STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265578	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Normandy Nursing Center	7301 St Charles Rock Rd Saint Louis, MO 63133

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify a resident's (Resident #2) representative after the resident had a change in condition. The resident had an unwitnessed fall on 04/26/26. The resident complained of pain. The physician ordered x-rays on 04/26/26. The resident refused the x-rays on 04/27/26. The x-rays were reordered on 04/29/26. The x-rays showed the resident had a fractured right hip. The resident was sent to the hospital on [DATE] for evaluation. Staff did not notify the resident's POA of the x-ray refusal, results and transfer to the hospital. The sample was four. The census was 95.Review of the facility's Notification of Change in Condition policy, revised 01/20/26, showed:-Policy: The attending physician/physician extender (nurse practitioner, physician assistant, or clinical nurse specialist) and the resident representative would be notified of a change in a resident's condition, according to standards of practice and federal and/or state regulations;-Responsibility: All licensed nursing personnel, nursing administration, and Director of Nursing (DON);-Guideline for notification of physician/resident representative (not all inclusive): -Significant change in medical or cognitive baseline; -Accident/incident; -Abnormal laboratory results in conjunction with a change in condition; -Significant weight loss/gain; -Refusal to take prescribed medications; -Missing resident;-Document in the Interdisciplinary Team (IDT) notes: -Resident change in condition; -Physician/physician extender notification; -Notification of resident representative. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 03/14/26, showed:-admission date: 01/23/26;-Severe cognitive impairment;-Diagnoses included Alzheimer's disease, dementia with psychotic disturbance, history of stroke, muscle weakness, delusional disorder, depression, difficulty walking, hallucinations, history of falling, and communication deficit. Review of the resident's face sheet showed Power of Attorney (POA) contact information including phone numbers. Review of the resident's progress notes showed on 04/27/26 at 9:58 A.M., Licensed Practical Nurse (LPN) A documented the resident was in his/her room in the bed. He/She yelled and screamed when touched. The x-ray technician was onsite to perform an x-ray. At 11:20 A.M., the resident refused x-rays this morning. The resident was noncompliant with technician and LPN A. Review of the resident's x-ray results, dated 04/29/26 at 10:58 A.M. and reported at 2:00 P.M., showed a nondisplaced impaction fracture of the right femoral neck (a stable crack in the narrow region of the right thighbone just below the hip ball). Review of the resident's progress notes, showed on 04/29/26 at 11:30 P.M., LPN E documented the resident refused all care, vital signs, meals and medication on his/her shift. The DON and Assistant Director of Nursing (ADON) were notified. X-ray results obtained and the physician and NP were notified. New order received to send the resident to the hospital for evaluation. The resident was transported to the hospital via ambulance at 11:21 P.M. Review of the resident's medical record showed no documentation the resident's POA was notified of the resident's refusal to complete the x-rays, the x-ray results and the resident's transfer to the hospital. During an interview on 06/30/26 at 11:06 A.M., LPN A said the resident's POA was onsite on 04/27/26 and he/she notified the POA of the resident's x-ray refusal. The POA said You know the resident could be resistant. He/She should have (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265578	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Normandy Nursing Center	7301 St Charles Rock Rd Saint Louis, MO 63133

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented the notification. During an interview on 06/30/26 at 3:15 P.M., the ADON said the risk management note showed the resident's POA was notified of the x-ray results and the fracture. She could not locate the risk management note when asked for the documentation. During an interview on 06/30/26 at 3:43 P.M., the Administrator said she would have expected the nurses to notify the POA of the resident's change of condition. 3002514

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265578	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Normandy Nursing Center	7301 St Charles Rock Rd Saint Louis, MO 63133

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 0689 Level of Harm - 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** Based on interview and record review, the facility failed to ensure staff provided adequate supervision and assistance to prevent accidents for one resident, (Resident #2) with a history of falls, when staff left the resident unattended on the toilet. The resident attempted to transfer him/herself from the toilet to his/her wheelchair without assistance and fell. When the nurse assessed the resident, he/she guarded his/her right hip and complained of pain. X-ray results showed the resident sustained a fractured right hip. In addition, the facility failed to address falls on the care plan. The sample was four. The census was 95.Review of the facility's Fall Management policy, dated 02/28/23, showed:-Policy: To provide an environment free of accident hazards. The facility completed a Morse Fall Scale Evaluation on residents to determine fall risks, developed appropriate interventions, provided supervision and assistive devices to prevent/minimize further falls and/or reduce injuries;-Upon Admission, the charge nurse completed a Morse Fall Scale Evaluation, baseline care plan, identified risk factors related to the resident and implemented interventions which included the resident and/or resident representative;-Residents were evaluated for fall risk at admission/re-admission, post- fall, quarterly, annually, and significant change using the Morse Fall Scale Evaluation;-Residents with a Morse Fall Scale Evaluation score greater than 44 were considered at High Risk for falling;-Identified risk factors were addressed in the resident's care plan to ensure individualized interventions were implemented;-Risk factors: Gait/balance disorder, muscle weakness, confusion, incontinence, stroke, depression, previous falls, prescribed five or more antipsychotics (used to treat symptoms like delusions, hallucinations, paranoia, and confused thoughts), tricyclic antidepressants (used the treat major depressive disorder (persistent feeling of sadness, emptiness and loss of interests in activities), anxiolytics (used to treat symptoms of anxiety (persistent, excessive, and uncontrollable fear or worry that is out of proportion to the actual situation), sedatives (used to treat anxiety and sleep disorders), and hypnotic (used to treat insomnia and sleep disruptions) medications;-Staff completed a neurological evaluation post-fall on residents with potential head injury or unwitnessed fall;-If injury was known or suspected: -Provided emergency first aid treatment as applicable; -Notified physician, and resident representative. -Notified supervisor and Director of Nursing (DON); -Notified the Administrator when appropriate; -Investigated the circumstances and surroundings where the fall occurred; -Implemented interventions to reduce further occurrences; -Documented in the resident's medical record; -Completed an incident report; -Implemented post-fall evaluation/documentation;-The care plan was reviewed after every fall and updated with a new intervention;-Interdisciplinary team (IDT) reviewed post-fall residents within 24-72 hours during clinical meeting, evaluated circumstances/probable cause for fall, revised/modified care plan, implemented interventions according to treatment approach to minimize further falls and reduce injury, and reviewed accident/incident report in risk management to ensure completion;-The risk review committee members reviewed/documented residents post-fall for accident/incident documentation/completion, physician/resident representative notification, interventions, resident compliance/response and care plan/Kardex (provided a concise summary of the resident current care needs, medical diagnosis, medication, and treatments) review. Review of Resident #2's medical record, showed:-admitted [DATE];-Diagnoses included Alzheimer's disease, dementia with psychotic disturbance, history of stroke, muscle weakness, delusional disorder, depression, difficulty walking, hallucinations, history of falling, and communication deficit. Review of the resident's Fall Risk evaluation, dated 01/23/26, showed:-Intermittent confusion;-No falls in the last three months;-Chairbound;-Balance problem while walking and required use of assistive device;-The resident had three or more predisposed diseases;-At risk for falls. Review of the resident's progress notes, showed:-On 01/23/26 at 10:08 P.M., the resident was a new admit. He/She (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265578	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Normandy Nursing Center	7301 St Charles Rock Rd Saint Louis, MO 63133

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 0689 Level of Harm - Actual harm Residents Affected - Few	yelled out loud during evening shift. He/She refused all medication and refused to get in the bed. He/She got in the bed, but hung his/her legs out of the bed. The bed was in the lowest position, call light was within reach, and the fall mat was in place;-On 01/24/26 at 6:20 A.M., the resident yelled and tried to get out of bed. Staff gave the resident a PRN (as needed) medication (medication given unknown). The resident was at the nurse's station in his/her wheelchair. At 9:01 P.M., the resident yelled out. Staff entered the resident's room. The resident was on the floor, on the right side of his/her bed. The resident's bed was in the lowest position. The fall mat was on the left side of the bed. The nurse completed a head-to-toe assessment. The resident had a hematoma (a closed wound where blood collects and fills a space inside the body) on the right side of his/her head. Two staff assisted the resident back to bed. The physician and the resident's representative were notified. The physician gave an order to apply an ice pack to the hematoma. A fall mat was placed on the right side of the bed. The resident refused pain meds. Neurological (neuro) checks started;-On 01/26/26 at 9:29 A.M., the resident remained on observation for incident. He/She was alert, ignored staff when addressed, was non-compliant with medications (meds) and care. The resident was up in his/her wheelchair;-On 01/27/26 at 12:32 P.M., the Nurse Practitioner (NP) documented the resident was seen for a fall out of bed. The resident was agitated and kicked at staff. The resident refused meds and nursing assessments. The plan was for the bed to be in the lowest position, visual checks intermittently, and to position the resident where nursing staff were present for safety concern. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 02/05/26, showed:-Cognitive ability blank;-No behaviors exhibited;-Wheelchair used for mobility;-Totally dependent on staff for toileting, showers, and personal hygiene;-Totally dependent on staff for all transfers;-Always incontinent of bowel and bladder;-No falls since admission. Review of the resident's care plan, in use during the survey, showed no documentation of the resident's fall, fall risk status, identified risk factors and fall interventions. Review of the resident's progress notes, showed:-On 04/26/26 at 11:05 P.M., Licensed Practical Nurse (LPN) D documented at approximately 7:40 P.M., the resident attempted to transfer him/herself from toilet to the wheelchair without assistance and fell on his/her right side. Upon assessment, the resident had an abrasion to his/her right elbow and right buttock. The areas were cleansed, and ointment was applied. The resident was assisted back to his/her wheelchair. The resident guarded his/her right leg and complained of pain. LPN D could not assess range of motion due to guarding and refusal. No bruising/discoloration or swelling noted. No obvious deformity noted. The physician was notified. New order obtained for x-rays of right hip, right femur, and right knee. The resident's representative and the DON were notified. The resident rested in bed and was easy to arouse. The call light was within reach;-On 04/27/26 at 9:58 A.M., LPN A documented the resident was in his/her room in the bed. He/She yelled and screamed when touched. The x-ray technician (tech) was onsite to perform x-ray. The resident said he/she was high on morphine (used to manage moderate to severe acute or chronic pain). The resident was not prescribed morphine. Some hallucinations were noted. Neuro checks were ongoing. At 11:20 A.M. the resident refused the x-rays. The resident was noncompliant with the x-ray tech and LPN A. Review of the resident's x-ray order showed it was received on 04/26/26 at 8:35 P.M. and cancelled on 04/27/26 at 3:00 A.M., due to the resident's refusal. Review of the NPs progress note dated 04/27/26, time unknown, showed the resident was seen for a fall with right thigh pain. The resident refused movement of his/her right leg. He/She said I cannot, I am high on Morphine. The resident was a poor historian. Staff reported the resident refused all medications. Staff reported the resident fell out of bed and guarded his/her right upper thigh/leg. The resident refused the x-ray. Staff reapproached and completed the x-ray with coaching and reassurance. A right femur fracture was indicated. Directive given to transfer the resident to the emergency room for evaluation. Review of the resident's care plan in use during the survey showed no documentation of the fall, updated fall status or new fall interventions. Review of the resident's progress notes, showed on 04/28/26 at 9:44 A.M., LPN A documented the resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265578	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Normandy Nursing Center	7301 St Charles Rock Rd Saint Louis, MO 63133

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 0689 Level of Harm - Actual harm Residents Affected - Few	remained on observation for incident. He/She was alert, quiet, and non-compliant with meds. The resident's family was aware. He/She remained on neuro checks. No acute distress noted. At 1:00 P.M., LPN E documented the resident refused all x-rays on the previous day. The Nurse Practioner (NP) and physician were notified. No new orders given. The resident was in his/her wheelchair at the nurse's station. He/She required extensive assistance with activities of daily living (ADLs) and transfers. No acute changes in medical needs noted. He/She continued to refuse meds. Review of the resident's x-ray results, showed:-Completed on 04/29/26 at 10:58 A.M.;-Results reported to facility on 04/29/26 at 2:00 P.M.;-Findings: Nondisplaced impaction fracture of the right femoral neck (a stable crack in the narrow region of the right thighbone just below the hip ball. It caused mild to moderate, deep ache in the groin or pain radiating toward the upper knee or thigh. Those affected could sometimes still walk or stand, though it caused significant discomfort. The leg typically did not show outward shortening or abnormal sideways rotation, because the bone had not shifted). Review of the resident's progress notes, showed on 04/29/26 at 9:58 A.M., LPN A documented the resident transferred to his/her wheelchair without difficulty. The resident's skin on his/her right hip was normal without bruising. The resident denied pain. LPN A offered pain meds and the resident refused. Neuro checks continued. At 11:30 P.M., LPN E documented the resident refused all care, vital signs, meals and medication on his/her shift. The DON and Assistant Director of Nursing (ADON) were notified. X-ray results were obtained. The physician and NP were notified. New order received to send the resident to the hospital for evaluation. The resident was transported to the hospital via ambulance at 11:21 P.M. During an interview on 06/30/26 at 11:06 A.M., LPN A said on 04/27/26 the resident yelled when an aide tried to get him/her out of bed. The resident refused to allow the x-ray tech to touch him/her. Sometimes the resident complained of pain and sometimes he/she did not. He/She refused pain meds. The resident did not have any bruising. His/Her leg was not warm to the touch. On 04/28/26, LPN A rubbed the resident's leg and asked him/her if it hurt. The resident said no. The physician wanted the x-ray. The x-ray tech returned to the facility on [DATE]. LPN A coached the resident into getting the x-rays. The resident had a fractured hip. During an interview on 06/30/26 at 1:41 P.M., Certified Nurse's Aide (CNA) B said he/she was not assigned to the resident on 04/26/26. CNA B could not remember the CNA's name assigned to the resident, but the CNA assigned to the resident told CNA B he/she put the resident on the toilet and left the room. The CNA went back to check on the resident and left the room again. CNA B and other staff heard the resident yelling. Staff entered the resident's bathroom and found him/her on the floor. The nurse said he/she wanted an x-ray, because the resident exaggerated his/her symptoms. He/She did not remember any other details. During an interview on 06/30/26 at 3:15 P.M., the Assistant Director of Nursing (ADON) said she was told by unknown staff that the resident fell when he/she attempted to transfer him/herself from the toilet to wheelchair. Staff, unknown, said he/she observed the resident on the floor. Staff, unknown, said he/she transferred the resident from the floor to the wheelchair. CNA C was assigned to the resident. The ADON was not sure what happened after staff got the resident off the floor. She would have expected the nurse to give the resident pain meds, notify the physician and request an x-ray order. Residents should never be left unattended in the bathroom. The resident did have a previous fall. The resident was resistive to care. The NP's note was a late entry. The x-ray was ordered on 04/26/26 and the resident refused it. On 04/28/26 the IDT decided to order the x-ray stat (immediate) and the x-ray was completed on 04/29/26. The NP said an x-ray was not necessary to send the resident to the hospital. The physician could have given an order to send the resident to the hospital. Staff were instructed to contact the NP first. He/She believed the physician would have sent the resident out. The resident could voice pain, but he/she always said no to everything. At baseline, the resident yelled curse words at staff. During an interview on 06/30/26 at 3:43 P.M., the Administrator said she would have preferred the aide to stay with the resident during toileting. She did not know what was going on when the aide left the resident. She has not interviewed the aide. During an interview on 06/30/26 at 11:39 A.M., the NP said he/she saw the resident on 04/27/26 for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265578	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Normandy Nursing Center	7301 St Charles Rock Rd Saint Louis, MO 63133

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 0689 Level of Harm - Actual harm Residents Affected - Few	a fall with right thigh pain. The resident would not allow the NP to move his/her leg. The resident said he/she was high on morphine, however, the resident did not take morphine. The fall occurred on 04/26/26. The initial x-ray was ordered on 04/27/26, by the physician. The resident refused the initial x-ray. He/She did not order a new x-ray on 04/27/26, because he/she thought staff said the initial x-ray was completed. He/She ordered a stat x-ray on 04/29/26. When asked why his/her note preceded the nurses' notes, he/she said he/she must have entered the wrong date. The NP said x-ray did not have to be completed to send the resident to the hospital. The resident yelled and resisted care at his/her baseline. The resident was a fall risk. The NP said the resident did not get out of bed and he/she would not have expected staff to get the resident up to toilet him/her. 3002514