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	08/13/2024

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 38511 Based on interview and record review, the facility failed to ensure the residents had the right to be free from abuse, neglect and misappropriation of property for 2 of 6 residents (Residents #2 and #3) reviewed for abuse, in that: 1. The facility failed to protect Resident #2 from physical abuse when Resident #1 grabbed, scratched and hit Resident #2 during a smoke break on [DATE]. The facility failed to respond to develop a plan of care, behavior monitoring, interventions or train staff on behaviors to prevent further abuse. 2. The facility failed to protect Resident #3 from physical and psychological abuse when Resident #1 repeatedly hit Resident #3 in the face and head and scratched him on [DATE] which resulted in swelling, redness, bruising to Resident #3's left eye, scratches to his face, neck, chest and arms and trauma. On [DATE] Resident #1 was arrested and charged with a class three felony for abuse of an elderly and currently resided in a local jail waiting indictment. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 8:17 p.m. While the IJ was removed on [DATE] at 6:57 p.m., the facility remained out of compliance at a scope of pattern and a severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the facility's need to monitor the implementation of the plan of removal. These deficient practices could affect all residents and place them at risk for abuse, trauma, psychosocial harm, injuries, hospitalization and/or death. The findings included: (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: 675823	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Record review of form 3613-A Provider Investigative Report dated [DATE] revealed the facility self-report of a resident-to-resident altercation and listed it as incident category other. The report indicated on [DATE] at 4:00 p.m., Resident #1 was found rummaging through another resident's purse during smoke break. Resident #2 intervened to remove the purse from Resident #1. Resident #1 slowly inched his way to Resident #2 striking him several times which resulted in scratches to neck, chest, bilateral arms (both arms) and ripping a small hole in Resident #2's shirt. A former Administrator (Administrator AA) marked the investigation as inconclusive. The facility documented their response as self-report protocols, in-service and re-education of staff initiated for abuse/neglect policy and an AD HOC QAPI meeting held. Record review of Resident #1's face sheet, dated [DATE], revealed a [AGE] year-old male admitted on [DATE] with diagnoses which included: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, schizophrenia and depression. Record review of Resident #1's hospital records for admission to the facility, dated [DATE], revealed Diagnosis, Assessment and Plan revealed [AGE] year-old male NF resident with history significant for schizophrenia, cirrhosis of the liver, behavior disorder and dementia brought to the ED for further evaluation of altered mental status. The physician documented he reviewed the electronic medical records from the previous NF that showed Resident #1 had a history of dementia, major depressive disorder, schizoaffective disorder, anxiety disorder, behavioral disturbance and epilepsy. On page 39 of hospital document titled discharge planning: revealed hospital case manager documented Resident #1's previous NF declined to accept Resident #1 back to their facility because they were concerned about the safety of the other residents. Record review of Resident #1's Admission MDS, dated [DATE], revealed a BIMS score of 12 which indicated a moderate cognitive impairment without behaviors or evidence of acute change in mental condition. Resident #1's functional status was listed as dependent on staff for ADL care, use of a wheelchair without assessment of transferring or walking functionality. Record review of Resident #1's Nurse Progress Note, dated [DATE] documented by RN C, revealed Resident #1 was seated in his wheelchair in the TV room .noted to have his right hand in a brown backpack on the sofa area. Seen with a soda and 1 dinner item. Verified the bag belonged to a staff (unspecified). Resident #1 advised not to take belongings of other. He stated he understood. Record review of Resident #1's Nurse Progress Noted, dated [DATE], revealed Resident #1 observed entering other resident's room and eating his jalapeno pork skins. Redirected to TV room and reminded not to enter other rooms. Resident pleasant and denies altered mental status. Record review of Resident #1's Physician's Progress Note, dated [DATE], revealed Nurses report some behaviors including going into other resident rooms and taking their things, requesting a visit for psychiatric services. Record review of Resident #1's Care Plan, last revised on [DATE], revealed Resident #1 required anti-psychotic and anti-depressant medications with interventions which included: monitor/record occurrence of target behavior systems (specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc.) and document per facility protocol. The care plan did not address any resident behaviors or behavior management. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's Nurse Progress Notes, dated [DATE], revealed Resident #1 entered other resident rooms and eats their snacks. Record review of Resident post-incident assessment, dated [DATE], revealed the AD came to nurses' station to inform nurse of an altercation between Resident #2 and another resident that occurred during smoke break. Resident #2 assessed and had noticeable random scratches to neck, chest, bilateral arms and had a torn shirt at the neckline. Resident had no complaints of pain. The assessment noted Resident #2 statement of the event He picked up her purse and hid it and I got it back and gave it back to resident's owner (sic) and the (sic) just started hitting and scratching me! Record Review of Resident #1's Nurse Progress Notes, dated [DATE], revealed LVN B documented that staff (unnamed) reported to nurse that Resident #1 had a physical altercation with another resident while in the smoking area. When asked what happened, Resident #1 stated He started it. Staff reported that Resident #1 had picked up a purse and was getting into it when another resident [Resident #2] took it from him. Resident #1 then stood up and began to hit and scratch the other resident causing scratches and a small bruise under the right eye, redness to the scratched areas and a torn shirt. The residents were separated, and Resident #1 was brought inside. He had no visible injuries. Record review of Resident #1's [DATE] MAR/TARs revealed no evidence of behavior monitoring. Record review of Resident #1's Psychological Initial Assessment, dated [DATE] (after incident with Resident #2 but before the incident with Resident #3), revealed diagnoses treating was antisocial personality disorder. Reason for referral: agitation, irritability, anger, paranoia, physical aggression. RN reports Resident #1 had been stealing from other patients at times and also becomes aggressive. Risk of aggression: None. Insight: Fair. Judgement: Fair. Short term memory: mildly impaired. Long-Term memory: intact. This document was signed by the psychological services physician. Record review of Resident #1 Psychological Services Progress Note, dated [DATE] (after incident with Resident #2 but before incident with Resident #3), revealed aggressive behavior was listed as none. Patient was polite. Patient reports having nothing to talk about and having no problems, struggles or worries. Patient displays depressive symptoms. This document was signed by psychological services LPC. Record review of Resident #2's face sheet, dated [DATE], revealed a [AGE] year-old male admitted on [DATE] with diagnoses which included: sequelae of cerebral infarction, hemiplegia (stroke with resulting paralysis on one side of the body) affecting right dominant side and schizoaffective disorder bipolar type and mild neurocognitive disorder due to known physiological condition with behavioral disturbance. Record review of Resident #2's Care Plan, last revised on [DATE], revealed the resident had wandering behaviors. No other behaviors were part of the plan of care. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #2's Nurse Progress Notes, dated [DATE], revealed Resident #2 was involved in an altercation during smoke break with Resident #1. Resident #2 was not faulted for the incident. Resident #1 was found rummaging through another resident's purse (unnamed). Resident #2 intervened to remove the purse from Resident #1. Resident #1 slowly inched his way to Resident #2, striking him several times, scratching him and ripping a small hole in his shirt. AA D (Activity Assistance D) and Laundry Attendant E peacefully diffused the incident, separating bath parties, Charge nurses notified, DON notified of incident. Documented by AA D. Record review of Resident #2's Psychiatric Clinical Treatment Plan, dated [DATE], revealed he was assessed for current mood and anxiety symptoms to ascertain current emotional functioning and process thoughts and feelings relative to recent physical altercation with another resident. The assessment listed his anxiety was moderate and rated as increased, his emotional withdrawal was listed as moderate and rated as increased, hostility was labeled as moderate and rated as increased and tension was labeled as moderate and rated as increased. The assessment noted he was moderately cognitively impaired. Record review of Resident #2's Quarterly MDS, dated [DATE], revealed a BIMS score of 6 which indicated a severe cognitive impairment, with continuously present behaviors which included inattention, disorganized thinking and altered level of consciousness but no physical, verbal or other behaviors exhibited. Resident #2's functional status was recorded as independent with walking and transferring. During an interview on [DATE] at 11:01 a.m., AA D stated he was responsible for supervising smoke break ([DATE]) when the incident between Resident #1 and Resident #2 occurred. He stated he believed it was the 4:00 p.m. smoke break but could not be certain. He stated another staff in housekeeping (identified as LA E) was also there taking her own personal break. AA D stated it started when one of the female residents left the smoking area because she said it was too hot and she wanted to go back inside where it was cooler, but she left her purse behind on the floor. AA D stated he saw Resident #1 bend over and go through something on the floor. He stated before he could get to Resident #1, he saw Resident #2 grab a purse from Resident #1. Resident #2 then handed the purse to him (AA D). AA D stated, after Resident #2 handed him the purse, both residents sat back down and resumed the smoke break. He stated a little bit later, Resident #1 was quiet and calm but started inching closer and then suddenly took some swipes at Resident #2 but made no contact. AA D stated Resident #1 then grabbed Resident #2 by his shoulder, scratching him in the process. AA D stated both staff immediately pulled the two residents apart and both calmed down quickly. AA D stated Resident #1 stopped his aggressive behavior. AA D stated there had been no other altercations between the two residents who both attended every smoke break. He stated they had never exhibited any aggressive behaviors before. AA D stated he had been told by the nurse (unknown) on Resident #1's unit that Resident #1 had a history of stealing but was not told of any aggressive behaviors. He stated he had been in-serviced on abuse/neglect, reporting and treating residents with respect. He stated he was working on an on-going computerized training program for dementia residents called [NAME] which he believed stood for personal assistance care training. He stated he had not received any facility in-service or training on dealing with physical aggression or behavioral interventions. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 11:25 a.m., Resident #2 stated he remembered the incident with the purse ([DATE]). He stated he grabbed the purse from that other resident (Resident #1) because it did not belong to him. Resident #2 pointed to his right shoulder and chest indicating where he had been scratched by Resident #1. He stated he feels fine, no pain. Resident #2 stated he thought Resident #1 left because he had not seen him and there were no further incidents with the resident. He stated he felt safe at the facility. During an interview on [DATE] at 11:29 a.m., LVN B stated Resident #1 was very hard to understand. She stated Resident #1 could be aggressive, but she had never had any problems with him. She stated when he would get upset, she would talk to him to calm him down. LVN B stated Resident #1 did have a bad habit of going into other residents' rooms and stealing and he smoked a lot. LVN B stated she was informed he had an altercation with another resident in the smoking area. She stated she could not remember when this occurred or whom the other resident was. She stated she didn't remember a lot about the resident but does remember he could be talked down. LVN B stated for interventions she just kept an eye on him and tried to keep him separated to keep other residents safe. LVN B stated Resident #1 was not like that all the time, just certain things would make him agitated. She stated Resident #1 did not go up to people with no reason. LVN B stated she does not recall if anyone in management gave her any interventions or instructions. LVN B stated she was not sure anything was in his care plan about it. After looking at his care plan, LVN B stated there was nothing in Resident #1's care plan about his klepto or behaviors. LVN B stated she doesn't really use care plans for resident care . She stated she gets to know the residents and their personality and that was how she knows how to care for them. LVN B stated she was trained to separate residents who had conflict and then assess them, speak to both parties and then let the DON and Administrator know and also report to the RP. Record review of Resident #15's face sheet, dated [DATE], revealed an admitted [DATE] and a readmitted [DATE] with diagnoses which included: Alzheimer's disease, recurrent depressive disorders and unsteadiness on feet. Record review of Resident #15's Annual MDS, dated [DATE], revealed a BIMS score of 12 which indicated a moderate cognitive impairment. During an interview on [DATE] at 10:48 a.m., Resident #15 stated Resident #1 had sticky fingers (slang term to indicate someone who steals). Resident #15 stated Resident #1 would go into other residents' rooms and had stolen many things. He stated Resident #1 stole some $1 bills from his wallet in his room . He stated he told staff (unknown) and was told to keep his wallet put away and not in the open. He stated it was a resolved issue, but he was glad Resident #1 was gone. Resident #15 stated Resident #1 did not belong at the facility. He stated he had not witnessed any aggression or abuse. He stated he felt safe at the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 11:00 a.m., CNA G stated she had not witnessed him be mean to residents. She stated she never worked directly with Resident #1. but he was mean (to staff). She stated when she went to check on him, he would tell her to get out and did not want help. She stated she had not received any training on resident behaviors. She stated she did not get any training following either incident with Resident #1. She stated if a resident had a behavior or acted aggressive, she would just go get the nurse to intervene. CNA G stated if she witnessed resident's arguing she would get in between them and try to get the aggressor away and let the nurse know. She stated if she saw a physical incident, she would go get help. She stated she was taught to tell the charge nurse and then let the administrator know if she saw abuse. Record review of Resident #4's face sheet, dated [DATE], revealed an admitted [DATE] and readmitted [DATE] with diagnoses which included: end stage renal disease with dependence on renal dialysis, major depressive disorder single episode moderate and generalized anxiety disorder. Record review of Resident #4's Quarterly MDS, dated [DATE], revealed a BIMS score of 00 which indicated a score could not be obtained. During an interview on [DATE] at 11:08 p.m., MA P stated Resident #1 demeanor was quiet. She stated he mumbled a lot. She stated she was in the building following Resident #1's altercation in the smoking area. She stated after the altercation he kept saying I am going to fuck you up. She stated the staff talked to him to get him to calm down and she told him it was considered assault what he did. She stated prior to this event she had never seen him with anger issues. MA P stated Resident #1 was a klepto (used as a slang word in this context, which is a shortened version of the word kleptomania, not the actual diagnosis of a mental health disorder. Kleptomania is a mental health disorder where a person feels an uncontrollable urge to steal things.). She stated he particularly targeted Resident #4's room for stealing. MA P stated Resident #4 went to dialysis three days a week and was gone from the facility a lot. She stated Resident #1 would go into Resident #4's room and steal his stuff. She stated after the second or third time the staff told the DON, and nothing was done. MA P stated the DON said she would speak to him (Resident #1) and the DON told the staff to watch him but nothing changed. MA P stated the CNA's had to handle it themselves. She stated they tried to keep an eye on Resident #1, and she kept Resident #4's door shut. She stated they would also give Resident #4's iPad to the nurses to lock up in their cart when Resident #4 was away. MA P stated she had received behavior training in [DATE]. She stated it was a computer-based training. She stated the training discussed how to interact with residents and how to report behaviors. She stated she was told to intervene and redirect and how to identify aggression when it first started. She stated she was also trained on abuse and was told to report abuse to the charge nurse, then the ADON and DON. Record review of Resident #53's face sheet, dated [DATE], revealed an admitted [DATE] and readmitted [DATE] with diagnosis which included: quadriplegia (paralysis of all 4 extremities), major depressive disorder and nicotine dependence. Record review of Resident #53's Annual MDS, dated [DATE], revealed a BIMS score of 15 which indicated the resident was cognitively intact. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 11:31 a.m., Resident #53 stated he had witnessed the incident involving Resident #1 and Resident #2 ([DATE]). He stated they were all out smoking as usual when a female resident started moving herself in her wheelchair towards the door to go back inside and dropped her purse on the ground. He stated the female resident did not appear to be know she had dropped her purse. Resident #53 stated he saw Resident #1 go towards the purse and start going through it. He stated he then saw Resident #2 get up and grab the purse, hand it to AA D and then sit back down. Resident #53 stated Resident #1 did not do anything at first, he was quiet. He stated a few minutes later he saw Resident #1 scoot his wheelchair towards Resident #2 and then grab his shirt and started hitting him. Resident #53 stated AA D pulled Resident #1 off Resident #2. He stated they (staff) took Resident #1 back inside. Resident #53 stated he felt safe and would tell staff if anyone threatened or hurt him. During an interview on [DATE] at 12:49 p.m., the DON and Regional Compliance Nurse stated the interim Administrator was not in the building. They stated the Administrator was the Abuse Coordinator and staff were trained to report abuse to the Administrator. During an interview on [DATE] at 1:45 p.m., LA E stated she was present during the altercation between Resident #1 and Resident #2 smoke break. She stated she thought it was the 1:30 p.m. smoke break but could not be certain. She stated she was there on her own personal smoke break. She stated she and AA D were talking when she saw a female resident go inside, wheeling herself in her wheelchair, but dropped her purse along the way. She stated AA D had gone to let the female resident inside, when she saw Resident #1 move toward the purse. She stated Resident #2 grabbed the purse from Resident #1 and handed it back to AA D. LA E stated Resident #1 was quiet for about 5 minutes and then started pushing himself in his wheelchair towards Resident #2. She stated as Resident #1 got closer to Resident #2, she saw Resident #1 saying something, like a whisper. She stated she could not hear what he was saying, but Resident #2 leaned forward to hear him. LA E stated Resident #1 stood up and grabbed Resident #2's shirt and started to hit him. She stated she did not know Resident #1 could stand before this occurred. She stated AA D moved Resident #1 away and she moved Resident #2 away and calmed him down by telling him it was going to be okay. LA E stated Resident #1 was moved inside and everyone calmed down. She stated she had not witnessed any other aggressive incidents between residents during smoke breaks and had not witnessed any other incidents involving Resident #1. LA E stated when she was first hired, she received training in abuse/neglect. She described abuse/neglect as a worker hitting a resident or not attending to their needs or even when two residents fought. She stated she was taught to report abuse/neglect immediately to the Administrator. She stated she had not received any training on how to deal with resident behaviors or fights. She stated she just followed her instinct to pull them apart when it happened. LA E stated she was frightened by Resident #1, but then was surprised when she saw both Resident #1 and Resident #2 together the next day at smoke break. She stated they acted like nothing had happened. (continued on next page)

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Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #3's Care Plan, last revised on [DATE], revealed had a history of depression and impaired cognitive function related to dementia with impaired thought process with interventions which included monitor for changes in mood, discuss concerns for confusion and use task segmentation to support short term memory deficits. There were no behaviors documented in the plan of care. Record review of Resident #3's TAR for [DATE] revealed behavior monitoring with no behaviors documented on [DATE] (date of incident) or multiple days before and after the incident. Record review of Resident #3's Event Nurse's Note, dated [DATE], revealed Resident #1 was standing over the resident and was throwing punches at the other [Resident #3] face. An assessment was completed with notes of bruising under the right eye, swelling to the right cheek and scratch on the side of the right elbow. Tylenol was administered to Resident #3 for pain. Resident #3's physician was notified, and neuro checks were completed for 72 hours. Record review of Resident #3's Nurse Progress Notes, dated [DATE] documented by ADON A, revealed she was notified of a verbal altercation between Resident #1 and Resident #3 by a CNA. She instructed the CNA to move this resident (unspecified) out of the room and the CAN agreed and said OKAY. While sitting at the nurses' station after coming back from the dining room, she heard a scream for help and all staff ran to the room. She noted Resident #1 standing over Resident #3 throwing punches at his face. The CNA tried to stop the resident and he continued to punch .ADON A grabbed the resident (Resident #1) by the shirt and pulled the resident off the other resident causing them to fall over the wheelchair. After removing Resident #1 from the room, she notified Resident #3's physician and made her aware of the bruising under the right eye, swelling aside (sic) of the right eye, and scratch to the side of the right eyebrow. The physician did a video call with DON and resident (Resident #3), new order neuro's x 72 hours. Record review of Resident #3's Nurse Progress Notes, dated [DATE], revealed Resident #3 was alert and oriented to person, place but not day or time of day. Bruising noted around right orbital fossa (right eye). When asked what happened (sic) That guy that takes me stuff beat me up. I was telling him to stay out of my stuff (sic) he started hitting me. I tried to fight but I (sic) couldn't. The nurses took him away (sic) I am okay now. (sic) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675823	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER: Normandy Terrace Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 841 Rice Rd San Antonio, TX 78220	

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a local police report, dated [DATE], revealed Resident #1 was arrested and charged with Class 3 Felony Texas Penal Code 22.04 (A) (Injury to a child, elderly individual, or disabled individual). The report indicated the police responded to the NF for an assault in progress call. Upon arrival ADON A advised that Resident #1 and Resident #2 shared a room. ADON A advised Resident #3 was bedridden and could not get up on his own and Resident #1 used a wheelchair but could walk from time to time. She reported to police that Resident #1 and Resident #2 got into a verbal argument and Resident #1 had been removed from the room. She stated Resident #1 later returned to the room and she heard a disturbance. She stated when she went into the room, she observed Resident #1 standing over Resident #3's bed, punching Resident #3 multiple times. ADON A advised that her and other nurses had to physically pull Resident #1 away from Resident #3. The police report indicated police contacted Resident #3 who stated he was lying in bed when Resident #1 came into the room. Resident #3 stated they were arguing over whose diaper was changed first. Resident #3 stated Resident #1 went over to his bed and began punching him multiple times. The police officer documented he observed that Resident #3 had a black eye and that his eye was slightly swollen. EMS responded to the scene. The report indicated Resident #1 told police Resident #3 was talking shit about his family member who was deceased . Resident #1 admitted to assaulting Resident #3. The report indicated due to the victim (Resident #3) being [AGE] years of age, the suspect (Resident #1) was placed under arrest, transported to the city detention center and booked. During an interview on [DATE] at 10:47 a.m., Resident #1's legal guardian stated Resident #1 had been arrested at the NF was still in the local jail, charged with a third-degree felony with intent to cause bodily injury. The guardian stated when he had visited with Resident #1 in the past he always presented as very passive. The guardian stated that historically he was very aggressive. He stated he was unsure if the current NF was aware of Resident #1's history of aggression. He stated Resident #1 was discharged from the previous NF for aggression. He stated the previous NF took it upon themselves to discharge Resident #1 from their facility. He stated Resident #1 ended up at a local hospital and the hospital placed Resident #1 at the current NF. The legal guardian stated the incident that ended with Resident #1 in jail was not his first incident at the current NF. He stated he was notified of the incidents but was not given specific details. During an interview on [DATE] at 12:01 p.m., Resident #3's RP described Resident #3 as happy-go-lucky. She stated he liked to talk to people and touch them. She stated when people would pass by, he would hold his hand out to be touched. She stated Resident #3 did have a touch of dementia and had recently had a decline which worried her. She stated he never had any anger management problems. The RP stated staff from the facility had called her and told her Resident #3 had an altercation with a roommate. She stated she was told the roommate attached him while he was laying down and he suffered a black eye. She stated she did not see the eye or the bruises because she had not been able to visit during that time. She stated she did talk to him on the phone about the incident. The RP stated Resident #3 made a joke about it, in a macho sort of way. She stated he did not say anything else to her about the incident. She stated she worried about him. During an interview on [DATE] at 10:05 p.m., Resident #3 stated he remembered the incide [TRUNCATED]

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

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 38511 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 3 of 4 residents (Residents #1, #2, and #3) reviewed for care plans, in that: 1. Facility failed to develop a person-centered care plan with interventions that addressed Resident #1's diagnoses of mental illness including depression, schizophrenia, dementia or antisocial personality disorder, and behaviors which included stealing, agitation, and aggression. 2. The facility failed to develop a person-centered care plan with interventions that addressed Resident #2's behaviors, specifically associated around smoke breaks, refusal of medications and mental illness or his altercation with Resident #1 associated with a smoke break and interventions to keep him safe from future events. 3. The facility failed to develop a person-centered care plan that addressed Resident #3's behaviors of screaming and crying out and cussing and his diagnosed mental illness, or his altercation with Resident #1 and follow up care for emotional evaluation/PTSD. An IJ was identified on 8/09/2024. The IJ template was provided to the facility on [DATE] at 8:17 p.m. While the IJ was removed on 8/11/2024 at 6:57 p.m., the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the facility's need to monitor the implementation of the plan of removal. These deficient practices could affect residents and place them at risk for not having their needs and preferences met. The findings included: 1. Record review of Resident #1's face sheet, dated 8/08/2024, revealed a [AGE] year-old male admitted on [DATE] with diagnoses which included: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, schizophrenia (mental health disorder) and depression. Record review of Resident #1's hospital records for admission to the facility, dated 6/14/2024, revealed Diagnosis, Assessment and Plan revealed [AGE] year-old male NF resident with history significant for schizophrenia, cirrhosis of the liver, behavior disorder and dementia brought to the ED for further evaluation of altered mental status. The physician documented he reviewed the electronic medical records from the previous NF that showed Resident #1 had a history of dementia, major depressive disorder, schizoaffective disorder, anxiety disorder, behavioral disturbance and epilepsy. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's admission MDS, dated [DATE], revealed a BIMS score of 12 which indicated a moderate cognitive impairment without behaviors or evidence of acute change in mental condition. The MDS assessment revealed related care area (CAA) triggers included cognitive loss/dementia, behaviors were not triggered on the assessment. Record review of Resident #1's Nurse Progress Note, dated 6/18/2024, revealed Resident #1 observed entering other resident's room and eating his jalapeno pork skins. Redirected to TV room and reminded not to enter other rooms. Resident pleasant and denies altered mental status. Record review of Resident #1's Nurse Progress Note, dated 6/20/2024, documented by RN C revealed Resident #1 was seated in his wheelchair in the TV room .noted to have his right hand in a brown backpack on the sofa area. Seen with a soda and 1 dinner item. Verified the bag belonged to a staff (unspecified). Resident #1 advised not to take belongings of other. He stated he understood. Record review of Resident #1's Physician's Progress Note, dated 6/25/2024, revealed Nurses report some behaviors including going into other resident rooms and taking their things, requesting a visit for psychiatric services. Record review of Resident #1's Care Plan, last revised on 6/25/2024, revealed Resident #1 required anti-psychotic and anti-depressant medications with interventions which included: monitor/record occurrence of target behavior systems (specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc.) and document per facility protocol. The care plan did not address any resident behaviors or behavior management. Record review of Resident #1's Nurse Progress Notes, dated 7/01/2024, revealed Resident #1 entered other resident rooms and eats their snacks. Record review of Resident post-incident assessment, dated 7/04/2024, revealed the AD came to nurses' station to inform nurse of an altercation between Resident #2 and another resident that occurred during smoke break. Resident #2 assessed and had noticeable random scratches to neck, chest, bilateral arms and had a torn shirt at the neckline. Resident had no complaints of pain. The assessment noted Resident #2 statement of the event He picked up her purse and hid it and I got it back and gave it back to resident's owner (sic) and the (sic) just started hitting and scratching me! Record Review of Resident #1's Nurse Progress Notes, dated 7/04/2024, revealed LVN B documented that staff (unnamed) reported to nurse that Resident #1 had a physical altercation with another resident while in the smoking area. Staff reported that Resident #1 had picked up a purse and was getting into it when another resident [Resident #2] took it from him. Resident #1 then stood up and began to hit and scratch the other resident causing scratches and a small bruise under the right eye, redness to the scratched areas and a torn shirt. Record review of Resident #1's Psychological Initial Assessment, dated 7/10/2024 (after incident with Resident #2 but before the incident with Resident #3), revealed diagnoses treating was antisocial personality disorder. Reason for referral: agitation, irritability, anger, paranoia, physical aggression. RN reports Resident #1 had been stealing from other patients at times and also becomes aggressive. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1 Psychological Services Progress Note, dated 7/17/2024 (after incident with Resident #2 but before incident with Resident #3), revealed patient displays depressive symptoms. Record review of Resident #1's Nurse Progress Notes dated 7/23/2024 at 5:45 p.m., ADON A documented while sitting in the dining room a CNA notified her that Resident #1 and another resident [Resident #3] had a verbal altercation. She told the CNA to move Resident #1 out of the room and the CNA agreed and stated okay. ADON A indicated she came back from the dining room and was at the nurses' station at 6:15 p.m., while the CNA was moving belongings into another room, she heard a scream for help and all staff ran to the room. ADON A documented Resident #1 was standing over [Resident #3] and throwing punches at the other resident's face. The CNA tried to stop Resident #1 as he continued to punch the other resident in the face. ADON A documented she grabbed Resident #1 by his shirt and pulled him off the other resident causing ADON A and Resident #1 to fall over the wheelchair. Resident #1 was breathing hard and was visibly made at [Resident #3]. ADON A and the CNA assisted Resident #1 off the floor and back to his wheelchair and removed him from the room. He tried to go back into the room and continue to fight [Resident #3]. ADON A documented she told Resident #1 that she would call the police if he did not stop and he replied I don't care . ADON notified the DON who stated to call 911. ADON then notified Resident #1's physician who also stated to call 911. ADON A documented she called 911 and EMS to evaluation the other resident [Resident #3]. A report was made and (police) officers handcuffed Resident #1 while in the wheelchair and escorted him out of the building. Record review of a local police report dated 7/23/2024 revealed Resident #1 was arrested and charged with Class 3 Felony Texas Penal Code 22.04 (A) (Injury to a child, elderly individual, or disabled individual). Resident #1 admitted to assaulting Resident #3. The report indicated due to the victim (Resident #3) being [AGE] years of age, the suspect (Resident #1) was placed under arrest, transported to the city detention center and booked. During an interview on 8/07/2024 at 11:01 a.m., AA D stated he was responsible for supervising smoke break (7/04/2024) when the incident between Resident #1 and Resident #2 occurred. AA D stated it started when one of the female residents left the smoking area because she said it was too hot and she wanted to go back inside where it was cooler, but she left her purse behind on the floor. AA D stated he saw Resident #1 bend over and go through something on the floor. He stated before he could get to Resident #1, he saw Resident #2 grab a purse from Resident #1. Resident #2 then handed the purse to him (AA D). AA D stated, after Resident #2 handed him the purse, both residents sat back down and resumed the smoke break. He stated a little bit later, Resident #1 was quiet and calm but started inching closer and then suddenly took some swipes at Resident #2 but made no contact. AA D stated Resident #1 then grabbed Resident #2 by his shoulder, scratching him in the process. AA D stated both staff immediately pulled the two residents apart and both calmed down quickly. AA D stated Resident #1 stopped his aggressive behavior. AA D stated there had been no other altercations between the two residents who both attended every smoke break. He stated they had never exhibited any aggressive behaviors before. AA D stated he had been told by the nurse (unknown) on Resident #1's unit that Resident #1 had a history of stealing but was not told of any aggressive behaviors. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 8/09/2024 at 11:08 p.m., MA P stated she was in the building following Resident #1's altercation in the smoking area (with Resident #2). She stated after the altercation he kept saying I am going to fuck you up. She stated the staff talked to him to get him to calm down and she told him it was considered assault what he did. MA P stated Resident #1 was a klepto (used as a slang word in this context, which is a shortened version of the word kleptomania, not the actual diagnosis of a mental health disorder. Kleptomania is a mental health disorder where a person feels an uncontrollable urge to steal things.). She stated after the second or third time the staff told the DON, and nothing was done. MA P stated the DON said she would speak to him (Resident #1) and the DON told the staff to watch him but nothing changed. MA P stated the CNA's had to handle it themselves. She stated they tried to keep an eye on Resident #1, and she kept Resident #4's door shut. During an interview on 8/09/2024 at 11:29 a.m., LVN B stated Resident #1 could be aggressive, but she had never had any problems with him. LVN B stated Resident #1 did have a bad habit of going into other residents' rooms and stealing and he smoked a lot. LVN B stated she was informed he had an altercation with another resident in the smoking area. She stated she could not remember when this occurred or whom the other resident was. LVN B stated for interventions she just kept an eye on him and tried to keep him separated to keep other residents safe. LVN B stated she was not sure anything was in his care plan about it. After looking at his care plan, LVN B stated there was nothing in Resident #1's care plan about his klepto or behaviors/mental illness. LVN B stated she doesn't really sue care plans for resident care. She stated she gets to know the residents and their personality and that was how she knows how to care for them. LVN B stated charge nurses do not alter care plans and she was not sure who was responsible. During an interview on 8/09/2024 at 1:45 p.m., LA E stated she was present during the altercation between Resident #1 and Resident #2 smoke break. She stated she thought it was the 1:30 p.m. smoke break but could not be certain. She stated she was there on her own personal smoke break. She stated she and AA D were talking when she saw a female resident go inside, wheeling herself in her wheelchair, but dropped her purse along the way. She stated AA D had gone to let the female resident inside, when she saw Resident #1 move toward the purse. She stated Resident #2 grabbed the purse from Resident #1 and handed it back to AA D. LA E stated Resident #1 was quiet for about 5 minutes and then started pushing himself in his wheelchair towards Resident #2. She stated as Resident #1 got closer to Resident #2, she saw Resident #1 saying something, like a whisper. She stated she could not hear what he was saying, but Resident #2 leaned forward to hear him. LA E stated Resident #1 stood up and grabbed Resident #2's shirt and started to hit him. During an interview on 8/07/2024 at 10:47 a.m., Resident #1's legal guardian stated Resident #1 had been arrested at the NF was still in the local jail, charged with a third-degree felony with intent to cause bodily injury. The legal guardian stated the incident that ended with Resident #1 in jail was not his first incident at the current NF. He stated he was notified of the incidents but was not given specific details. 2. Record review of Resident #2's face sheet dated 8/10/2024 revealed a [AGE] year-old male admitted on [DATE] with diagnosis which included: schizoaffective disorder bipolar type (mental illness with features of both schizophrenia and bipolar mood disorder with symptoms that include mania and heightened emotion). Major depressive disorder recurrent, generalized anxiety disorder, paranoid schizophrenia, paraphilia (preference for or obsession with unusual sexual practices) and mild neurocognitive disorder due to known physiological condition with behavioral disturbance (behavioral and psychological symptoms of dementia. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #2's Care Plan last revised on 4/29/2024 revealed the resident had wandering behaviors and exit seeking behaviors and resided in the locked unit. The care plan also addressed the use of antidepressant and anti-anxiety medication. The care plan did not address dementia or cognitive deficits related to understanding/communication, it did not address his mental health diagnoses and how to relate/approach/interventions for depression and anxiety and it did not address mental illness of schizoaffective disorder with bipolar symptoms and it did not address paraphilia or any behavior monitoring. The care plan also did not address Resident #2's altercation with another resident (Resident #1) with interventions to prevent recurrence. Record review of Resident #2's progress note, dated 6/20/2024, revealed Resident #2 actively involved in smoke break. He receives 5 smoke breaks daily. Behaviors (unspecified) present before the start of smoke break, nurse is aware. Record review of Resident #2's progress note, dated 6/21/2024, revealed he was refusing medications. Record review of Resident #2's progress note, dated 6/23/2024, revealed Resident refused all his medications this shift. Record review form 3613-A Provider Investigative Report, dated 7/04/2024, revealed the facility self-report a resident-to-resident altercation and listed it as incident category other. The report indicated on 7/04/2024 at 4:00 p.m., Resident #1 was found rummaging through another resident's purse during smoke break. Resident #2 intervened to remove the purse from Resident #1. Resident #1 slowly inched his way to Resident #2 striking him several times which resulted in scratches to neck, chest, bilateral arms (both arms) and ripping a small hole in Resident #2's shirt. A former Administrator (Administrator AA) marked the investigation as inconclusive. The facility documented their response as self-report protocols, in-service and re-education of staff initiated for abuse/neglect policy and an AD HOC QAPI meeting held. Record review of Resident #2's Nurse Progress Notes, dated 7/04/2024, revealed Resident #2 was involved in an altercation during smoke break with Resident #1. Resident #2 was not faulted for the incident. Resident #1 was found rummaging through another resident's purse (unnamed). Resident #2 intervened to remove the purse from Resident #1. Resident #1 slowly inched his way to Resident #2, striking him several times, scratching him and ripping a small hole in his shirt. AD (Activity Assistance D) and laundry attendant (LA-E) peacefully diffused the incident, separating bath parties, Charge nurses notified, DON notified of incident. Documented by AA D. Record review of Resident #2's Psychiatric Clinical Treatment Plan, dated 7/10/2024, revealed he was assessed for current mood and anxiety symptoms to ascertain current emotional functioning and process thoughts and feelings relative to recent physical altercation with another resident. The assessment listed his anxiety was moderate and rated as increased, his emotional withdrawal was listed as moderate and rated as increased, hostility was labeled as moderate and rated as increased and tension was labeled as moderate and rated as increased. The assessment noted he was moderately cognitively impaired. Record review of Resident #2's progress notes, dated 7/28/2024, revealed Resident #2 upset, yelling, being aggressive when told there was no one to take them to smoke. Resident yelling, cursing and demanding to smoke. Resident easily redirected to room. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #2's quarterly MDS, dated [DATE], revealed a BIMS score of 6 which indicated a severe cognitive impairment, with continuously present behaviors which included inattention, disorganized thinking and altered level of consciousness but no physical, verbal or other behaviors exhibited. Resident #2's functional status was recorded as independent with walking and transferring. 3. Record review of Resident #3's face sheet, dated 8/08/2024, revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] and readmitted [DATE] with diagnoses which included: senile degeneration of brain (dementia), schizoaffective disorder bipolar type (mental health disorder), and anxiety disorder. Record review of Resident #3's Annual MDS, dated [DATE], revealed a BIMS of 5 which indicated a severe cognitive impairment with no behavior symptoms. Record review of Resident #3's Care Plan, last revised on 5/13/2024, revealed there were no behaviors documented in the plan of care and no interventions for behaviors. The Care Plan also did not address his mental health diagnosis of schizoaffective disorder bipolar type or diagnoses of anxiety. The care plan did not address Resident #3's altercation with another resident and/or interventions for potential PTSD. Record review of Resident #3's progress note dated 7/02/2024 revealed the resident was yelling Let me off this bus. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 8/09/2024 at 11:57 a.m., the MDS Coordinator stated she began working at the facility on 6/24/2024. She stated there were a lot of assessments (MDS) that were getting behind and since she was new some people in management had been helping her when she asked. She stated when a resident first admitted to the facility the admitting nurses completed a baseline care plan and then she does an admission assessment where she looks at the care plan. She stated she does care plans associated with assessments and the nurses were supposed to do acute care plans. She stated anything not acute and associated with an assessment would be her responsibility. She stated once admitted a comprehensive care plan should be completed by day 21. She stated she reviews all sorts of records for her assessments/care plans including admission records, history and physicals, therapy, nursing documentation, CNA documentation. She then does an interview with the resident or family member, social services, any ancillary services, and reviews dietary notes and assessments. She stated she took in all that knowledge for the MDS assessment and the care plan that followed. She stated she does not complete a physical examination of the resident. She stated she was taught that was not her role. She stated her role was to code what was documented by other nurses. She stated she was unsure if Resident #1's care plan was a baseline care plan or a comprehensive care plan. She stated she had not seen the facilities baseline care plans since she started working at the facility and did not know if the comprehensive was built on the baseline. She stated Resident #1 should have had a comprehensive care plan and acknowledge Resident #1, #2 and #3 were incomplete mental illness nor behaviors were care planned and it was her responsibility. She stated as of this interview, it was the first time she had looked at Resident #1's care plan. The MDS Coordinator stated when she went to write his care plan Resident #1 had already been discharged (7/23/2024) and she had not admitted him. She stated Resident #1 was not part of her assignment and was not on her radar. She stated she did not know who was responsible for completing Resident #1's care plan. The MDS Coordinator stated Resident #2 and Resident #3 did not have care plans that addressed their mental illness, behaviors or interventions. She stated the care plans of all residents should address their mental illness with interventions, not just management of their medication. She stated the facility used to have another MDS Coordinator, but she no longer worked at the facility. She stated she did not really have an assignment, she just worked on whomever was next. She stated Resident #1 was not due for a care plan. The MDS Coordinator stated she had heard about Resident #1's fight where he hit someone while they were in bed (Resident #3). She stated she did not realize there was a previous fight (Resident #2). She stated she did not remember and was not sure but she stated the two people were in the first fight were separated and were not in direct contact with each other so she could not say she would have put that in the resident's care plans. She stated she could not judge what she did not know. She stated it would have been important to add to the care plan so people could be aware Resident #1 was violent. The MDS Coordinator stated she had a lot of MDS assessments to complete and was getting behind. The MDS Coordinator stated she was aware there was a resident at the facility with stealing behaviors because she heard about it during morning meeting, but she did not know it was Resident #1. She stated they might have mentioned Resident #1's name during morning meeting but she was not good with names and could not remember. She stated multiple residents and behaviors were discussed during morning meetings. The MDS Coordinator stated Resident #1's stealing behaviors had not been care planned. The MDS Coordinator stated it was important for residents' behaviors and mental illness to be care planed because it was a behavior and that was reason alone. She stated they should have been care planned but she was completely overwhelmed by the RUGS/MDS system. She stated she was mostly focused on completing assessments and not on the care plans. . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675823	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 8/09/2024 at 11:19 p.m., CNA J stated Resident #1 had a temper and was always stealing money, tennis shoes and food, mostly from Resident #4. CNA J stated he stole tennis shoes from another resident (unknown name) and stole money from another resident. CNA J stated she told ADON A about the stealing and Resident #1 denied it. CNA J stated there was nothing on his Kardex (care plan) about his behaviors. During an interview on 8/09/2024 at 2:56 p.m., the SW stated he did have influence on the care plan and the social worker role was to add interventions especially if it was a social work goal or change in condition. He stated at this facility they documented interventions into the facility investigation incident report but not into the care plan. He said the incident is documented in a binder and not in a residents medical record. He stated he was told by a former administrator (unknown name, not current administrator) not to document behaviors in the care plan. He stated his role at the facility was case management. He stated Resident #3 did not have any behaviors that he was aware of but was grumpy at times. The SW stated the facility did not get much information about him initially because it was an emergency placement. He stated they reviewed the hospital records, and sometimes later, not at admission, they reviewed the records from his previous NF placement. The SW stated the records indicated he had a habit of theft, and he was moved from his last NF placement because he had an altercation at the NF and was either sent to jail or to the hospital. The SW stated the facility got Resident #1 from the hospital. He stated when he reviewed the reports from the previous facility the altercation was a physical altercation with unknown injuries. He stated other residents at the facility were telling him he was stealing. Staff were also reporting he was stealing. The SW stated Resident #1's behaviors were discussed during morning meetings. He stated the discussions were around what he had done. He stated they talked about what he had stolen, and which residents were accusing him of stealing. He stated they also discussed the incident between Resident #1 and #2. When asked if they discussed interventions to keep the other resident's safe the SW stated they encouraged other residents to keep their personal items put away. The SW stated Resident #1 did not have access to Resident #2 because Resident #2 resided in the locked unit and during smoke breaks, they encouraged them to sit farther away from each other. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 8/09/2024 at 4: 44 p.m., the DON said behaviors were discussed during morning meeting, and it was her expectation for the MDS Coordinator to document them in the residents' care plans. She stated behaviors were also discussed during evening stand down meetings (end of day meetings). The DON stated Resident #1's care plans should have been documented by a former MDS Coordinator. After reviewing the termination date of the former MDS Coordinator (6/22/2024), the DON stated she was not sure who was responsible. She stated she might have been a gap between, or one (MDS Coordinator) might of have in orientation for a few days. She stated right now the facility only had one MDS Coordinator. The DON stated the charge nurses completed the initial care plan and periodically reviewed the care plans as needed. She stated the care plan was part of the POC and Kardex for CNA's to review for care. She stated the staff should document behaviors in their notes, including CNA's who document in POC. The DON stated it was important for resident behaviors and mental illness to be care planned so they didn't have what they currently have going on (in reference to the investigation of the resident-to-resident abuse). She stated when Resident #1 first arrived at the facility he was fine. She stated he was going out for cigarette breaks. She stated on one of those smoke breaks Resident #1 found a purse and was going through it. She stated another resident, Resident #2 intervened and took the purse away. The DON stated Resident #1 retaliated by scratching Resident #2 all up on his arms and neck. The DON stated after this incident occurred, they kept an eye on Resident #1 during smoke breaks and in other areas. The DON stated most of the time Resident #1 was in a good mood. She stated Resident #1 thought everything belonged to him, which meant he stole items. She stated anything left out; he would take. The DON stated a CNA left her bag out and Resident #1 ate her lunch. The DON stated for interventions people were told to put things away and they monitored Resident #1. She stated monitored meant they just watched him through the day. The DON stated she did not think there was a place for staff to document the monitoring. The DON stated Resident #1 did not have any orders for behavior monitoring. She stated they were not doing behavior monitoring because the incident between Resident #1 and Resident #2 was a first-time occurrence and the incident was provoked by Resident #2 when he removed the purse from Resident #1. The DON stated she had not expected behaviors from Resident #1. She stated they were just watching him, not monitoring for behaviors. The DON stated the first time she became aware of the stealing behaviors was when Resident #1 stole the purse and when he stole the CNA's bag. The DON stated she did consider stealing a behavior, but they were just monitoring him as part of the incident reporting and not as part of Resident #1's medical record. The DON stated they had discussed behaviors during morning meetings and had expected the MDS Coordinator to document it in the care plan. The DON stated she expected the charge nurses to review the care plan upon admission and then periodically. She stated the care plan was part of POC and on the Kardex for the CNA's. The DON stated she would expect staff to respond to behaviors by following their dementia training which was to allow the resident space and allow them to calm down. The DON stated the facility was working on dementia training currently and it was not completed. The DON stated she expected the CNAs to report behaviors to the charge nurse and she expected the charge nurses to use basic nursing knowledge to intervene and was not based on interventions documented in a plan of care. The DON stated the staff should have taken Resident #2 out separately from Resident #1. She stated this was a verbal agreement with staff and not part of the care plan. The DON stated, IF I took something your you, you would probably act up too. It was an expected behavior. When asked about the other residents' safety the DON stated she did not feel like other residents were at risk The DON stated she had been monitoring UDAs for behaviors and had not seen any behaviors documented. When asked how she would see a UDA for behaviors if they were not monitoring for behaviors, she stated the ADON's look for behaviors in the medical record and she does the same. She stated if she saw a behavior in the medical record, she would tell the ADON to go check on it. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 8/12/2024 at 1:10 p.m., the Administrator stated she had been out of the facility from the time of surveyor arrival (8/07/2024) until today. She stated she was the interim Administrator until the facility could find a permanent Administrator. She stated she was hired on 7/20/2024 after the incidents between Resident #1 and #2 had occurred. She stated when she arrived, she did review and discuss the resident-to-resident altercations with the DON prior to surveyor arrival. The Administrator stated the nursing staff, SW and activities were responsible for the resident care plans. She stated all of them could alter/update the care plan. She stated the MDS Coordinator and IDT team provided oversight to ensure accurate and complete care plans. The Administrator stated the ADON and DON were responsible for monitoring nursing staff. She stated the DON could delegate quite a bit of her duties if needed. The Administrator stated the facility prevented harm by reviewing resident history, observation of resident behaviors. She stated everyone was responsible for resident safety. Record review of a facility policy, titled Behavior management Policy last revised April 19, 2005, revealed: Policy: Behavior management includes the management of anger, confusion, hallucination, and other behavior by utilizing techniques such as area limitation, self-responsibility, group interactions, limit setting, and behavior modifications depending on individual needs. Procedures: 15. Develop and facilitate a behavior modification program .19. Document behavior modification on the interdisciplinary plan of care. Monitor effectiveness of interventions. Record review of a facility policy, titled Comprehensive Care Planning (undated) revealed: The facility will develop and [TRUNCATED]