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	08/18/2025

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 - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(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 - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown sources are reported immediately but not later than 2 hours to the administrator of the facility and to other officials, including to the State Survey Agency in accordance with State law through established procedures, for 1 of 1 Residents (Resident #1) reviewed for Neglect, in that: The facility did not report an allegation of Neglect to the State Survey Agency (HHSC) within the 2 hours time frame of Resident #1's elopement from the facility This deficient practice could affect any resident and could contribute to further neglect. The findings were: Review of Resident #'s 1 face sheet dated 8/17/25, revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included: multiple sclerosis (a condition in which nerve damage affects the communication between the brain and body), type 2 diabetes mellitus (a condition in which the body's blood sugar was not controlled), and unspecified dementia (a condition in which there is a decline in cognition). Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a blank BIMS score, indicating the resident could not complete the interview. The MDS revealed that Resident #1 was ambulatory and had wandering behavior. Record review of Resident # 1's care plan initiated on 1/16/25 revealed Resident #1 had an identified risk for elopement behavior. The interventions for elopement behavior included close supervision, reporting of risk factor such as wandering behavior and requests to leave the facility to the MD, and increased monitoring. The care plan for Resident #1 was updated on 8/16/25 to include the elopement incident. Record review of the facility incident report dated 8/16/25 revealed Resident #1 eloped from the facility at 5:10 am and that staff first learned of the incident at 7:30 am and a search on the secure unit was initiated with a Code Orange being called at 9:00 am. Record review of the e-mail notification by the Administrator of the elopement incident to the Complaint and Incident Intake Department revealed the notification was made on 8/16/25 at 7:00pm. During an interview with Family Member A on 8/17/25 at 8:00 am, Family Member A stated Resident #1 had gotten out of the facility's secure unit door shortly after 5:00 am on 8/16/25 and was not located until 2:30 pm on 8/16/25. Family Member A stated Resident #1 was found by family members inside of a closed car on a private residence that was one block from the facility. Family Member A stated Resident #1 was then transported to the hospital from this location. During an interview with hospital RN B on 8/17/25 at 9:10 am, hospital RN B stated Resident #1 had been admitted to the hospital on [DATE] with a diagnosis of heat stroke related to the elopement incident. Hospital RN B stated Resident #1 would be given IV fluids along with Magnesium, Potassium, and Electrolytes. During an interview on 8/18/25 at 8:40 am the Administrator stated he had e-mailed the initial report to the Complaint and Incident Intake Department of Resident #1's elopement from the facility on 8/16/25 at 7:00 pm. The Administrator stated he felt the notification report could be made once it was determined Resident #1 was safe and accounted for in a hospital setting. During an interview on 8/18/25 at 8:45 am the RN Compliance Nurse stated she thought the facility reporting time frame requirement for missing residents to the Complaint and Incident Intake Department was 24 hours. Record review of the Nursing Policy and Procedure Manual Section TG 03-1.0 titled, Abuse/Neglect that was undated, reflected, If the allegation involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation.

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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 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. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 1 of 1 residents (Resident #1) reviewed for accidents and supervision in that: The facility failed to supervise Resident #1 who eloped from the facility on 08/16/25 and was gone from the facility for more than nine hours and found in a closed car and had sustained a heat stroke. The non-compliance was identified as PNC. The Immediate Jeopardy (IJ) began on 08/16/2025 and ended on 08/16/2025. The facility had corrected the non-compliance before the survey began on 08/17/2025. This deficient practice could place residents who were elopement risks at-risk of harm, serious injury, or death. The findings included: Review of Resident's #1 face sheet, dated 8/17/25, revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included: multiple sclerosis (a condition in which nerve damage affects the communication between the brain and body), type 2 diabetes mellitus (a condition in which the body's blood sugar was not controlled), and unspecified dementia (a condition in which there is a decline in cognition). Record review of Resident #1's quarterly MDS assessment, dated 7/29/25, revealed a blank BIMS score, indicating the resident could not complete the interview. The MDS revealed that Resident #1 was ambulatory and had wandering behavior. Record review of Resident #1's elopement assessment, dated 1/16/25, revealed Resident #1 had the potential for wandering behavior and was at risk for elopement. Record review of Resident #1's care plan, initiated on 1/16/25, revealed Resident #1 had an identified risk for elopement behavior. The interventions for elopement behavior included close supervision, reporting of risk factor such as wandering behavior and requests to leave the facility to the MD, and increased monitoring. The care plan for Resident #1 was updated on 8/16/25 to include the elopement incident. Record review of Physician Order Summary, dated 8/16/25, revealed Resident #1 was taking Depakote Sprinkles 125 mg for (General Anxiety Disorder), Humalog SQ 100 unit/ML for (Diabetes Mellitus), Metformin HCl 500 MG for (Diabetes Mellitus) and Lantus SQ 300 unit for (Diabetes Mellitus). Record review of the facility incident report, dated 8/16/25, revealed Resident #1 eloped from the facility at 5:10 am and that staff first learned of the incident at 7:30 am and a search on the secure unit was initiated with a Code Orange being called at 9:00 am. Record review of the National Weather Service weather data (https://www.weather.gov/wrh/Climate?wfo=ewx) for 8/16/2025 revealed a high temperature that day of 98 degrees Fahrenheit. Record review of the employee statement from CNA P, dated 8/16/25, revealed she said she took out the trash on the secure unit side door shortly after 11:10 pm on 8/15/25 and made sure the door was locked. Record review of the employee statement from LVN B, dated 8/16/25, revealed he said he took out the trash on the morning of 8/16/25 thru the gate in the courtyard and made sure the courtyard gate was closed. The actual time in the morning was not specified on the statement. Observation of the facility's camera footage revealed Resident #1 exiting the secure unit thru the side door on 8/16/25 at 5:04 am and thru the courtyard gate at 5:10 am. Record review of the facility's actual elopement exercise for Resident #1 revealed the drill was initiated on 8/16/25 at 7:30 am and cleared at 2:55 pm. During an interview with Family Member A on 8/17/25 at 8:00 am, Family Member A stated Resident #1 had gotten out of the facility's secure unit door shortly after 5:00 am on 8/16/25 and was not located until 2:30 pm on 8/16/25. Family Member A stated Resident #1 was found by family members inside of a closed car on a private residence that was one block from the facility. Family Member A stated Resident #1 was then transported to the hospital from this location. Family Member A stated Resident #1 would be returned to the same nursing home facility. During an interview with hospital RN B on 8/17/25 at 9:00 am, hospital RN B stated Resident #1 was admitted to the hospital with a diagnosis of heat stroke. Hospital RN B stated Resident #1 would be given IV fluids along with Magnesium, Potassium, and Electrolytes. During an interview with Resident #1 on 8/17/25 at 9:10 am at her hospital room she stated she did not know where she was currently at or what had happened to her on 8/16/25. During an interview with Family Member C on 8/17/25 at 9:15 am, Family Member C stated she was told by the facility administrator that the side door on the secure unit apparently had a malfunction in its locking mechanism which allowed for Resident #1 to be able to leave the facility. Family Member C stated she was told by the Administrator the cameras on the secure unit were not fully operational at the time of Resident #1's elopement on 08/16/25. Family Member C stated Resident #1 would be returning to the same nursing facility upon hospital discharge. Record review of the facility's staff checklist in-service log dated 8/16/25 revealed