident #35) residents reviewed in that: Resident #35 was discharged on [DATE] and did not have a discharge summary report in the chart. This could affect all residents that had been discharged and could result in an inappropriate discharge. The findings were: Record review of Resident #35's Admission record dated 4/5/2024 revealed he was admitted on [DATE] with a diagnosis of Huntington's disease and was on hospice services . Resident #35's cognition was modified independence ([NAME] difficulty in new situations only) Record review of Resident #35's discharged MDS dated [DATE] reveled a discharge was done due to behaviors. Record review of Resident #35's chart revealed no discharge summary was completed. Interview on 4/5/2024 at 4:00 PM, VP Clinical RN stated she would try to find the discharge summary for Resident #35. Corporate nurse provided surveyor with Resident #35's discharge summary report signed and dated by MD on 4/5/2024. Surveyor asked for the policy on discharge summary repots. No policy was provided before the exit

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observation, interview and record review the facility failed to ensure resident environment remains as free of accident hazards for 1 of 8 (#2) residents reviewed in that: Resident #2 had at bedside with no nurse supervision the following items: Insulin needles x 7, Pen needles x 9, Alcohol wipes, and a test strip container. This could affect all residents and could result in harm. The findings were: Record review of Resident #2's Admission Record dated 4/4/2024 revealed he was admitted on [DATE], readmitted on [DATE] with diagnoses of diabetes II (condition that happens because of a problem in the way the body regulates and uses sugar as a fuel). Record review of Resident #2's Quarterly MDS dated [DATE] revealed his BIMs score was 12/15 (moderate cognitively impaired) and had diabetes. Record review of Resident #2's care plan dated 9/4/2024 revealed he had diabetes. Observation on 4/4/24 at 1:40 p.m. in Resident # 2's room revealed at bedside were Insulin needles x 7, Pen needles x 9, Alcohol wipes and a test strip container . Interview on 4/04/24 at 1:59 PM. RN D stated it was her fault she left the insulin needles x 7, Pen needles x 9, Alcohol wipes, a test strip container on Resident #2's bedside table and should not have left the medications by the bedside. RN D stated she was coming right back to Resident #2's room, she went out to look for the glucometer device. Interview 4/05/24 at 4:52 PM, the DON stated the risk of leaving insulin needles x 7, Pen needles x 9, Alcohol wipes, and a test strip container at a residents bedside table could cause harm to Resident #2 or any other resident by poking themselves with needles . The DON stated the nurse should not leave medical items at resident bedside and not supervise. Interview on 4/4/2024 at 4:45 PM, the Administrator discussed the policy for medical paraphernalia left a resident bedside. No policy had been provided before 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44906 Based on observation, interview, and record review, the facility failed to ensure that the medication error rate was not 5 percent (%) or greater. The facility had a medication error rate of 35.71%, based on 10 errors of 28 opportunities, which involved five of six residents (Residents #19, #13, #29, #2, and #17) and two of two staff (LVN B, and MA C) reviewed for medication administration, in that; The facility failed to ensure: 1.a. LVN B failed to administer Resident #13's: eye drops a. Benzonatate, a cough suppressant, at the prescribed time. b. Buspirone, an antianxiety agent, at the prescribed time. c.b. Olopatadine 0.2%, an antihistamine to treat itching and redness in the eye due to allergies. 2.2. MA C failed to administer Resident #29's Refresh liquid gel 1% eye drops, an eye lubricant to treat dry eye, at the prescribed time. 3.3. MA C failed to administer Resident #2's Lidocaine Patch 4%, a local anesthetic for pain relief.45.4. MA C failed to administer Resident #17's: a. Calcium Carbonate, a mineral and electrolyte to replace calcium in the body, at the prescribed time. b. Vitamin D3, a fat-soluble vitamin that help the body absorb calcium and phosphorus, at the prescribed time. c. Claritin, an antihistamine to treat allergies, at the prescribed time. d. Multivitamin supplement at the prescribed time. e. Docusate, a laxative that treats constipation, at the prescribed time. These deficient practices could place residents at risk for not receiving therapeutic effects of their medications and possible adverse reactions. The findings included: Resident #13 Record review of the optional MDS assessment, dated 2/06/2024, revealed Resident #13 was an [AGE] year-old female originally admitted on [DATE]. Resident #13 had a BIMS summary score of 11, indicative of moderate cognitive impairment. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Diagnosis Report, printed 4/04/2024 at 11:23 AM, revealed Resident #13 had Cough diagnosed [DATE]; Mood disorder diagnosed [DATE]; Dermatochalasis [excess skin around the eye; can contribute to dry eye] diagnosed [DATE]. Record review of the Care Plan revealed a focus area of chronic cough and dry eye; with the associated interventions: give medications as ordered with an initiated date of 3/10/2024. Additional focus area of, coping, with a goal of, be without fear or anxiety; associated interventions did not address medication regimen. Record review of Order Details revealed Resident #13 had a physicians' order for Benzonatate, 200 mg, by mouth, dated 1/31/2024, three times a day: 8:00 AM, 2:00 PM, and 8:00 PM. Resident #13 had a physicians' order for Buspirone, 5 mg, by mouth, dated 3/26/2024, two times a day: 8:00 AM, and 6:00 PM. Resident #13 had a physicians' order for Olopatadine, 0.2% solution, 1 drop both eyes, dated 1/31/2024, two times a day: 9:00 AM, and 6:00 PM. Record review of Medication Admin[istration] Audit Report, printed on 4/04/2024 at 11:56 AM, revealed Resident #13's Benzonatate Schedule Date was for 4/04/2024 at 8:00 AM; Administration Time was 4/4/2024 at 9:51 AM. Resident #13's Buspirone Schedule Date was for 4/04/2024 at 8:00 AM; Administration Time was 4/4/2024 at 9:51 AM. Resident #13's Olopatadine Schedule date was for 4/04/2024 at 9:00 AM. Record review of Progress Note dated 4/04/2023 at 10:09 AM, authored by the DON, revealed, notified MD olopatadine pending delivery, received order to hold until available and adjust administration times if needed. In an observation and interview on 4/04/2024 at 9:48 AM, LVN B administered Benzonatate and Buspirone to Resident #13. LVN B did not administer the olopatadine eye drops as they were not available. LVN B stated he would let the supervisor know that he did not have olopatadine in the cart. Resident #29 Record review of the comprehensive MDS assessment, dated 3/14/2024, revealed Resident #29 was a [AGE] year-old male originally admitted on [DATE]. Resident #29 had a BIMS summary score of 13, indicative of intact cognition. Record review of the Care Plan revealed Resident #29 had a focus area of Dry Eyes, with the following associated interventions: give medications as ordered. Record review of a Diagnosis Report, printed 4/04/2024 at 11:29 AM, revealed Resident #29 had dry eye syndrome diagnosed [DATE]. Record review of Order Details revealed Resident #29 had a physicians' order for Refresh Liquigel Ophthalmic Gel 1%, 1 drop both eyes, two times a day, dated 3/25/2024: 9:00 AM and 6:00 PM Record review of Medication Admin[istration] Audit Report, printed on 4/04/2024 at 11:56 AM, revealed Resident #29's Refresh Liquigel Ophthalmic Gel 1% Schedule Date was for 4/04/2024 at 9:00 AM; Administration Time was 4/4/2024 at 10:11 AM. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 4/04/2024 at 10:11 AM, MA C administered Refresh Liquigel Ophthalmic Gel 1% to Resident #29. Resident #2 Record review of the quarterly MDS assessment, dated 3/08/2024, revealed Resident #2 was a [AGE] year-old male originally admitted on [DATE]. Resident #2 had a BIMS summary score of 12, indicative of moderate cognitive impairment. In the 5 days prior to the assessment, Resident #2 received scheduled pain medication regimen. [Active diagnosis did not address shoulder pain.] Record review of a Diagnosis Report printed 4/04/2024 at 12:09 PM, revealed Resident #2 was diagnosed with acute osteomyelitis [infection in a bone], unspecified site on 2/10/2021 (resolved 11/10/2021); unspecified pain on 2/10/2021. Record review of the Care Plan revealed Resident #2 had a focus area of .chronic pain related to .right shoulder pain; with the following associated interventions: administer analgesia as per orders; give before treatments or care. Record review of Order Details revealed Resident #2 had a physicians' order for Lidocaine Patch 4%, topically to right front shoulder, dated 12/20/2023, daily: 9:00 AM. In an observation and interview on 4/04/2024 between 10:12 AM and 10:35 AM, MA C attempted to administer Resident #2's Lidocaine Patch 4%, but the medication was not available in the cart. MA C stated she would let her supervisor know. Resident #17 Record review of the quarterly MDS assessment, dated 3/22/2024, revealed Resident #17 was a [AGE] year-old female originally admitted on [DATE]. Resident #17 had a BIMS summary score of 13, indicative of intact cognition. Active diagnoses included acute pancreatitis [inflammation of the pancreas that can affect digestion and nutrition]. Record review of Order Details revealed Resident #17 had a physicians' order for Calcium Carbonate, 600 mg, by mouth, dated 2/16/2024, daily: 9:00 AM; Resident #17 had a physicians' order for Cholecalciferol, 1000 units, by mouth, dated 2/16/2024, daily: 9:00 AM; Resident #17 had a physicians' order for Claritin, 10 mg, by mouth, dated 2/26/2024, daily: 9:00 AM; Resident #17 had a physicians' order for Multivitamin, by mouth, dated 1/24/2024, daily: 9:00 AM; Resident #17 had a physicians' order for Docusate, 100 mg, by mouth, dated 2/20/2024, two times a day: 9:00 AM, and 6:00 PM. [Care Plan for Resident #17 did not address vitamin deficiencies, allergies, or constipation.] Record review of Medication Admin[istration] Audit Report, printed on 4/04/2024 at 11:56 AM, revealed Resident #17's Calcium Carbonate Schedule Date was for 4/04/2024 at 9:00 AM; Administration Time was 4/4/2024 at 10:39 AM; Resident #17's Cholecalciferol Schedule Date was for 4/04/2024 at 9:00 AM; Administration Time was 4/4/2024 at 10:26 AM; Resident #17's Claritin Schedule Date was for 4/04/2024 at 9:00 AM; Administration Time was 4/4/2024 at 10:26 AM; Resident #17's Docusate Schedule Date was for 4/04/2024 at 9:00 AM; Administration Time was 4/4/2024 at 10:27 AM. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 4/04/2024 at 10:36 AM, MA C administered Resident #17's Calcium Carbonate, Cholecalciferol, Claritin, Multivitamin, and Docusate to Resident #17. MA C stated she normally worked at a different facility but was called last minute to fill in at the facility that day. MA C stated she knew when she got there, she would be late administering medications because the staff originally schedule had an emergency and was unable to work as scheduled. In a group interview on 4/04/2024 at 4:00 PM, the DON, the ADM and the VP Clinical RN present, the VP Clinical RN stated she had questions regarding time frames on the orders versus the times they were administered. The ADM stated they had a staff member call out, and it took a while to get another staff member to replace her, so medications were late before MA C even started. In an interview on 4/05/2024 at 4:50 PM, the DON stated the facility policy was for medication to be administered in a timely manner. The DON stated residents could be harmed if medications were not administered on time. The DON stated new hires were trained to administer medications within a two-hour window, up to one hour before the scheduled time, and up to one hour after the scheduled time. The DON stated this principle was included in annual competencies for all nursing staff that have the role of administering medications. The DON stated that In-Servicing were given on an as needed basis if an issue were to arise. The DON stated late administration of medications were spot checked by the ADONs and the DONs, along with randomized spot checks by the pharmacy during their rounds and reviews. Review of administering oral medications policy, reviewed December 2023, revealed, under the heading Steps in The Procedure, 23.) if medication is not available, notify the physician and pharmacy for an estimated arrival time then clarify administration time with the physician. Under the heading Recording, 2.) report other information in accordance with facility policy and professional standards of practice. [Facility policy did not address acceptable professional standards of administering medications timely.] Review of Lippincott procedures, Oral Drug Administration, revised 5/21/2023, accessed 1/17/2024, https://procedures.lww.com/lnp/view.do?pId=4420477, revealed under the heading Implementation, Verify that you're administering the medication at the proper time .to reduce medication errors.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 44906 Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 3 medication carts (the Treatment Cart) reviewed for medication storage, in that. The facility failed to ensure the Treatment Cart was locked when it was left unattended in the common area of the 300-hallway. This deficient practice could place residents at risk of medication misuse or drug diversion. The findings were: In an observation and interview on 4/03/2024 at 4:50 PM, the Treatment Cart was observed unlocked and unattended outside of a resident's room on the 300-hallway. There were residents, staff, and visitors in the area. The Treatment Cart contained prescription, over the counter medications and supplies for skin and wound care. LVN A stated the Treatment Cart was her responsibility. LVN A stated she had forgotten to lock the Treatment Cart as she walked away from it to assist a resident. LVN A stated she did not think it had been unlocked and unattended for more than a few minutes. LVN A stated that the items in the Treatment Cart could be harmful if not used properly. LVN A stated that she knew the cart should be locked when unattended. LVN A stated the facility had trained her to lock the cart when it was not in active use. In an interview on 4/05/2024 at 4:50 PM, the DON stated the facility policy was for medication treatment carts not to be left unlocked and unattended for safety. The DON stated residents could be harmed if items were taken from the Treatment Cart and not used in the intended manner. The DON stated new hires were trained in this procedure. The DON stated this principle was included in annual competencies for all nursing staff that have the role of administering medications. The DON stated that In-Servicing were given on an as needed basis if an issue were to arise. The DON stated the medication security was spot checked by the ADONs and the DONs, along with randomized spot checks by the pharmacy during their rounds and reviews. Review of Storage of Medications policy, reviewed December 2023, revealed under the heading Policy Interpretation and Implementation, 7.) Compartments (including, but not limited to .carts .) shall be locked when not in use . shall not be left unattended if open or otherwise potentially available to others. Review of Lippincott procedures, Oral Drug Administration, revised 5/21/2023, accessed 1/17/2024, https://procedures.lww.com/lnp/view.do?pId=4420477, revealed under the heading Reducing Medication Risk in an Older Adult, store medications in a secure, dry location away from sunlight.

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observation and interview, the facility failed to provide a minimum of 80 square feet per resident in 32 of 39 resident rooms (Rooms 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 202, 203, 204, 205, 206, 208, 209, 210, 211, 302, 304, 307, 308, 309, 310, 311, 312, 313, 314, 317, and 319) reviewed in that: This deficient practice could result in inadequate space to provide care and resident dissatisfaction with the environment. The findings were: During interview on 4/25/2024 at 9 AM with the Administrator stated on the room waivers everything was the same and there were no changes to the room waivers. Interview with the Administrator requested room waivers for 32 rooms. Observations on 3/6/2023 starting at 3:05 PM to 4:08 PM: residents in room room [ROOM NUMBER]-two residents - 71.86 square feet per resident. room [ROOM NUMBER]-two residents- 79.74 square feet per resident. room [ROOM NUMBER]-two residents - 71.91 square feet per resident. room [ROOM NUMBER]-two residents - 75.049 square feet per resident. room [ROOM NUMBER]-two residents - 66.79 square feet per resident. room [ROOM NUMBER]- one resident - 74.81 square feet per resident. room [ROOM NUMBER]-two residents - 72.59 square feet per resident. room [ROOM NUMBER]-two residents - 74.80 square feet per resident. room [ROOM NUMBER]- two residents - 71.42 square feet per resident. room [ROOM NUMBER]-One residents - 74.63 square feet per resident. room [ROOM NUMBER]-two residents - 70.89 square feet per resident. room [ROOM NUMBER]-One resident - 77.24 square feet per resident. room [ROOM NUMBER]-two residents - 73.21 square feet per resident. room [ROOM NUMBER]-One residents - 75.28 square feet per resident. (continued on next page)

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room [ROOM NUMBER]-two resident - 72.57 square feet per resident. room [ROOM NUMBER]-one resident - 74.59 square feet per resident. room [ROOM NUMBER]-two resident - 76.31 square feet per resident. room [ROOM NUMBER]-two residents - 73.36 square feet per resident. room [ROOM NUMBER]-one resident - 73.53 square feet per resident. room [ROOM NUMBER]-one residents - 73.77 square feet per resident. room [ROOM NUMBER]-No resident - 71.92 square feet per resident. room [ROOM NUMBER]-No resident - 71.48 square feet per resident. room [ROOM NUMBER]-No residents - 68.30 square feet per resident. room [ROOM NUMBER]- No resident- 69.14 square feet per resident. room [ROOM NUMBER]-no residents - 68.02 square feet per resident. room [ROOM NUMBER] and 311-no residents- 67.46 square feet per resident. room [ROOM NUMBER]- no resident - 69.59 square feet per resident. room [ROOM NUMBER]-no resident - 67.79 square feet per resident. room [ROOM NUMBER]- no resident - 69.19 square feet per resident. room [ROOM NUMBER]-no resident - 68.82 square feet per resident. room [ROOM NUMBER]- no resident - 68.87 square feet per resident.