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	04/25/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619 42031 44020 Based on observation, interview, and record review the facility failed to ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse, to the administrator of the facility and to other officials including to the State Survey Agency where state law provides for jurisdiction in long-term care facilities in accordance with State law through established procedures for 7 of 12 residents (Residents #2, #3, #4, #5, #7, #8, and #9), reviewed for freedom from abuse, neglect, and exploitation. 1. The facility failed to report when Resident #2 physically attacked Resident #3 for 2 days after the incident. 2. Facility failed to report an incident of suspected abuse, from 12/23/2024 when Resident #5 pushed Resident #4 down until 02/24/2025. 3. DON failed to report an incident of suspected abuse, from Saturday 04/19/2025 when Resident #7 accused staff hurting her, until Monday 04/21/2025. 4. The facility failed to report Resident #8 hit Resident #9 on 3/7/25 to the Administrator and to HHSC until 3/10/25. These failures could put the residents at risk of abuse, allegations of abuse not being reported immediately, and could result in physical and psychosocial harm. The findings were: (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Record review of Resident #2's electronic face sheet dated 12/19/2024 reflected she was initially admitted to the facility on [DATE] and readmitted after a hospitalization on [DATE]. Her diagnoses included: moderate dementia (symptoms affecting memory, thinking and social abilities that interfere with daily life) with agitation (severe restlessness, crankiness, or uneasiness), anxiety (feelings of worry, fear, and apprehension) and major depressive disorder (mental disorder characterized by a persistent low mood, loss of interest or pleasure in activities). Review of Resident #2's quarterly MDS assessment with an ARD of 10/01/2024 reflected she was rarely/never understood and sometimes understands. She scored a 3/15 on her BIMS which signified she was severely cognitively impaired. She had little interest or pleasure in doing things. She was dependent on staff for assistance with ADL's. No behaviors were exhibited for the MDS assessment. Review of Resident #2's comprehensive care plan revised date 12/24/2024 reflected: Focus, the resident has potential to demonstrate physical behaviors dementia, poor impulse control. Altercation with another resident per hx. Interventions, intervene to protect the residents involved and call for assistance. If intervening would be unsafe, call out for assistance immediately and notify the charge nurse of any physically abusive behaviors. Review of Resident #2's Psychiatric Initial assessment dated [DATE] reflected Reason for Referral: Physical Aggression, Risk of Aggression: None. Review of Resident #2's Psychiatric Discharge Summary dated 12/4/2024 reflected Patient IS NOT considered to be at risk of harm to self or others. Record review of LVN B's progress note reflected: 12/7/2024 08:25 pm Nursing Progress Note Note Text: Another resident found by doorway of room [ROOM NUMBER] pulling residents hair. Red scratches on her right arm were noted. CNA separated the alteration. Residents separated by staff and assessed for injuries. Red surface scratches to right upper arm noted. Vital signs completed. Observation on 04/22/2025 at 11:00 am of Resident #2 revealed she was lying in her room, clean and well-groomed on a scoop mattress with a bed in the low position and a mat on the floor beside her bed. Interview on 04/22/2025 at 11:00 am with Resident #2 using direct questions, when asked how she was, she stated good. She did not appear to be restless or agitated. Record review of Resident #3's electronic face sheet dated 04/22/2025 reflected she was initially admitted to the facility on [DATE] and readmitted on readmitted on [DATE]. Her diagnoses included: cerebrovascular disease (conditions that affect blood flow to the brain), severe dementia (late stage of dementia, decline in memory, reasoning, language, coordination, mood, and behavior) and anxiety (common emotional response characterized by feelings of worry, fear, and apprehension). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's quarterly MDS assessment with an ARD of 10/01/2024 reflected she could understand and sometimes be understood. She scored a 0/15 on her BIMS which signified she was severely cognitively impaired. She had no noted behaviors. She could independently eat but was dependent on staff for other ADL's. Record review of Resident #3's comprehensive care plan revised date 08/19/2024 reflected Focus, has a behavior problem r/t dx: dementia to include but not limited to frequent hallucinations, removes stitching from helmets and mattresses, and screws from her wheelchair, takes them apart, hits at, kicks and tries to bite staff while performing ADL's, Interventions, intervene as necessary to protect the rights and safety of others. Observation on 04/22/2025 at 11:05 am of Resident #3 revealed she was sitting in her wheelchair in the day room on the secure unit. She was well groomed and clean. She was not interview able. No aggressive behaviors were seen. She appeared calm and not agitated. Interview on 04/23/2025 at 1:22 pm with ADM C revealed he was not here for the incident between Resident #2 and #3. He stated the staff needed to immediately protect the resident. He stated he provided his phone number for staff to call him directly to report an incident. He stated the incident that involved Resident #2 and #3 should have been reported to HHSC within 2 hours if injuries were severe, and within 24 hours and that did not happen. He stated the implications of not reporting within the directed time limit could result in a delayed investigation and further harm to residents. He stated he was accountable for how staff responded to incidents or allegations of abuse or neglect. Interview on 04/23/2025 at 3:26 pm with the SW revealed that the facility had psychiatric services involved to evaluate Resident #2 and #3 after the incident. He stated he checked on Resident #2 and #3 frequently after the incident. He stated staff was trained to report any incident immediately or ASAP to the Administrator so an investigation could begin or more harm would occur. Interview on 04/23/2025 at 4:20 pm with the DON, she stated she was informed about the incident between Resident #2 and #3 on 12/07/2024 and she reported immediately to ADM D. She stated she immediately started to educate staff on abuse and neglect, the policy, procedure, and reporting. She stated she was at home and did not have access to what she needed to report the incident to HHSC. She thought ADM D would report the incident. She stated when an incident was not reported timely it could delay the investigation and training of staff required to stop or prevent further incidents. Interview on 04/24/2025 at 10:57 am with C NA A revealed she was coming out of the shower and heard a commotion. She saw Resident #2 and she had an outburst about her husband and men. Resident #2 was pulling Resident #3's hair and hitting her on the head. She stated she tried to separate them, and it was difficult because Resident #3 was in a wheelchair and sideways. She stated Resident #2 was upset. She stated she redirected Resident #2 and reported the altercation immediately to LVN B. She stated staff was trained on implementation of the abuse and neglect policy and procedure and she was trained to report an incident to the charge nurse. She stated to report abuse and neglect ASAP was important because residents could be harmed further. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/22/2025 at 4:09 pm with LVN E, a charge nurse on the secure unit revealed Resident #2 had all her remaining teeth pulled on 12/03/2025 and after the procedure her condition declined. She stated she had her psychiatric medications adjusted and she was monitored for aggression. She stated after the incident between Resident #2 and #3 she was placed on 1:1 supervision. She stated the C NAs were good about reporting incidents to the nurses right away and then the DON would be notified. She stated the importance of reporting incidents immediately to start an investigation into the incident. Interview on 04/24/2025 at 10:00 am with previous Administrator, ADM B revealed she did not remember the DON calling her about the incident on 12/7/2024 between Resident #2 and #3. She stated she first heard about the incident on Monday 12/9/2024 and reported it to HHSC at that time. She stated she realized the reporting was late IAW the facility policy and procedure on abuse and neglect which is 2 hours or 24 hours, but she did not remember being informed of the incident. She stated the importance of reporting an incident immediately, so it was investigated as soon as possible to prevent further harm and to keep residents safe. Record review of the facility PIR for the incident between Resident #2 and Resident #3 reflected the incident occurred on 12/7/2024 and was reported to HHSC on 12/9/2024. Record review of LVN B's training dated 11/18/2024 reflected she was trained on the abuse and neglect policy and procedure titled Abuse and Neglect. Record review of CNA A's training and proficiency audit on abuse and neglect reflected she was trained on the abuse and neglect policy and procedure on 11/18/2024 and successfully completed a proficiency audit to report any incidents to the charge nurse, DON, or administrator on 09/20/2024. 2. Record review of Resident #4's face sheet, dated 04/22/2025, revealed she was admitted on [DATE] with diagnoses which included: unspecified dementia (a general term for the loss of mental abilities, like memory, thinking, and reasoning, that are severe enough to interfere with daily life), , unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, vascular dementia, unspecified severity, with other behavioral disturbance, delusional disorders, and generalized anxiety. Record review of Resident #4's Significant Change MDS assessment, dated 02/07/2025, revealed the resident's BIMS score 6 for severe cognitive impairment with no behaviors coded. Record review of Resident #4's care plan, initiated date of 02/24/2025, revealed Resident #4 had a focus of [Resident's name] has a behavior problem r/t Dementia to include but not limited to verbal behaviors towards staff and other residents, uses racial slurs . and interventions read Intervene as necessary to protect the rights and safety of others. Approach/Speak n a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Record review of Resident #4's progress notes, dated 12/23/2025, revealed Resident had a resident-to-resident event that ended in this resident falling against the cart and landing on bilateral gluteus. Residents separated. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's face sheet, dated 04/22/2025, revealed she was admitted on [DATE] with diagnoses which included: vascular dementia (a general term for the loss of mental abilities, like memory, thinking, and reasoning, that are severe enough to interfere with daily life), , moderate, with other behavioral disturbance, dementia in other diseases classified elsewhere, unspecified severity, with agitation and adjustment disorder with disturbance of conduct. Record review of Resident #5's Quarterly MDS assessment, dated 03/17/2025, revealed the resident's BIMS score 4 for severe cognitive impairment with no behaviors coded. Record review of Resident #5's care plan, initiated date of 02/24/2025, revealed Resident #5 had a focus of Resident has potential for trauma, resident is protective of her safe zone, (room, person) she feels a personal intrusion is occurring verbally by others (residents and staff). She will become verbally defensive or physically protective and interventions read Monitor for escalating anxiety, depression, sleep disturbance, substance abuse, or suicidal thoughts and report immediately to the physician and to the mental health provider is applicable. Record review of Resident #5's progress notes, dated 12/23/2025, revealed Resident involved in resident-to-resident event in hallway at nurses' station while arguing with another resident. Residents redirected and both residents continued the behavior. This resident pushed the other resident and other resident fell against med cart and then fell to floor. This resident had no c/o pain or c/o at assessment. residents redirected and separated and continued to argue. no other altercations will continue to monitor. Observation on 04/22/2025 at 11:19 a.m. revealed Resident #4 walking with staff and other residents on the secure unit. Resident #4 smiling and talking with others. Resident #4 very pleasant and neat appearance. Observation on 04/22/2025 at 11:40 a.m. revealed Resident #5 in her room lying in bed with call light in reach. Resident #5 neat appearance and pleasant. During an interview on 04/23/2025 at 10:03 a.m. RN I stated Resident #5 was standing at the nurses' desk when Resident #4 came over and started talking about Resident #5. RN I further stated she separated Resident #4 and Resident #5 when Resident #4 again approached Resident #5 making derogatory statements in which Resident #5 pushed Resident #4. RN I stated she reported the incident to the DON, ADON, Administrator and all nurses using the facility chat. During an interview on 04/23/2025 at 4:20 p.m. the DON stated she was notified during the day and ADM D had told her about it after she went back to the secure unit. The DON stated she did not know why it wasn't reported when it happened. The DON further stated normally the administrator would report allegations of abuse. The DON stated it was reported after another incident occurred with Resident #5 and they realized the incident between Resident #4 and Resident #5 was not reported. The DON stated possible incidents of abuse should be reported within 2 hours of the incident to the State Survey agency (HHSC). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/24/2025 at 10:01 a.m. ADM D stated they did not report the allegation to HHSC State Survey agency at the time did not think it was reportable due to Resident #4's being the instigator, her condition and not being injured. ADM D stated abuse was to be reported anytime the facility suspected abuse. ADM D stated they sought the guidance of corporate office. ADM D further stated the DON had spoken to someone in corporate who informed her based on the BIMS scores of the resident, there being no injuries and Resident #4 was receiving ABT for a UTI it was not reportable. ADM D stated if there were an allegation of abuse the facility should report in 2 hours from the time of the incident. ADM D further stated by not reporting the abuse could the failure of keeping residents safe. ADM D stated she did believe the incident should have been reported the State Survey agency (HHSC). ADM D stated she did not speak with corporate herself but discussed it with the DON. During an interview on 04/25/2025 at 4:12 p.m. RN F stated she was not notified of the incident on 12/23/2025 between Resident #4 and Resident #5. RN F further stated she found out about the incident between Resident #4 and Resident #5 when she was doing clinical reviews of resident records, and it was reported immediately to State Survey agency HHSC after she found it. RN F stated by not reporting possible abuse could hinder it being investigated and it could cause it to happen again. Record review of the facility PIR for the incident between Resident #4 and Resident #5 reflected the incident occurred on 12/23/2024 and was reported to HHSC on 02/24/2025. Record review of DON's training dated 09/10/2024 reflected she was trained on the abuse and neglect policy and procedure titled Abuse and Neglect. Record review of ADM D's orientation training dated 11/11/2024 reflected she was trained on the abuse and neglect policy and procedure titled Abuse and Neglect. Record review of ADM D's training dated 12/08/2024 reflected she was trained on the abuse and neglect policy and procedure titled Abuse and Neglect. 3. Record review of Resident #7's face sheet, dated 04/25/2025, revealed he was admitted on [DATE] with diagnoses which included: Parkinson's disease (a progressive neurodegenerative disorder that primarily affects movement, often starting with tremors, but can also cause slowness, rigidity, and balance problems) without dyskinesia, without mention of fluctuations, delusional disorders without dyskinesia, without mention of fluctuations, delusional disorders, depression, unspecified, and anxiety disorder, unspecified. Record review of Resident #7's revealed a Comprehensive MDS assessment had not been completed due to new admission. Record review of Resident #7's care plan, initiated date of 04/25/2025, revealed Resident #7 had a focus of Resident has a behavioral issue related to making negative statements towards staff at times. resident states that staff have put witchcraft on her. Record review of Resident #7's progress notes, dated 04/19/2025, revealed resident called 911 asking for help. went to check on patient she was crying saying CNA hit her and hurt her arm. Both CNAs in room resident crying and accusing one of them hit her. Other CNA saying that did not happen they just pulled her with the draw sheet. resident now states that something was put on her that burned her, and it was witchcraft. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/22/2025 at 9:00 a.m. ADM C stated he had reported the alleged incident that occurred over the weekend and when he was aware of it on Monday 04/21/2025. ADM C further stated staff were aware they were to contact him immediately with allegations of abuse. Observation and interview on 04/25/2025 at 10:40 a.m. revealed Resident #7 lying in her bed with her call light within reach. Resident #7 was difficult to understand due to flight of thoughts. Resident #7 talking about her brother and sister living in the attic, staff at her prior facility selling drugs, pancakes, lady bugs, then about the facility staff touching her all over and spreading her legs where it smelled like marijuana. Resident #7 further stated the staff caused bruising to her arms, pointing at arms to bruises that look to be from her IVs from recent hospital stay. Resident #7 continued to jump from topic to topic. During an interview on 04/25/2025 at 2:14 PM LVN K stated she was at the nurses' station charting when she received a call from 911 stating they had received a call, and they were informed a resident in [room number] had called them. LVN K stated Resident #7 had told her somebody hit her in the face with her purse and was accusing staff who were not working and did not come in until later. LVN K stated she contacted the DON informing her of the allegation made by Resident #7 and further stated she used the facility chat to communicate the situation. During and interview on 04/25/2025 at 4:00 p.m. the DON stated she was not notified of the incident, but when she came in on 04/19/2025 (Saturday) it was said in conversation. The DON stated she was informed by LVN K Resident #7 had said staff were poisoning her and thinking staff were going to hurt her then calling the police. The DON stated she was notified via text, but it was only regarding Resident #7's fall. The DON stated she did not receive report of the alleged allegations until the morning and when she received the report the resident was placed on 2-person care. The DON further stated Resident #7 was saying CNA H had hurt her however, CNA H had left early that day and was not in the facility at the time of the allegations. The DON stated she should have called ADM C or RN F however, due to Resident #7's clinicals from the hospital Resident #7 had a history of saying these things. The DON stated she took the allegation as just one of Resident #7's behaviors. The DON stated by not reporting allegations of abuse to the State Survey agency (HHSC) there was the risk of penalties, citation and of not being an advocate for the patient. During an interview at 04/25/2025 at 4:24 p.m. ADM C stated allegations of abuse should be reported to him immediately after making sure the resident is safe. ADM C stated the facility was to report to State Survey agency (HHSC) if there was any significant injury or abuse allegations within 2 hours and 24 with anything else. ADM C stated there was a possible consequence when not reporting an allegation in that it might not be thoroughly investigated in a time frame to ensure a patient's safety. Record review of the facility PIR for the alleged incident involving Resident #7 reflected the incident occurred on 04/19/2025 and was reported to HHSC on 04/21/2025. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Record review of Resident #8's face sheet dated 4/24/25 revealed the resident was a [AGE] year-old male originally admitted to the facility on [DATE] with readmissions on 7/28/23 and 9/19/24. The resident's diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (hemiplegia and hemiparesis (weakness and loss of strength on one side of the body), cognitive communication deficit (impairment in organization/thought organization, sequencing, attention, memory, planning, problem-solving), and unspecified lack of coordination (a problem with movement, balance, or coordination). Record review of Resident #8's quarterly MDS assessment dated [DATE] revealed the resident had a BIMS score of 11 out of 15, indicating the resident was moderately cognitively impaired. The resident had no physical, verbal, or other behaviors directed towards others. The resident had impairment of his upper extremity and lower extremity on one side of his body, and the resident used a manual wheelchair independently. Record review of Resident #8's undated care plan revealed a focus initiated on 3/10/25 for potential for Resident #8 to become physically aggressive and hit another resident. Interventions included to notify, document, and report to the charge nurse and physician. (There were no other focus's for behaviors prior to the incident on his care plan). Record review of Resident # 8's progress notes revealed no documentation on 3/7/25, 3/8/25, and 3/9/25 that the resident hit another resident. Record review of Resident #9's face sheet dated 4/24/25 revealed the resident was a [AGE] year-old male originally admitted to the facility on [DATE] with readmissions on 8/17/23 and 2/23/25. The resident's diagnoses included ESRD (medical condition in which the kidneys cease functioning on a permanent basis leading to the need for long-term dialysis or a kidney transplant to maintain life), major depressive disorder, recurrent, mild (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), unspecified lack of coordination (a problem with movement, balance, or coordination). Record review of Resident #9's quarterly MDS assessment dated [DATE] revealed the resident had a BIMS score of 14 out of 15, indicating the resident was cognitively intact. The resident had no physical, verbal, or other behaviors directed towards others. The resident had impairment of both of his lower extremities and the resident used a wheelchair independently but not documented if manual or electric. Record review of Resident #9's undated care plan revealed a focus initiated on 12/13/24 for the resident had demonstrated verbally aggressive behaviors towards other residents. Interventions included to notify the charge nurse of any abusive behaviors. Another focus initiated on 3/10/25 for the resident having verbal outbursts towards other residents and using his electric wheelchair to express negative emotions. Interventions included if resident to resident physical altercation occurs - separate the residents immediately to different locations, notify MD, Administrator, RP, DON, and if needed call sheriffs. Another focus initiated on 3/10/25 for the resident having a history of attempting to hit other residents with his electric wheelchair with interventions that included notifying the charge nurse of any physically abusive behaviors. Record review of Resident #9's progress notes revealed no documentation on 3/7/25, 3/8/25, and 3/9/25 the resident was hit by another resident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility self-reported intake 570022 with a received date of 3/10/25 revealed Resident #8 hit Resident #9 on 3/7/25 with an allegation of abuse. Record review of facility PIR for intake 570022, fax cover dated 3/13/25 revealed the incident was reported to HHSC on 3/10/25 and the incident occurred on 3/7/25 at 5:00 p.m. The PIR named RN L and staff M as witnesses to the incident. The PIR was signed by the DO and dated for 3/14/25. Further review revealed CNA N and CNA O were discussing the incident and RN L had overheard the conversation and immediately asked Resident #9 about it and assessed the resident to have no injuries. In an observation and interview on 4/24/25 at 1:40 p.m. Resident #8 was in bed and stated he did not remember the incident and when asked if he had hit another resident or had been hit or injured the resident stated, I don't know. The Resident was alert and oriented to his name and place. There was no redness, bruising, or injuries noted to the resident's face, arms, neck, or legs. In an observation and interview on 4/24/25 at 1:55 p.m. Resident #9 was sitting outside in his electric wheelchair in a small courtyard in front of the facility under shade trees with his wheelchair leaned back listening to his ear pods. The resident stated he remembered the incident with Resident #8 and stated it had happened on Saturday 3/8/25. Resident #9 stated Resident #8 was in his way and he told him to move and that was when Resident #8 hit him on the right side of his face with a closed fist. Resident #9 stated it did not hurt and he had no pain or discomfort from hit and further stated he did not hit him hard. Resident #9 stated staff separated them and there had been no further issues. There was no redness, bruising, or injuries noted to the resident's face, arms, or neck. In an interview on 4/24/25 at 11:43 a.m. Staff M stated she was on her break in the lobby area and Resident #8 was in his wheelchair near the entrance door and Resident #9 was in his electric wheelchair and the residents were near each other. Staff M stated she did not hear exactly what was said but Resident #9 said something about getting out of his way and moved closer to Resident #8 and all she remembers is it got loud and the residents were talking loudly to each other and were close to each other. Staff M stated she and CNA H separated the residents and Resident #8 left the area and went back to his room and Resident #9 went to sit outside. Staff M stated she did not witness Resident #8 hit Resident #9. Staff M did not report it to anyone as CNA H did . Staff M stated she had been trained on ANE and reporting. In a telephone interview on 4/24/25 at 12:04 p.m. RN L stated she did not recall the details of what she overheard between CNA N and CNA O only that there was an incident on the Saturday (3/8/25) prior. She immediately asked Resident #9 about it and he confirmed Resident #8 had hit him on the side of his face during an altercation at the front entrance. RN L stated she assessed the resident and he had no injuries and denied pain or discomfort and told her he was fine. RN L stated she had asked CNA N and CNA O about it and they both stated it had been reported at the time but she went to double check with the DON as they were between Administrators and she learned it had not been reported. RN L stated it should have been reported immediately to the DON and Administrator and she had been trained on ANE and reporting. RN L stated she had assessed Resident #8 as well and he had no injuries and could not really remember the incident. (continued on next page)

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	675823	A. Building B. Wing	04/25/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 4/24/25 at 12:15 p.m. CNA H stated on Saturday 3/8/25 she was in the lobby waiting for her time to clock in and Resident #9 approached Resident #8 in the lobby at the front entrance door and told Resident #8 to move and get out of his way. CNA H stated Resident #9 got really close to Resident #8 with his electric wheelchair aggressively and the residents started talking loudly to each other and she did not recall what was said but Staff M and herself separated the residents and Resident #9 stated Resident #8 had hit him. CNA H stated she did not witness Resident #8 hit Resident #9 but it was possible. CNA H stated she sent Resident #8 back to his hallway and Resident #9 went outside and neither resident was injured. CNA H stated she did not tell anyone right away but after clocking in she notified the nurse. CNA H stated she was unsure which nurse but it was probably RN G. CNA H stated she was trained on ANE and stated it was required to be reported immediately but she did notify the nurse within 10-15 minutes after clocking in and going to her assigned hall which was Resident #8 and #9's hall. In an interview on 4/24/25 at 12:20 p.m. the DON stated she was off the week this incident happened and did not return until 3/10/25. The DON stated the nurses for Resident #8 and Resident #9 on 3/7/25 and 3/8/25 was either LVN J or RN G. In an attempted interview on 4/24/25 at 12:44 p.m. a call was placed to RN G and a message left to return call for investigation. In a telephone interview on 4/24/25 at 12:50 p.m. LVN J stated she was not working the day Resident #8 and Resident #9 had an altercation on 3/8/25 and had no firsthand information regarding the incident. In a telephone interview on 4/24/25 at 1:49 p.m. ADM D stated she does not recall being notified of any incident between Residents #8 and #9 from 3/7/25 through 3/10/25 and further stated she would have immediately reported it to HHSC as required. ADM D stated her last day in the facility as the Administrator was 3/10/25 and she would have reported to HHSC any incidents she was notified of prior to that. In an attempted interview on 4/24/25 at 4:32 p.m. a call was placed to RN G, the call was answered and then the call disconnected after introduction, attempted to call back and call went straight to voicemail. A text message was sent to RN G with a return response that she could not talk right now. In an attempted interview 4/24/25 at 7:59 p.m. a call was placed by another surveyor to RN G and she answered the call and when the state surveyor introduced herself, RN G stated, um yeah I'm a little busy and hung up the phone. No further contact with RN G was attempted after this attempt. In an interview on 4/25/25 at 10:16 a.m. ADM C stated RN G went PRN and then quit to work elsewhere and had not worked for the facility since 4/6/25. In an interview on 4/25/25 at 1:35 p.m. the DO stated on 3/10/25 she was at the facility and it was ADM D's last morning and after ADM D left, she was notified of the incident by the DON. The DO stated she had made the report to HHSC according to the information provided to her and completed the investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 4/25/25 at 4:00 p.m. the DON stated the possible consequences of abuse allegations not being reported to the Administrator immediately or to HHSC within the required timeframes was penalties, citations, and not being an advocate for the residents . In an interview on 4/25/25 at 4:24 p.m. ADM C stated all abuse allegations should be reported immediately to the Administrator after resident safety was ensured and reported to HHSC within 2 hours and 24 hours depending on if the allegation included abuse and injury. ADM C stated the possible consequences of not reporting to the Administrator or HHSC immediately and in the required timeframes could be the allegation would not be thoroughly investigated and not in a timely manner to ensure resident safety. Review of the faci[TRUNCATED]

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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** 42031 Based on observation, interview, and record review, the facility failed to ensure each resident receives adequate supervision to prevent accidents for 1 of 6 residents (Resident #1), reviewed for quality of care. The facility failed to supervise Resident #1 who eloped out of a side door of the facility on 2/17/25 at approximately 7:12 p.m. without staff knowledge, through a side door that the alarm had been turned off on and was found ambulating down the sidewalk approximately 400 feet from the facility. An Immediate Jeopardy was identified as past noncompliance on 4/23/25. The IJ began on 2/17/25 and ended on 2/18/25. The facility had corrected the noncompliance before the survey began. This failure could put residents at risk of accidents, and could result in serious injury, harm, impairment, and death. The findings were: Record review of Resident #1's face sheet dated 4/22/25 revealed the resident was a [AGE] year-old female initially admitted to the facility on [DATE] with readmission on 1/10/25. The resident's diagnoses included non-traumatic subarachnoid hemorrhage, unspecified (bleeding in the space below one of the thin layers that cover and protect your brain not caused by caused by, or associated with trauma), schizoaffective disorder (mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania), muscle weakness, and other abnormalities of gait and mobility (abnormal walking pattern and the ability to move freely, coordination). Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed the resident had a BIMS score of 3 out of 15 indicating the resident was severely cognitively impaired. The resident had no behaviors and no wandering. The resident used a walker and was independent for lying to sitting on side of bed, required supervision, or touching assistance to stand, transfer, and walk 150 feet. Record review of Resident #1's undated care plan revealed a focus initiated on 2/18/25 for the resident to reside in the secure unit due to elopement, and the resident had an actual elopement. Interventions included encourage the resident to participate in activities and monitor for statements of wanting to go home or leave the facility and wandering, and to stay with the resident and notify the charge nurse if exit seeking. (There were no focus's for wandering or exit seeking prior to this incident). Record review of Resident #1 Elopement risk assessment, dated 1/11/25, had a score of 0 indicating the resident was not an elopement risk. (1-9 not a risk, 10 or greater is an elopement risk). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility PIR for intake #565261 dated 2/24/25 revealed on 2/17/25 at approximately 7:12 p.m. the facility was notified Resident #1 had left the building by another resident sitting outside. The DON went out the front door and noted the resident walking with her walker on the sidewalk on the same side of the street as the facility walking towards local chicken restaurant next door to the facility. The DON caught up to Resident #1 at approximately 7:20 pm as she was walking down the sidewalk. The DON stayed with the resident and staff brought a wheelchair for the resident and she was back in the facility at 7:28 pm. The resident stated she was going home. The resident was assessed by the DON to have no injuries. The resident was placed on 1:1 supervision until she was moved to the secure unit. The MS checked all facility doors on 2/17/25 at approximately 8:20 p.m. and found the double doors by the B wing by the dining room were not functioning properly and were immediately fixed. Record review of Resident #1's event nurses' note for elopement dated 2/17/25 by the DON revealed she was notified by receptionist Resident #1 had left the building through double doors and was not out of the building more than 15 minutes. The Resident's physician who was also the facility Medical Director and the resident's RP were notified and the resident was moved to the secure unit. Record review of Resident #1's progress notes revealed a nurses' note dated 2/17/25 at 7:56 p.m. by the DON she was notified by the receptionist Resident #1 was outside the facility and she observed her walking on the sidewalk on the same side of the street as the facility and she was redirected back to the facility with no visible injuries. In an observation and interview on 4/22/25 at 11:10 a.m. Resident #1 was lying in bed on top of her covers and was dressed in a t-shirt and pants. Facility staff had assisted Resident #1's roommate and was leaving the room. Resident #1 was alert and oriented to person only. Resident #1 was unable to answer questions about the elopement. The resident stated she was happy living here and liked to watch the birds through the windows, felt safe, and liked the staff pointing to a staff member at the doorway and calling her by the wrong name and stated, she's good people and smiled. The resident was able to communicate well in English despite preferring Spanish. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 4/22/25 at 3:05 p.m. The DON stated on 2/17/25 at approximately 7:12 p.m. the receptionist was notified by another resident that was sitting outside that Resident #1 had been walking up the sidewalk on the side of the kitchen and lobby but still in front of the facility due to the shape of the building. The DON stated she immediately went out the front door and observed the resident walking on the sidewalk with her walker headed towards local chicken restaurant on the right next door to the facility. The DON stated she was unsure of the timeframes but it did not take her long to catch up to the resident. The DON stated Resident #1 was still in front of the facility on the edge of the property line when she caught up with her. The DON stated the resident did not cross the driveway into the local chicken restaurant that interrupted the sidewalk immediately after the facility fence line. The DON stated she pulled out her phone and called staff who brought out a wheelchair and she brought Resident #1 back inside the facility by wheelchair without resistance or issues. The DON stated Resident #1 had told her she was going home. The DON stated she assessed Resident #1 and she had no injuries. The DON stated she had notified the physician and RP and received verbal consent from the resident's RP to move the resident to the secure unit and the resident was moved that same evening, not sure of the time. The DON stated ADM D was notified and the MS came to the facility at about 8:20 p.m. and checked all the facility doors and found something wrong with the double doors between B wing and the dining room and they were immediately fixed and all doors rechecked and were working properly and all door codes were changed as well. The DON stated she started in-servicing staff the same night on 2/17/25 on ANE, Elopement response policy/code orange, and staff were not allowed to work until training was completed. The DON stated Resident #1 was not an elopement risk prior to this incident the resident would go places in the facility but did not attempt to elope. In an observation and interview on 4/23/25 at 12:30 p.m. the MS stated when he was checking the door alarms on the night of 2/17/25 he found the double doors between B hall and the dining room were not alarmed and had been turned off. He showed me the red stop sign box attached to the doors with a key slot and the words off and on next to the key slot. The key slot was turned to the on position. The MS demonstrated without disarming the alarm that a key had to be inserted to turn it from on to off and vice versa. The MS stated all the nurses had keys to turn the alarm off as well as himself and he was unsure of who else had keys. The MS then showed me the secondary alarms that were placed on all facility exit doors and the secure unit on 2/18/25 and stated they cannot be turned off and the alarms sound the entire time the doors were open. This was demonstrated by opening the secure unit doors after entering the code to enter, an alarm sounded until the door was closed. In an interview on 4/23/25 at 5:00 p.m. the ADM C stated he was not the Administrator at the time of this incident and was hired about 4 weeks ago, around 3/14/25. The ADM C stated he had continued with the elopement plan of action and had further trained staff on ANE and notifications to be made. In an interview on 4/25/25 3:05 p.m. the MS stated he knew the door alarms were working as they had been checked that day on 2/17/25. The alarmed door that was turned off was what the facility calls the kitchen staff emergency exit. The MS stated the front facility entrance already had a secondary alarm. The MS stated the push button release for the front entrance door was relocated on 2/18/25 to a hidden place inside the receptionist desk and mounted in place with screws and the drawer is locked and the receptionist has the key. Review of the facility policy on elopement prevention revised January 2023 indicated under environmental modification . 4. Use door alarms or monitoring devices to notify staff when residents try to leave the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	It was determined the failure placed Resident #1 in an IJ situation on 4/23/25. The ADM C was notified on 4/23/25 at 3:18 p.m., that a PNC IJ had been identified due to the above failure. The facility implemented the following interventions: 1. Resident #1 was placed on 1:1 monitoring and then moved to the secure unit on 2/17/25. 2. All facility doors were checked and all alarms were verified to be on and working on 2/17/25. 3. The DON began in-servicing all staff on 2/17/25 for ANE, elopement response policy/code orange, elopement prevention policy, and door alarm safety, and staff were not allowed to work until training was completed. 4. On 2/17/25 at 8:50 pm an off-cycle QAPI by phone was conducted with the DON and Medical Director. 5. On 2/18/25 an ADHOC QAPI review of corrective action plan was conducted. 6. All new staff to be in-serviced during orientation and agency staff to have training prior to working if used. 7. On 2/18/25 Elopement risk assessments were completed and evaluated for changes on all residents in the facility. 8. On 2/18/25 secondary alarms were placed on all alarmed doors that cannot be turned off. 9. Door alarm checks daily and as needed 5 times weekly x 4weeks. 10. 5 staff members to be interviewed 3 times weekly on elopement prevention and response 5 times weekly for 4 weeks. Review of facility signature sheet for ADHOC QAPI meeting on 2/18/25 had 14 attendees and included the facility Medical Director, corporate compliance nurse, DON, ADON, director of rehabilitation, MDS nurse, SW, housekeeping, dietary, and nursing staff. Record review of elopement drills revealed drills were completed on 2/18/25, 2/21/25, 2/20/25, 2/28/25, and 3/19/25. Review of facility staff list revealed 8 newly hired staff from 2/17/25 to 4/23/25 employee files reviewed revealed they were ADM C, staff PP, QQ, RR, CNA SS, staff TT, UU, and CNA VV. The orientation training packet was included and signed by each staff for ANE, elopement response policy, elopement prevention policy, door alarms, and elopement drills training was completed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In interviews conducted on 4/24/25 starting at 11:27 p.m. to 4/25/25 at 12:22 a.m., 11 interviews of the night shift staff RN CC, LVN NN, LVN P, LVN DD, LVN Z, CNA X, CNA II, CNA S, CNA JJ, CNA R, and CNA U stated they had been trained on ANE, elopement response policy, elopement prevention policy, door alarms, and elopement drills and were able to state appropriate responses. During these interviews LVN NN, RN CC, CNA S, and CNA II stated they had been participants in elopement drills recently. Record review of the facility door alarm check log completed by MS or maintenance staff revealed they were completed daily on all wings on 2/17/25 through 2/24/25, 2/24/25 (different time) through- 2/27/25, 3/2/25, 3/10/25 through 3/14/25, 3/17/25 through 3/21/25, 3/24/25 through 3/28/25, 3/31/25 through 4/4/25, and 4/7/25 through 4/11/25. In an interview on 4/22/25 at 4:09 p.m. LVN E (6a-6p) stated she had been trained on ANE, elopement response policy, elopement prevention policy, door alarms, and elopement drills and was able to state appropriate responses. In interviews conducted on 4/23/24 starting at 10:30 a.m. to 11:20 a.m. staff from shifts (7a-3p)- AA, Q, OO, FF, W, EE (6a-6p)- BB, LVN KK (8a-5p)- HH, MM, RN V, RN LL, and Y all stated they had been trained on ANE, elopement response policy, elopement prevention policy, door alarms, and elopement drills and were able to state appropriate responses. In an interview on 4/23/25 at 10:03 a.m. RN I (6a-6p) stated she had been trained on ANE, elopement response policy, elopement prevention policy, door alarms, and elopement drills and was able to state appropriate responses. In an interview on 4/23/25 at 3:26 p.m. the SW (8a-5p) stated he had been trained on ANE, elopement response policy, elopement prevention policy, door alarms, and elopement drills and was able to state appropriate responses. In an interview on 4/23/25 at 5:10 p.m. CNA O (3p-11p) stated she had been trained on ANE, elopement response policy, elopement prevention policy, door alarms, and elopement drills and was able to state appropriate responses. In an interview on 4/24/25 at 11:43 a.m. staff M (8a-5p) stated she had been trained on ANE, elopement response policy, elopement prevention policy, door alarms, and elopement drills and was able to state appropriate responses. In an interview on 4/24/25 at 12:04 p.m. RN L (6a-6p) stated she had been trained on ANE, elopement response policy, elopement prevention policy, door alarms, and elopement drills and was able to state appropriate responses. In an interview on 4/24/25 at 12:15 p.m. CNA H (3p-11p) stated she had been trained on ANE, elopement response policy, elopement prevention policy, door alarms, and elopement drills and was able to state appropriate responses. In an interview on 4/24/25 at 12:50 p.m. LVN J (6a-6p) stated she had been trained on ANE, elopement response policy, elopement prevention policy, door alarms, and elopement drills and was able to state appropriate responses. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 4/24/25 at 1:15 p.m. CNA T (7a-3p) stated she had been trained on ANE, elopement response policy, elopement prevention policy, door alarms, and elopement drills and was able to state appropriate responses. In an interview on 4/24/25 at 3:30 p.m. CNA N (3p-11p) stated she had been trained on ANE, elopement response policy, elopement prevention policy, door alarms, and elopement drills and was able to state appropriate responses. In an interview on 4/25/25 at 11:22 a.m. LVN GG (6a-6p) stated she had been trained on ANE, elopement response policy, elopement prevention policy, door alarms, and elopement drills and was able to state appropriate responses.