| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675205 | A. Building<br>B. Wing | 07/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Atrium Rehabilitation Center | 7602 Louis Pasteur St.<br>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.

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety, for 1 of 1 kitchen reviewed for food safety. The facility failed to label foods for safety, which were opened and available for use:X2 5lb. containers of cottage cheese without a date when the product was received, opened, and a date when the food should be thrown out.X2 5lb. containers of sour cream without a date when the product was received, opened, and a date when the food should be thrown out.The facility had personal items on kitchen counters where food was prepared:A personal electronic vape (battery-operated device that heats a liquid to create an aerosol, which is then inhaled into the lungs. Used as an alternative to smoking).A personal drink tumbler.X2 personal cell phones and cell phone charger and wires. These failures could place residents at risk for food borne illness.The findings included: During an observation and interview on 7/7/2026 at 11:00 AM, revealed the facility's refrigerator stored X2 5lb. containers of cottage cheese without a date when the product was received, opened, and a date when the food should be thrown out and X2 5lb. containers of sour cream without a date when the product was received, opened, and a date when the food should be thrown out. The FSM stated the food should have been labeled with the date the food was received, when the food was opened. The FSM stated the dates indicated when the food should be discarded, food which has been opened should be discarded after 7 days. The FSM stated the unlabeled foods which were available for meal service could potentially contribute to food borne illnesses. During an observation and interview on 7/7/2026 at 11:10 AM , the facility's kitchen food preparation counters had personal items which were in use. Observations revealed the following items:X2 personal cell phones.One was used to play musicOne was being charged by a wire and charger plugged into the electrical outlet.A personal electronic vapeA personal drink tumbler.The Food Service Manager stated the expectation was for those items not to be stored in the kitchen. The FSM stated the items belonged to the dietary staff which were currently in the kitchen preparing for the noon meal service. The FSM stated the personal items kept on the food preparation counters could potentially contribute to an unsanitary food preparation area. A record review of the facility's undated Food Safety policy revealed, We will insure all food purchased shall be wholesome and manufactured, processed, and prepared in compliance with all State, Federal, and local laws and regulations. Food shall be handled in a safe manner. Procedure: . 2. Food is to be wrapped or sealed and covered in clean containers. Opened food shall be labeled, dated and stored properly. Perishable opened foods shall be used within 7 days or less, in compliance with the Texas Food Establishment rules. Non-perishable foods will be used as long as the quality of the product is maintained. 9. Do not keep potentially hazardous food in refrigerator past the labeled expiration date. |

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 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's comprehensive care plan was reviewed and revised after each assessment for 1 of 8 residents (Resident #6) reviewed for care planning. The facility failed to ensure Resident #6's comprehensive care plan was revised to include planning and interventions for a fluid restriction ordered by the resident's physician. This failure could lead to residents not receiving intended care and decreased quality of life. Findings included: Record review of Resident #6's Face Sheet dated 7/09/2026 reflected an [AGE] year-old male admitted to the facility on [DATE]. Diagnoses included chronic combined systolic (congestive) and diastolic (congestive) heart failure [a condition in which parts of the heart are weakened or stiffened and cannot pump blood efficiently, leading to a back-up of fluid in the lungs, liver, and/or legs]. Record review of Resident #6's quarterly MDS dated [DATE] reflected a BIMS score of 15, which indicated intact cognition. Record review of Resident #6's Order Summary Report dated 7/09/2026 reflected the following physician's order dated 7/01/2026:1500cc Fluid Restriction/24 Hours- 300cc Total Nursing. 100cc (6-2), 100cc (2-10), 100cc (10-6). Total Dietary 1200cc. 480cc-breakfast, 360cc-Lunch, 360cc-Dinner Record review of Resident #6's Care Plan Report undated/ printed 7/09/2026 reflected the following care planning related to food/fluid intake:I am on a NAS Diet, THIN [sic] Liquids, REGULAR [sic] Texture. Date Initiated: 06/06/2026No additional care planning was in the care plan related to restriction of fluid intake. In an interview on 7/09/2026 at 1:37 PM, LVN B said Resident #6 was recently put on a fluid restriction by his doctor, and she said Resident #6 was typically non-compliant with the restriction. She said staff were all aware of the fluid restriction because of discussion and the physician's order. She was unsure if the fluid restriction was in Resident #6's care plan. In an interview on 7/09/2026 at 2:15 PM, the ADON said he is involved in updating care plans. He said Resident #6's newly ordered fluid restriction should have been added to his care plan, as well as his non-compliance with the order. He said care plans are revised by himself and the DON after any changes are noted to the residents' care. He said the potential risk of not including the fluid restriction in the care plan was staff not being aware of the fluid restriction. Record review of the facility policy titled Comprehensive Assessments and the Care Delivery Process dated December 2025 reflected the following: .Monitoring results and adjusting interventions includes:a. Periodically reviewing progress and adjusting treatments.1) Continue to define or refine the objectives of specific treatments as well as overall care and services . |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents received treatment 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 #26) reviewed for admission with a right foot fracture. Resident #26 was admitted to long term care without orders and care plans for a right foot fracture. These failures could place residents at risk for a decline in health status without physicians' orders and planned care.The findings included: A record review of Resident #26's admission record dated 7/9/2026 revealed an admission date of 4/30/2026 with a diagnosis of a right foot 3rd and 4th metatarsal fractures (Broken long bones in the mid-foot; metatarsals are a group of five long bones located in the midfoot, between your ankle and your toes.) A record review of Resident #26's admission MDS dated [DATE] revealed Resident #26 was a [AGE] year-old female admitted post hospitalization for a right foot fracture. Resident #26 was assessed with a BIMS score of 03 which indicated severe cognition impairment. A record review of Resident #26's hospital discharge records dated 4/30/2026 revealed Resident #26 was discharged with a right foot fracture and wore a camboot (a medical walking boot to immobilize the foot and ankle, protect healing tissues, and offload pressure.) A record review of Resident #26's base-line care plan dated 4/30/2026 revealed LVN C documented Resident #26 had a right foot fracture and was supported with a boot. A record review of Resident #26's physicians orders dated 5/9/2026 revealed no physicians care orders for Resident #26's right foot boot. A record review of Resident #26's care plan dated 7/9/2026 revealed there were no focuses, goals, nor interventions for Resident #26's right foot boot. During an observation on 7/7/2026 at 12:50 PM Resident #26 wore an orthopedic support boot on her right foot as she was seated in her wheelchair in the dining room. During an interview on 7/9/2026 at 10:08 AM LVN B stated she was the charge nurse for Resident #26. LVN B stated Resident #26 wore a boot on her right foot to immobilize her foot fracture. LVN B stated she reviewed Resident #26's medical record and recognized she did not have an order nor care plan for her boot. During an interview on 7/9/2026 at 3:10 PM the ADON stated Resident #26 had received a daily right foot orthopedic boot to support her right foot fracture. The ADON stated the expectation for Resident #26's foot boot was that it would be supported with a physicians' order and a care plan to detail the application and removal of the boot. The ADON stated Resident #26 did not have an order nor a cl for her right foot boot. The ADON stated there would be several points where the boot could have been addressed: upon leaderships' review of new admissions, the care plan meeting, and by charge nurse review of the residents' care plans. The ADON stated the potential negative outcome for Residents who received care without orders or care plans could be inconsistent care. A record review of the facility's Quality of Care Policy dated December 2025, revealed, Purpose:Our goal is to provide top-quality care. This policy keeps patients safe and ensures our staff meets all healthcare rules.2. Our Rules Patient Rights: We always treat clients with respect. We keep all health details private. Safety First: We watch for and report mistakes. We fix them fast to stop harm. Trained Staff: Only workers who have the right licenses help patients. Patient Feedback: We ask clients if they like our care. We use their answers to improve. 3. How We Check Our Work We look at patient records to check our own work. We hold staff meetings to talk about how to do better. If a rule is broken, we fix it immediately to protect the patient. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate administering of drugs, to meet the needs of each resident, for 1 of 4 residents (Resident #16) reviewed for medication administration. The facility failed to ensure Resident #16 received the ordered dosage of her antidepressant medication. This failure could lead to residents not receiving the intended therapeutic effects of prescribed medications. Findings included: Record review of Resident #16's Face Sheet dated 7/09/2026 reflected a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included major depressive disorder, recurrent, unspecified [repeated episodes of low mood that impact daily functioning]. Record review of Resident #16's quarterly MDS dated [DATE] reflected a BIMS score of 13, which indicated intact cognition. Section N0415 of the MDS reflected Resident #16 was prescribed antidepressant medication. Record review of Resident #16's Order Summary Report dated 7/09/2026 reflected the following physician's order dated 6/25/2026:Sertraline HCl [a medication used to treat depression] Oral Tablet 100 MG (Sertraline HCl) Give 1.5 tablet by mouth in the morning for Depressiongive one and half tabs to = 150mg dose Qday Record review of Resident #16's progress notes reflected the following documentation dated 6/24/2026 authored by the DON:-Reviewed sertraline therapy; mood symptoms persist. Zoloft [brand name for sertraline] increased from 100ˆmg daily to 150ˆmg daily for improved symptom control. Record review of Resident #16's Medication Administration Record for July 2026 dated 7/09/2026 reflected the following scheduled medication: Sertraline HCl Oral Tablet 100mg (sertraline HCl)Give 1.5 tablet by mouth in the morning for Depression [sic] give [sic] one and half [sic] tabs tp = 150mg dose Q dayStart Date10/20/2026 19:00 In an observation on 7/09/2026 at 7:53 AM, MA A was observed preparing medications for administration to Resident #16. One of the medications was in a package with a label that identified the contents as sertraline HCl 100mg tab for Resident #16. The instructions on the label were Give 1 tablet by mouth in the morning for depression. MA A dispensed 1 tablet of sertraline 100mg tablets and administered the medication to Resident #16 with other scheduled medications. In an interview with MA A on 7/09/2026 immediately following the administration, approximately 8:00 AM, MA A was asked to clarify the dosage of sertraline administered to Resident #16 in comparison to the physician's order. MA A said she noticed when she was obtaining the medication that the order said one and a half tablets, but she was nervous and did not want to pause the medication administration to clarify the order prior to giving the medication. She said she was not informed by the nurse of a change to the sertraline dosage, and if she noticed a discrepancy in the medication order and medication label, she should notify the nurse. She said the potential harm of giving residents the incorrect dosage of medication was that the medication would not be effective. In an interview with the VPCS on 7/09/2026 at 10:15 AM, she said she was serving as DON due to unforeseen emergency. She said it is the responsibility of the nurse who accepts a changed medication order to label the medication package notifying staff the order has changed and to refer to the MAR prior to administration. She said staff should be checking all orders for all medications prior to administering medications, and the potential harm to residents was medication error. Record review of the facility policy titled Administering Oral Medications dated December 2025 reflected the following: . Steps in the procedure .3. Place the MAR within easy viewing distance .6. Check the label on the medication and confirm the medication name and dose with the MAR .8. Check the medication dose. Re-check to confirm the proper dose . |

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| F 0912<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide rooms that measured at least 80 square feet per resident in multiple resident bedrooms for 2 of 39 rooms (rooms [ROOM NUMBERS]) reviewed for physical environment. The facility failed to ensure residents were not admitted into double occupancy rooms [ROOM NUMBERS] measuring less than 80 square feet per resident while having unoccupied rooms available. This failure could lead to decreased quality of life of residents. Findings included: Record review of the facility document titled ROOMS LESS THAN REQUIRED SQUARE FEET undated/provided by the facility on 7/07/2026, reflected rooms 102, 104, 106, 108, 110, 202, 204, 206, 208, 210, 301, 302, 303, 304, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 317, and 319 (26 total). Record review of the facility document titled Residents by Hall dated 7/07/2026 reflected rooms [ROOM NUMBERS] were both occupied by two residents. The other 24 rooms on the aforementioned list were occupied by only 1 resident per room. Additionally, rooms 101, 206, 207, 202, 305, 306, 307, 308, 310, 311, 312, 313, 314, 315, 317, and 319 (16 total rooms) were vacant or being temporarily repurposed for non-resident use. In an observation on 7/09/2026 at 11:21 AM, the Maint. Dir. measured the dimensions of room [ROOM NUMBER] with a tape measure as 15 feet 7.5 inches and 9 feet 3 inches, totaling 144.53 square feet, or 72.265 square feet per resident. In an observation on 7/09/2026 at 11:22 AM, the Maint. Dir. obtained the same dimensions for room [ROOM NUMBER], also equaling 72.265 square feet per resident. In an interview on 7/09/2026 at 9:00 AM, the ADM said she was aware the rooms on the list provided during entrance conference were licensed for two residents but had dimensions that equated to less than 80 square feet per resident. She said the reason rooms [ROOM NUMBERS] were occupied by two residents was the facility wanted to admit residents to the front halls of the facility first and keep the back of the facility closed until the census grew. She said the unoccupied rooms were able to be occupied, but it was convenient for the staff to keep the residents physically closer together. She said the facility had not applied for a room size waiver at the time the rooms [ROOM NUMBERS] became dually occupied. In an interview on 7/09/2026 at 12:00 PM, the VCSP said the facility did not have a policy related to room size requirements. |