STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675823	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Normandy Terrace Nursing & Rehabilitation Center	841 Rice Rd San Antonio, TX 78220

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 - Immediate jeopardy to resident health or safety 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** 47611 Based on interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 1 of 2 residents (Resident #1) reviewed for accidents and supervision, in that: Resident #1 eloped from the facility on 02/21/2024 and again on 03/04/2024. The facility failed to prevent Resident #1 from eloping on 2/21/24. Resident #1 eloped again when he was not being monitored on 3/4/24. An Immediate Jeopardy (IJ) was identified as past non-compliance on 04/18/2024. The non-compliance began on 02/21/2024 and ended on 03/05/2024. The facility had corrected the non-compliance before the survey began. This deficient practice could place residents who were elopement risks at-risk of harm, serious injury, or death. The findings were: Record review of Resident #1's face sheet, dated 04/18/2024, revealed the resident was admitted to the facility on [DATE] with diagnoses including: unspecified dementia (memory loss), alcohol dependence, epilepsy (a condition that causes frequent seizures) and depression. Further review revealed the resident was discharged from the facility on 4/11/2024 to home, and the resident's family member was the resident's Responsible Party. Record review of Resident #1's Admission MDS, dated [DATE], revealed the resident had a BIMS score of 6 which indicated a sever cognitive impairment. Further review revealed resident did not have any behavioral issues, his level of ambulation was independent. Record review of Resident #1' doctor orders, dated 2/20/2024, revealed the resident was admitted to the secured unit upon admission. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's progress notes, dated 02/21/2024, revealed the resident had eloped from the facility via his bedroom window on 2/20/2024 at 5:05 p.m Further review revealed the resident had eloped from the facility by pulling out the glass windowpane from the window frame, and he was found walking back to the facility with beer and cigarettes. Record review of Resident #1's doctor orders, dated 2/21/2024, revealed the resident was placed on 15-minute checks. Record review of Resident #1's progress notes, dated 03/04/2024, revealed Resident #1 eloped on 03/04/2024 at 5:00 p.m Further review revealed the resident had eloped by breaking a window in another resident's room and was found sitting at a bus stop that was down the street from the facility. The resident returned to the facility with staff. Record review of Resident #1' doctor orders, dated 3/5/2024, revealed the resident was placed on 1:1 while in his room. Record review of Resident #1's care plan, dated 03/06/2024, revealed the facility implemented elopement precautions with interventions: the resident was placed on 1:1 observation while in his room and visual checks every 15 minutes checks when he was not in his room. Further review of other interventions also included: redirection, distraction, offering the resident a beer, inquiring as to why the resident wants to leave, phoning the resident's wife to speak to him to discourage the resident from eloping. During an interview with LVN B on 4/17/2024 at 9:40 a.m., LVN B stated Resident #1 was, very difficult to care for. LVN B further stated the resident would threaten staff when he was redirected from attempting to elope. During an interview with the DON on 4/17/2024 at 1:10 p.m., the DON stated that when it became apparent Resident #1 was missing on 2/20/2024 and 3/4/2024 the facility enacted their elopement response policy which included calling a code, Orange, notifying staff, performing a search of the facility and surrounding areas, assessing the resident once found and making notifications. The DON stated the resident had been discharged home after it was deemed safer for the resident. During an interview with CNA C on 04/18/2024 at 11:23 a.m., CNA C stated she was assigned to work on the resident hall where Resident #1 resided. CNA C stated Resident #1 would often verbalize that if he wanted to leave the facility, no one could stop him. During an interview with ADON A, the Unit Manager for the secure unit, on 04/18/2024 at 2:05 p.m., ADON A stated after Resident #1's first elopement on 02/21/2024 one of the interventions the facility implemented was changing the resident's room to a room across the hall from his original room. ADON A stated Resident #1's room, upon admission, had a window which faced the street, however, after the elopement on 02/21/2024 the resident was moved to a room with a window facing the facility's courtyard. ADON A further stated when the resident eloped on 03/04/2024 he went to another resident's room which had a window facing the street. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Resident #1's Responsible Party on 4/18/2024 at 4:08 p.m., Resident #1's Responsible Party stated the resident was doing fine at home, and he did not try to leave the house. The resident's Responsible Party stated that when the facility notified her of the resident's second elopement, she began going to the facility daily and stayed with the resident. Resident #1's Responsible Party further stated she was trying to find another, more appropriate facility for the resident as she had medical issues which would not allow her to care for the resident. The Administrator and DON were notified on 4/18/2024 at 6:53 p.m., that a past non-compliance IJ situation had been identified due to the above failures. The facility course of action prior to surveyor entrance included: Observations made by staff on the secured unit on 4/16/2024 at 10:11 a.m., showed that the door code, locking mechanism and door alarm were functioning properly. Observations made by staff on the secured unit on 4/17/2024 at 9:38 am, showed that the door code, locking mechanism and door alarm were functioning properly. Observations made by staff on the secured unit on 4/18/2024 at 2:03 p.m., showed that the door code, locking mechanism and door alarm were functioning properly. During an interview with the DON on 04/16/2024 at 12:15 p.m., the DON stated that Resident #1 no longer resided at the facility. During an interview with the DON on 04/17/2024 at 1:45 p.m., the DON stated the two in-service trainings for staff were developed and presented to staff as a result of Resident #1's elopement incidents on 02/21/2024 and 03/04/2024. Record review of the facility's training documentation revealed an in-service titled Elopement Response given by DON on 03/06/2024, which indicated that all 101 staff at the facility had been in-serviced regarding elopements. Summary: Staff must intervene when a resident attempts to elope, must notify Administrator, DON and ADONs and search must be conducted until the resident is found. Record review of document titled, Missing Resident/Elopement Monitoring, was completed 2/28/2024 through 3/31/2024 and included checking that the locking mechanism or alarm function properly, changing the secured unit door code, performing spot checks on Resident #1. Record review of an in-service training, dated 3/5/2024, related to Elopement Response revealed 101 of 101 staff member signatures. Interviews with 12 employees who consisted of RNs, LVNs, CNAs, Housekeeping, Activities and Dietary from 4/17/2024 at 10:30 a.m. to 4/18/2024 at 1:30 p.m. revealed they had received in-services on Elopement Response. All were able to state the key elements of the elopement policy, which include: If a resident is discovered missing: - Immediate search of the resident in resident rooms, bathrooms, showers, closets, recreation areas, outside area (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Notify charge nurse/DON - Call Code Orange - Specifically, to the secure unit, since they know what the residents on the unit look like, describe what the resident looks like to staff outside the unit - After 30 minutes, if the resident had not been located, call the police, RP If a resident is observed trying to leave: - Attempt to stop the resident. Speak in a calm voice to the resident. - Get help if needed. - Tell another staff member to inform the charge nurse/DON.