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	05/30/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to send a copy of the residents' discharge notice, prior to discharge, to the representative of the Office of the State Long-Term Care (LTC) Ombudsman of the residents' transfer or discharge and the reasons for the move, for 4 of 8 residents (Residents #24, #25, #30, and #35) reviewed for notifying the LTC Ombudsman of the residents' discharge. 1. Resident #30 was discharged to the hospital on 3/29/2025 without a notice to the LTC state ombudsman. 2. Resident #35 was discharged on 4/15/2025 without a notice to the LTC state ombudsman. 3. Resident #25 was issued a 30-day notice on 5/8/2025 of an intended discharge on [DATE], without a notice to the LTC state ombudsman. 4. Resident #24 was issued a 30-day notice on 5/14/2025 of an intended discharge on [DATE], without a notice to the LTC state ombudsman. These failures could place residents at risk of not knowing their rights and receiving the services of the state LTC Ombudsman. The findings included: 1. A record review of Resident #30's admission record dated 5/30/2025 revealed an admission date of 2/12/2025 and a discharge date of 3/29/2025 with diagnoses which included end stage renal disease (kidney failure to the point they cannot keep someone alive) and dependence on renal hemodialysis (a real time treatment where a machine filters out toxins from a patient's blood, usually performed in a clinic 3 time a week.) (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #30's quarterly MDS assessment dated [DATE] revealed Resident #30 was a [AGE] year-old male admitted for LTC and assessed with the need for hemodialysis and a BIMS score of 15 out of a possible 15 which indicated intact cognition. A record review of Resident #30's physicians' orders dated 9/16/2024 revealed Resident #30 received renal hemodialysis 3 times a week on Monday, Wednesday, and Fridays. A record review of Resident #30's hospital admission document dated 3/30/2025 revealed Resident #30 on the night of 3/29/2025 around 11 PM was in bed when he turned in bed and his dialysis access port caught on something and became dislodged and required hospitalization. A record review of Resident #30's medical record from 2/12/2025 through 5/30/2025 revealed no evidence of a notice to the state LTC ombudsman of Resident #30's discharge to the hospital. 2. A record review of Resident #35's admission record revealed an admission date of 2/26/2025 and a discharge date of 4/15/2025 with diagnoses which included atherosclerotic heart disease (the buildup of plaque leading in the arteries causing hardening and narrowing). A record review of Resident #35's discharge MDS assessment dated [DATE] revealed Resident #35 was a [AGE] year-old female admitted for rehabilitation care. A record review of Resident #35's progress notes revealed LVN D documented on 4/15/2025 Resident #35 was discharged home accompanied by her representative. A record review of Resident #35's medical record from 2/26/2025 through 5/30/2025 revealed no evidence of a notice to the state LTC ombudsman of Resident #35's home discharge. 3. A record review of Resident #25's admission record revealed an admission date of 1/29/2024 with diagnoses which included sepsis (a serious condition in which the body responds improperly to an infection. The infection-fighting processes turn on the body, causing the organs to work poorly) due to Escherichia coli (a bacteria that is commonly found in the lower intestine), chronic obstructive pulmonary disease (COPD an ongoing lung condition caused by swelling and irritation inside the airways that limit airflow into and out of the lungs), and dependence on other enabling machines and devices. A record review of Resident #25's quarterly MDS assessment dated [DATE] revealed Resident #25 was a [AGE] year-old female admitted for LTC and weighted 386 lbs. at a height of 5 feet 2 inches, could not bear weight and required mechanical assistance with transfers from bed to wheelchair. The resident was assessed with the need for continuous supplemental oxygen . The resident was assessed with a BIMS score of 15 out of a possible 15 which indicated intact cognition. A record review of Resident #25's medical record revealed a facility initiated Notice of 30-day Discharge letter dated 5/8/2025. The letter revealed the facility intended to discharge Resident #25 for her inability to pay for services. Further review revealed no evidence the ombudsman was notified. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Record review of Resident #24's admission record revealed a [AGE] year-old female resident with an admission date of 11/16/2024 with diagnoses which included unspecified dementia (group of thinking and social symptoms that interferes with daily functioning), hypertension (condition in which the force of the blood against the artery walls is too high), and chronic kidney disease. A record review of Resident #24's quarterly MDS assessment, dated 02/27/2025 revealed Resident #24 had a BIMS of 0, indicating severe cognitive impairment. Further review of Resident #24's MDS assessment revealed that she was dependent on all of the following activities of daily living: eating, oral hygiene, toileting hygiene, bathing, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. Record review of Resident #24's medical record reflected a facility initiated, Notice of 30-Day Discharge letter, dated 5/14/2025. The letter revealed the facility intended to discharge Resident #24 for her inability to pay for services . Further review revealed no evidence the ombudsman was notified. During an interview on 5/27/2025 at 1:20 PM Resident #25 stated she was anxiously concerned she would be discharged with nowhere to go. Resident #25 stated she was vulnerable and could not survive without help. Resident #25 stated she was a widow and had utilized an attorney to assist her with the sale of her home and used the proceeds to pay for care at the facility and as of April 2025 she had run out of money and on May 8th, 2025, received a notice she would be discharged . Resident #25 was unaware of the services and oversight of the state LTC ombudsman and would like to be connected to her services and oversight. During an interview on 5/27/2025 at 2:00 PM the state LTC Ombudsman for the facility stated she had not received any discharge notices from the facility in the past year. The Ombudsman stated the lack of discharge notices denied residents the opportunity to avail themselves to the services and oversight of the ombudsman. The Ombudsman stated some of the services and oversight an ombudsman may provide varied and could include coordination with the resident and the facility to provide payor sources, and or to ensure the facility supported residents with their full exercise of their rights and potentially apply for government resources such as Medicaid services. During an interview on 5/30/2025 the LTC Ombudsman for the facility stated she had spoken to Resident #25 on 5/28/2025 and the Administrator and the facility would not discharge Resident #25 pending an appeal. During an interview on 5/27/2025 at 11:46 AM, Resident #24's and her representative stated they were not comfortable with Resident #24's discharge and had not been informed of a way to appeal the discharge. Resident #24's family member stated that he was a disabled veteran and would be unable to take care of Resident #24 appropriately, considering her level of care. Resident #24 stated the facility Administrator had not discussed options other than discharge for Resident #24. During an interview on 05/29/2025 at 9:11 AM, the Administrator stated he would not be able to evidence that 30-day discharge notices were sent to the office of the Ombudsman unless he went to the Ombudsman's office and looked through the Ombudsman's mail. The Administrator stated they would subpoena the mailman, if necessary, to show that the 30-day discharge notifications were mailed. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/30/2025 at 1:50 PM the Business Office Manager (BOM) stated she was responsible for reviewing residents for their ability to pay for services rendered either through private pay and or insurance supported payments. The BOM stated if a resident was approaching an instance where they would be reaching the end of a payor source, such as a payor source which would be depleted and or exhausted, the office would notify the resident of a pending 30-day discharge. The BOM stated she would mail a copy of the letter to the address of the LTC ombudsman, however the BOM stated she had no receipt to evidence the letter was mailed. The BOM stated she was not trained to keep evidence for the mailing of the letter. The BOM stated she had not notified the LTC Ombudsman of any discharges for any residents. The BOM stated she was unaware the notification to the LTC Ombudsman of any resident discharge was a requirement. During an interview on 5/30/2025 at 2:40 PM the DON stated she was unaware of the requirement for the facility to report any discharged residents to the LTC Ombudsman. The DON stated a record review of residents' records would not reveal evidence of discharge notices to the LTC Ombudsman because the facility was not reporting the discharged residents. During an interview on 5/30/2025 at 4:55 PM with the Administrator and the DON, the Administrator stated, and the DON agreed, the facility had not developed and implemented a system to ensure the state LTC Ombudsman received notices for residents who were discharged . The Administrator stated the risk for residents could be the residents would not receive the oversight and services of the state LTC Ombudsman. A policy was requested, and the Administrator stated the facility adheres to HHSC Guidelines. A record review of the facility's Transfer or Discharge Notice policy dated December 2016, revealed, Policy Statement: Our facility shall provide a resident and/or the resident's representative (sponsor) with a thirty (30)-day written notice of an impending transfer or discharge. Policy Interpretation and Implementation: A resident, and/or his or her representative (sponsor), will be given a thirty (30)-day advance notice of an impending transfer or discharge from our facility. 4. A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct an accurate comprehensive assessment of each resident's functional capacity including the resident's needs, strengths, goals, life history and preferences for 2 of 8 Residents (Residents #9, #13) reviewed for assessments. Resident #9 and Resident #13's Quarterly MDS Assessments did not reflect their significant weight loss. This failure could place residents at risk for not receiving the care and services as needed. The findings included: Record review of Resident #9's face sheet, dated 05/30/2025, reflected an [AGE] year-old resident initially admitted on [DATE] with diagnoses of metabolic encephalopathy (change in how your brain works due to an underlying condition), dependence on renal dialysis, and end stage renal disease (kidney failure, where your kidneys no longer work as they should to meet your body's needs to adequately filter waste). Record review of Resident #9's medical record reflected that on 03/20/2025, Resident #9 weighed 118 lbs. and on 04/27/2025, Resident #9 weighted 109.2 lbs., which is a -7.46% loss in body weight. Due to the significant loss in weight, on 04/28/2025, the facility dietician recommended adding an appetite stimulant to Resident #9's medicine regiment. Record review of Resident #9's Quarterly MDS assessment dated [DATE], reflected under Section K - Swallowing/Nutritional Status, subsection Weight Loss reflected that Resident #9 did not have weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. Record review of Resident #9's Care Plan, dated 05/30/2025, reflected that the resident had unplanned/unexpected weight loss with interventions such as providing dietary supplements as ordered by physician. Record review of Resident #13's face sheet, dated 05/30/2025, reflected a [AGE] year-old resident initially admitted on [DATE] with diagnoses of sepsis (a life-threatening complication of an infection), encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition), and type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Record review of Resident #13's medical record reflected that on 03/03/2025, Resident #13 weighed 242 lbs. and on 04/2/2025, Resident #9 weighed 225.4 lbs., which was a -7.00% loss in body weight. Record review of Resident #13's Quarterly MDS assessment dated [DATE], reflected under Section K - Swallowing/Nutritional Status, subsection Weight Loss reflected that Resident #13 did not have weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #13's Care Plan, dated 05/30/2025, reflected that the resident had unplanned/unexpected weight loss with interventions such as alerting the dietician if the resident has poor food consumption for more than 48 hours and notifying the physician if there is more weight loss. Interview on 05/30/2025 at 10:22 AM, the MDS Coordinator stated she had just begun her employment at the facility and began completing MDS' in the first week of May of 2025. The MDS Coordinator stated both Resident #9 and Resident #13's significant weight loss should have been indicated in their MDS Assessments completed on 04/27/2025, and 04/22/2025, respectively. The MDS Coordinator stated she would take that into account moving forward and complete an audit to ensure all MDS' had accurate weight assessments and would correct any MDS' that did not .

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F 0684 Level of Harm - Minimal harm or potential for 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** Based on interviews and record reviews the facility failed to ensure that residents received treatments and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, for 1 of 8 residents (Resident #11) reviewed for professional standards with medication administration. On 5/25/2025 and 5/26/2025 Medication Aides B and C did not administer Resident #11's alprazolam (a medication which reduces brain sensitivity to stimulation, which has a calming effect) medications 4 out of a possible 5 opportunities. Medication Aides B and C did not report the missed medication administrations to the nursing leadership. These failures could place residents at risk for harm by adverse reactions to sudden cessation of the medication which could include seizures and thoughts of suicide. The findings included: A record review of Resident #11's admission record dated 5/30/2025 revealed an admission date of 1/23/2025 with diagnoses which included anxiety disorder and major depressive disorder. A record review of Resident #11's quarterly MDS assessment dated [DATE] revealed Resident #11 was a [AGE] year-old female admitted for long term care and assessed with a BIMS score of 13 out of a possible 15 which indicated intact cognition. Resident #11 was assessed with moderate difficulty with hearing and highly impaired vision. A record review of Resident #11's care plan dated 5/17/2024 revealed, I use anti-anxiety medications related to anxiety disorder . I will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date . I am taking anti-anxiety meds which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia, falls, broken hips and legs, monitor for safety. A record review of Resident #11's physician's orders dated 1/30/2025 revealed the physician prescribed Resident #11 to receive alprazolam 0.5mg, for anxiety, 3 times a day, morning, noon, and evening. A record review of Resident #11's medication administration record for the month of May 2025 revealed on 5/25/2025 Resident #11 received only 1 of the 3 prescribed administrations of alprazolam, the morning medication which was administered by MA B. Further review revealed Medication Aide B (MA B) documented the 5/25/2025 the noon dose and the evening dose were not available. A record review of Resident #11's medication administration record for the month of May 2025 revealed on 5/26/2025 Resident #11 received only 1 of the 3 prescribed administrations of alprazolam, the evening medication. Further review revealed Medication Aide C (MA C) documented the 5/26/2025 morning dose and the noon dose were not available . Further review revealed the 5/26/2025 the evening dose was administered by medication Aide D (MA D). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/27/2025 at 10:02 AM Resident #11 stated she could not recall if she received all her medications over the last 2 days (Sunday and Monday). Resident #11 stated she had difficulty with her recollection, had difficulty with her vision, and hearing. Resident #11 stated she was feeling well and calm without any anxiety and was treated well by the staff. During an interview on 5/28/25 at 1:22 PM MA C stated she worked Monday 5/26/2025 as the medication aide from 6:00 AM to 2:00 PM. MA C stated Resident #11 did not have any alprazolam for her morning nor her noon medication administration. MA C stated she had reported the missed medication administration to the charge nurse LVN D. MA C stated she was unaware if Resident #11 had missed any other doses. MA C stated she had not reported the missed doses to anyone else other than the charge nurse LVN D. MA C stated she had not documented her verbal report to LVN D. MA C stated the alprazolam was an anti-anxiety medication and the missed doses could have the risk of not receiving the therapeutic effects of her anti-anxiety medication. MA C stated the facility had a pharmacy emergency kit and vaguely recalled LVN D stated the medication was not available from the pharmacy's emergency kit. During an interview on 5/29/2025 at 11:00 AM LVN D stated she worked Monday 5/26/2025 with MA C. LVN D stated she was not given any reports that Resident #11 had missed 4 of the 5 doses of alprazolam from 5/25/2025 noon to 5/26/2025 noon. LVN D stated the risk to Resident #11 for missing 4 consecutive doses could be varied to include anxiety. LVN D stated on the evening of 5/26/2025 she was given a report by MA E that Resident #11 had no alprazolam for the 5/26/2025 evening medication administration, accessed the pharmacy's emergency kit and supplied the alprazolam to MA E for administration. LVN D stated she SBAR'ed the PCP with no new orders and coordinated with the pharmacy for a refill of Resident #11's medication. LVN D stated she continued to access the medication from the pharmacy's emergency kit until Tuesday's (5/27/2025) refill from the pharmacy. During an interview on 5/30/2025 at 3:00 PM the DON stated she received a report from LVN D on 5/26/2025 of the lack of reporting and documenting where MA C had not reported to nursing leadership Resident #11's missed doses of alprazolam on 5/26/2025. The DON stated she investigated and discovered MA B and MA C had not administered Resident #11's alprazolam for 4 consecutive doses on Sunday 5/25/2025 to Monday 5/26/2025. The DON stated she terminated MA B and suspended MA C until further investigation. The DON stated MA C worked the weekends as a medication aide and would not take a shift until further review. The DON stated Resident #11 was assessed with no adverse reactions to the missed doses and her physician had received a report with no new orders. The DON stated the pharmacy refilled the medication and included the emergency kit on Tuesday 5/27/2025 . During an interview on 5/30/2025 at 4:50 PM with the Administrator and the DON, the DON stated, and the Administrator agreed, the expectation for any missed doses of medications was for the resident to be assessed by nursing, the physician to receive a report, and any new orders to be supported. The DON stated the alprazolam for Resident #11 should have been reordered by any staff who could for see the medication needed to be refilled and at a minimum by MAs B and C. The DON stated the medication aides should have reported to nursing leadership and documented the reports, that Resident #11 had missed the medication administration. The DON stated the risk for residents who missed their medication administration could be the missed therapeutic effects of their medications. A policy was requested and provided with the additional verbal statement The facility follows HHSC guidelines. A record review of the facility's Administering Oral Medications dated 12/2024, revealed, . Documentation: Follow documentation guidelines in the procedure entitled Documentation of Medication Administration. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reporting l. Notify the supervisor if the resident refuses the procedure. 2. Report other information in accordance with facility policy and professional standards of practice.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for 1 of 1 facility reviewed for food service safety. The facility failed to maintain the cleanliness of the facility ice maker. This failure could place residents who receive food and/or snacks from the facility at risk for food borne illness. The findings included: Observation on 05/27/2025 at 09:18 AM revealed a black substance build-up within the ice maker. Interview on 05/29/2025 at 2:00 PM, the DON stated that she saw the buildup in the ice machine in the photo, and her expectation was for the ice machine to be appropriately cleaned. The DON stated the Kitchen Manager generally cleans the ice machine. Record review of Ice Machine Cleaning and Sanitizing Log reflected that the ice machine was cleaned once monthly on the following dates, 09/06/2024, 10/14/2024, 11/15/2024, 12/2/2024, 01/10/2025, 02/03/2025, 03/03/2025, 04/08/2025, and 05/05/2025. Record review of facility policy titled, Sanitization, dated revised October 2008, reflected, Ice machines and ice storage containers will be drained, cleaned, and sanitized per manufacturer's instructions and facility policy. No other facility policy regarding cleanliness of the facility ice maker was provided.

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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 interviews and record reviews the facility failed to maintain medical records on each resident that were complete, accurately documented, readily accessible, and were systematically organized, for 2 of 8 residents (Resident #3 and #8) reviewed for consents for accurate medical records. 1. Resident #3 was prescribed and received the antipsychotic medication risperidone for schizophrenia without evidence in his medical record of the state consent form 3713. 2. Resident #8 was prescribed and received the antipsychotic medication aripiprazole for depression without evidence in her medical record of the state consent form 3713. These failures could place residents at risk for inaccurate and unorganized medical records. The findings included: 1. A record review of Resident #3's admission record dated 5/28/2025 revealed an admission date of 10/28/2023 with diagnoses which included schizophrenia (a chronic brain disorder characterized by symptoms like hallucinations, delusions, and disorganized thinking.). A record review of Resident #3's quarterly MDS assessment dated [DATE] revealed Resident #3 was a [AGE] year-old male admitted for long term care (LTC) and was assessed with a BIMS score of 8 out of a possible 15 which indicated severe cognitive impairment. A record review of Resident #3's care plan dated 2/11/2025 revealed, [Resident #3] resident rights will be respected and maintained through the review date February 11th 2025, . participation in my care: I have the right to: receive information about prescribed psychoactive medications, prescribed and administered, in a responsible manner as mandated the Texas Health and safety code 242 505 and the right to refuse consent to the prescription of psychoactive medications. Access personal and clinical records which will be maintained as confidential and may not be released without my consent. A record of Resident #3's physicians' orders, dated 4/27/2024 revealed the physician prescribed Resident #3 to receive risperidone 4mg every bedtime for his diagnosed schizophrenia. A record of Resident #3's medication administration record for the month of May 2025, revealed Resident #3 received risperidone 4mg every bedtime for his diagnosed schizophrenia. A record review of Resident #3's medical record from 4/27/2024 to 5/30/2025 revealed no evidence of a state required psychotropic medication consent form 3713. (continued on next page)

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	05/30/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A record review of Resident #8's admission record dated 5/30/2025 revealed an admission date of 08/24/2023 with diagnoses which included bi-polar disorder (a mental health condition characterized by extreme mood swings, ranging from periods of elevated mood (mania or hypomania) to periods of depression.). A record review of Resident #8's quarterly MDS assessment dated [DATE] revealed Resident #8 was a [AGE] year-old female admitted for long term care (LTC) and was assessed with a BIMS score of 15 out of a possible 15 which indicated no cognitive impairment. A record review of Resident #8's care plan dated 10/14/2024 revealed, I use antipsychotic medication for diagnosis of bipolar disease . give antipsychotic medications as ordered by physician A record of Resident #8's physician's orders, dated 4/4/2025 revealed the physician prescribed Resident #8 to receive aripiprazole 5mg every bedtime for her diagnosed depression / bi-polar disorder. A record of Resident #8's medication administration record for the month of May 2025, revealed Resident #8 received aripiprazole 5mg every bedtime for her diagnosed depression / bi-polar disorder. A record review of Resident #8's medical record from 10/14/2024 to 5/30/2025 revealed no evidence of a state required psychotropic medication consent form 3713. During an interview on 5/30/2025 at 3:00 PM the DON stated a record review for state required antipsychotic consent forms #3713 for Residents #3 and #8 were not in the medical record. The DON stated Residents #3 and #8 did have consents however the psychotropic consent forms were in her desk awaiting to be scanned into the medical record. During a joint interview on 5/30/2025 at 5pm with the Administrator and the DON, the DON stated, and the Administrator agreed, all residents who were prescribed and receive antipsychotic medications should have antipsychotic consent forms evidenced in their medical record. The DON stated the facility currently had no 1 specific staff member to scan medical records and the task of scanning antipsychotic consents had befallen on herself to which she had yet to scan into the record. The DON stated the risk to residents could be inaccurate medical records. A policy was requested, and the Administrator and the DON stated the facility followed HHSC guidelines.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure standard and transmission-based precautions which included hand hygiene procedures, were followed by staff involved in direct resident contact, to prevent spread of infections, for 1 of 8 residents (Resident #8) reviewed for transmission-based precautions. On 5/29/2025 LVN A provided a wound care bandage change for Resident #8 and did not change gloves and continued with soiled gloves when he removed Resident #8's dirty bandage, cleaned the wound, applied wound care treatment medication, and applied a clean bandage. This failure could place residents at risk for infections. The findings included: A record review of Resident #8's admission record dated 5/30/2025, revealed an admission date of 3/20/2025 with diagnoses which included respiratory failure with hypercapnia (excess carbon dioxide in the blood stream), diabetes mMellitus, and laceration without foreign body, left lower leg (a wound to the left leg 'calf'). A record review of Resident #8's quarterly MDS assessment dated [DATE] revealed Resident #8 was a [AGE] year-old female admitted for long-term-care and assessed medically complex with a BIMS score of 15 out of a possible 15 which indicated no cognitive impairment. A record review of Resident #8's physician's orders dated 5/21/2025 revealed the physician ordered for Resident #8 to receive Enhanced Barrier Precautions (EBP) every shift and daily wound care to her left lower calf, Resident is on EBP, and standard precautions related to wound care. [NAME] [sic(wear)] PPE (personal protection Equipment) inside the room. Every shift or enhanced barrier precautions medical condition staff must [NAME] gown and gloves when performing high contact care such as bathing, showering, peri-care, brief changes, dressing changes . wound care: left medial [sic(middle)] calf: cleanse with wound cleanser, normal saline, pat dry with 4 by 4 gauze, apply collagen powder sic[a critical protein which maintained skin, tendons, bones, and connective tissue] and (sic[Brand name occlusive dressing is a sterile, non-adhering protective dressing consisting of absorbent, fine-mesh gauze impregnated with a petrolatum blend]) to the wound bed, then cover it with a dry dressing. During an observation and interview on 5/29/2025 at 2:49 PM revealed Resident #8 in her room in bed accepting wound care to her left calf from LVN A. Further observation revealed LVN A wore a gown and gloves. LVN A changed gloves, performed hand hygiene, and applied new gloves. LVN A proceed to remove Resident #8's old, soiled bandage from her wound located on her left lower inner calf. Continued observation revealed LVN A discarded the soiled bandage, did not change gloves, and continued with the same gloves. LVN A cleaned Resident #8's wound and applied collagen powder and a nonstick gauze and clean bandage. After the dressing change LVN A stated he had not changed gloves, performed hand hygiene, and applied new gloves and stated he should have to prevent infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/2025 at 3:01 PM the ADON Infection Preventionist (IP) stated the training and expectation was for all staff who perform wound care to change gloves whenever they were going from a soiled to clean situation and LVN A should have removed the soiled gloves, performed hand hygiene, and applied new clean gloves prior to cleaning the wound and again after cleaning the wound and applying the clean bandages. During a joint interview on 5/30/2025 at 4:31 PM with the Administrator and the DON, the DON stated the training and expectation was for all staff who perform wound care to change gloves whenever they were going from a soiled to clean situation and LVN A should have removed the soiled gloves, performed hand hygiene, and applied new clean gloves prior to cleaning the wound and again after cleaning the wound and applying the clean bandages. The DON and the Administrator stated the risk to residents was potential infections. A record review of the facility's Wound Care policy dated December 2024, revealed, Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Steps in the Procedure: . 2. Perform hand hygiene. 3. Position resident to facilitate the dressing change. 4. Put on exam gloves. Loosen tape and remove dressing, discard dressing into appropriate receptacle. 5. Remove gloves. Perform hand hygiene. 6. Put on gloves. Gowns will only be necessary if soiling of your skin or clothing with blood, urine, feces, or other body fluids is likely. Masks and eyewear will only be necessary if splashing of blood or other body fluids into your eyes or mouth is likely. 8. Wear gloves for holding gauze to catch irrigation solutions that are poured directly over the wound. 9. Wear gloves when physically touching the wound or holding a moist surface over the wound. (continued on next page)

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