

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/17/2026
NAME OF PROVIDER OR SUPPLIER Normandy Terrace Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 841 Rice Road 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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives for 1 of 3 residents (Resident #2) reviewed for death. The facility failed to provide immediate basic life support interventions for Resident #2 upon finding Resident #2 unresponsive on [DATE], and Resident #2 was declared deceased on [DATE]. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 5:33 PM. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of actual harm because Resident #2 expired, and the facility needed to evaluate training outcomes. Failure to provide basic life support to residents requiring emergency care could lead to death. Findings included: Record review of Resident #2's admission Record dated [DATE] reflected a [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE]. Relevant diagnoses included tracheostomy [an artificial opening in the airway to allow for oxygenation] status. Record review of Resident #2's MDS submitted [DATE] reflected Resident #2 had expired in the facility. Record review of Resident #2's progress notes reflected the following documentation from RN AB dated [DATE] at 7:24 AM: At approximately 0400hrs, resident was found in prone position [face down] on fall mat. Resident was unresponsive to verbal and painful stimuli. Resident repositioned to supine and found to have absent lung sounds and heartbeat. CPR was initiated and code blue initiated. At 0407 fire department arrived and took over CPR. Unable to revive resident after exhausting all efforts, time of death was called at 0426am by EMS and [EMS MD] on phone. [Police department] was contacted by EMS and arrived shortly thereafter. After initial [sic] [Police Department] investigation and confering [sic] with the M.E., the decision was made to end the investigation citing resident past medical history. Family member was notified at 0600 hrs, spoke to [family member] who stated funeral arrangements would be through [funeral home]. Resident was transferred [sic] to bed, bed bath provided, and family enroute to visit. Record review of document EMS Run Report dated [DATE] at 3:59 AM reflected EMS was notified of cardiac arrest by the facility and arrived at 4:10 AM, and the resident was already receiving CPR from an additional fire department team who arrived several minutes earlier. The documentation reflected the facility staff could not relay a time at which Resident #2 was last seen at her baseline status. The documentation also reflected Resident #2's jaw showed signs of rigor [the natural stiffening of muscles that happens hours after death] when EMS attempted to place an artificial airway in Resident #2's mouth, and that Resident #2's body was very cold to the touch. In an interview with CNA AJ on [DATE] at 7:41 AM, he said he rounded on resident at approximately 11:00 PM on [DATE] and again at an unknown time after 3:00 AM on [DATE]. He said he noticed Resident #2's bed looked (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to, based on the comprehensive assessment of a resident, ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 4 residents (Resident #1) reviewed for quality of care. The facility failed to identify and address Resident #1's fall with injury appropriately, leaving Resident #1 with a fractured hip for over 24 hours without treatment. An Immediate Jeopardy (IJ) situation was Identified on 07/13/2026. While the IJ was removed on 07/13/2026 the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of corrective systems. This failure could place residents at risk for unrecognized issues, including injury, and could result in uncontrolled pain, loss of the residents' highest practicable well-being, or death. The findings included: Record review of Resident #1's admission Record, dated 07/11/2026, revealed an [AGE] year-old female who admitted to the facility on [DATE], with diagnoses which included: age-related osteoporosis (occurs when bone breakdown outpaces bone growth as you age, leading to brittle, porous bones), encounter for orthopedic aftercare (a scheduled medical visit for recovery, therapy, or ongoing management following a musculoskeletal procedure), rheumatoid arthritis (a chronic autoimmune disorder where the immune system mistakenly attacks the lining of your joints), and dementia (an umbrella term for a decline in cognitive abilities-such as memory, thinking, and reasoning-severe enough to interfere with daily life). Record review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS score of 02, which indicated severe cognitive impairment. The resident was dependent for both bed mobility and transferring as well as having had falls since admission. Record review of Resident #1's Care Plan, dated 07/01/2026, revealed the resident was a fall risk, with multiple falls since admission to the facility. Resident #1 had, staff x1 to assist with transfers, initiated on 10/07/2025; ?requires total assist x2 staff for transfers initiated 02/27/2026; and, Hoyer lift for transfers, initiated on 03/09/2026. Record review of Resident #1's Kardex, dated 07/12/2026, revealed, Staff x1 to assist with transfers, Hoyer lift for transfers, and requires total assist x2 staff for transfers. Record review of Resident #1's MAR, dated 07/12/2026, revealed no pain medication was administered to Resident #1 after the fall on 07/06/2026. Record review of Resident #1's Progress Notes, dated 07/11/2026, revealed late entry on 07/06/2026 at 8:55 PM entered by ADON C for the resident's fall. ADON C documented Resident #1, was seen to have slipped from her chair while attempting to self-propel using a nearby banister. ADON C further documented Resident #1 had stated, leave me alone, and no, when staff attempted to lift her into her wheelchair. ADON C documented MD/NP notification on 07/06/2026 at 3:00 PM and RP notification on 07/06/2026 also at 3:00 PM. The next note in Resident #1's Progress Notes was on 07/07/2026 at 5:23 AM, LVN K documented, resident showing c/o pain to left hip shouts out and or facial grimace if left hip is touched, Resident #1 was, often confused unable to ascertain verbal pain contacted [NAME] physicians spoke to NP orders to x-ray left hip 2 views along with orders for Tylenol 650mg q 6 hrs for pain resident RP no answer left message to contact facility for patient update. prn Tylenol for pain administered. Following note documented 07/07/2026 at 4:59 PM revealed, resident noted to have fall yesterday on dayshift. Night nurse reported to NP, orders given for bilat Hip x-ray. Results showing fracture- order to send out to hospital, and PRN tramadol every 8 hours for 14 days. Progress Notes on 07/07/2026 at 5:09 PM revealed called place to ambulance company for transport with ETA of 6:30 PM to send out via stretcher. Record review of hospital (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	discharge paperwork, dated 07/10/2026, revealed on 07/09/2026 Resident #1 had a surgical procedure related to acute intertrochanteric left hip fracture with impaction and angulation. Fracture treated with left femur cephalomedullary nail. Post-op instructions revealed orders for weight bearing as tolerated with a walker, a follow-up with orthopedic physician 2 weeks after discharge, and to keep dressing dry and intact. 393 During an interview on 07/11/2026 at 1:47 PM, MA B revealed she was on B hall on 07/06/2026 and responded to Resident #1's fall after a staff member notified her of the resident being found on the floor in the main dining room. MA B stated she believed the fall happened just before dinner and MA B arrived before the nurses and started collecting vital signs. MA B stated when staff were attempting to get Resident #1 up from the floor the resident did not want to be touched nor could she answer any questions. MA B stated Resident #1 was yelling, Stop don't do that. MA B stated ADON C was the Charge Nurse over both A and B halls on 07/06/2026. During an interview on 07/11/2026 at 1:54 PM, CNA A revealed she usually worked B hall and was on shift the day of Resident #1's fall. CNA A stated she believed Resident #1 fell before dinner. CNA A stated Resident #1 was lying flat on her back and breathing heavily but did not say she was in pain. CNA A stated she did not remember Resident #1 responding when she was lifted into her wheelchair. CNA A stated the nurses treated Resident #1 pretty much like, pick her up and put her in bed. CNA A stated the DON told her to pick up Resident #1 and put her in her chair, along with a couple of other staff, and that she, CNA A, did not see anyone get vital signs on the resident. CNA A stated Resident #1 was an assist x1 staff member, CNA A stated she put the resident back to bed by herself. CNA A said Resident #1 was changed on shift and she did not notice anything different with changing her. During an interview on 07/11/2026 at 3:31 PM, LVN K stated he came onto shift at 6:00 PM and received no shift report from ADON C or DON. LVNK stated CNA N came and told him Resident #1 looked to be in pain and something was not right. LVN K stated he went to the resident's room and did a head-to-toe assessment and found the resident's left hip to be tender to touch. LVN K stated he contacted ADON D, called the NP, who told him she was not previously notified of the fall, and Tylenol and x-rays were ordered. LVN K stated an incident in the Risk Management System had been initiated, however it was empty, with no information in it. LVN K further stated that on 07/06/2026 at 6:00 PM when he came onto shift there was no documentation related to a fall during ADON C's shift for Resident #1. During an interview on 07/11/2026 at 2:10 PM, MA F stated she was on shift for Resident #1's fall, however ADON C directed MA F to stay on the hall and not leave it and to call ADON C with any issues. MA F stated ADON C was covering both the A and B halls as the charge nurse. MA F stated ADON C, when covering both halls, stayed on A hall and directed the MA to manage the floor unless there was an emergency or major issue. MA F stated ADON C told her she was going to get Resident #1 something to, calm her down, and she was going to, handle the situation. MA F stated ADON C was aware Resident #1 was hurting but only wanted to give the resident something for agitation, not pain. MA F stated ADON C said, not to tell the next shift. MA F stated she worked with Resident #1 at their sister facility and she was never a problem. MA F stated ADON D expressed frustration to her about ADON C, and stated ADON C never documented or did what she was supposed to do. During an interview on 07/11/2026 at 2:57 PM, ADON D revealed she was off on 07/06/2026, but had returned to the facility on [DATE]. ADON D stated LVN K called her on 07/07/2026 at around 5:00 AM to ask if Resident #1 had a fall the previous day on 07/06/2026. ADON D stated she reached out in the management group chat and learned Resident #1 had a fall on 07/06/2026 around 3:00 PM. LVN K stated he notified the NP about the change in residents' condition, and the NP told him she was not previously aware of the resident's fall. The NP ordered Tylenol and x-rays. ADON D stated when the results for the x-ray came back with a fracture, the NP ordered the resident to be sent out to the hospital. ADON D stated if (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 was resistant to care while lying on the floor or while the staff lifted her back into her wheelchair, it may have been due to pain. ADON D stated in their group chat, ADON C stated she notified the NP and the RP of the fall and after confronting her in the chat ADON C then changed her comment to that she must have forgotten to call right after the fall due to being so busy. During an interview on 07/11/2026 at 3:56 PM, Resident #1's Responsible Party, RP, stated she did not receive a call on 07/06/2026 regarding a fall. The RP stated she received a call on 07/07/2026 around 5:30 AM or so stating they were requesting x-rays due to pain. The RP stated she spoke with a female nurse, whose name she could not recall, who stated she was not assigned to Resident #1 but wanted to let her know the resident was being sent out to the hospital regarding her x-ray results. During an interview on 07/11/2026 at 4:15 PM, the DON and the ADMIN stated after watching the camera footage of the fall Resident #1 had, for that camera angle, was hard to determine if she fell out of her wheelchair versus sliding out of her wheelchair. The ADMIN and the DON both stated the two residents who had claimed to see the fall were not in the main dining room when the fall happened. The DON stated a nurse's note should have been completed as soon as possible and that 5 hours after the fall was too long. The ADMIN stated her expectation was that falls and other incidents were documented in chart as quick as possible. During an observation on 07/11/2026 at 4:15 PM, revealed camera footage from the main dining room showed Resident #1 in the main dining room with several unknown residents. The unknown residents were not facing Resident #1 in the camera footage. Resident #1 was observed attempting to ambulate self in the wheelchair towards a pillar in the middle of the dining room. Resident #1 was observed falling forward onto floor and the camera angle showed no staff. Resident #1's fall occurred at 3:15 PM on 07/06/2026. Two staff were observed entering the main dining room from different areas and then leaving, together, to get help. The two staff members were observed re-entering the main dining room and crossing the space, passing Resident #1 on the floor, and exiting the other side of the main dining room, together. An unknown kitchen aide was observed entering the main dining room and stood with Resident #1 while appearing to turn back towards the kitchen with hands at their mouth. MA B was observed entering the main dining room immediately after unknown kitchen aide puts hands at their mouth and appeared to call out. MA B was observed standing over Resident #1 for a second before reaching down to obtain vital signs. The DON was observed entering the main dining room with one of the two staff that left together previously in the camera footage. The DON stood over Resident #1 for a minute and then leaned over her. Staff lifted Resident #1 into wheelchairs shortly after the DON leaning over Resident #1. The two residents who claimed to have witnessed the fall were not observed in the camera footage. During an interview on 07/12/2026 at 10:22 AM, the ADMIN, DON and ADON C all stated any incident should be reported to the family and MD/NP immediately as best practice. The ADMIN, DON and ADON C stated two residents who witnessed the fall in the main dining room shared that Resident #1 slid off of her wheelchair. The ADMIN, DON and ADON C stated there were no witness statements from the residents who witnessed the fall, that was just shared with them verbally, but they stated the statements being given should have been documented in Resident #1's chart. The DON stated one of the witnessing residents stopped her in hall after the incident, around 4-4:30 PM, to tell her they saw Resident #1 trying to self-ambulate towards a pillar in her wheelchair. The ADMIN, DON, and ADON C could not recall who claimed to have spoken to the other witness for the incident, or how the other resident was involved. During an interview on 07/12/2026 at 11:00 AM, the ADMIN stated that the new camera angle showed Resident #1's fall better and you could see the resident fall from her wheelchair onto her left hip before laying on her side and then onto her back. During an observation on 07/12/2026 at 11:00 AM, the camera footage revealed Resident #1 was observed attempting to (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(IJ) on 07/13/2026 at 5:38 PM. The ADMIN was notified and provided with the IJ template on 07/13/2026 at 5:38 PM. The following Plan Of Removal was submitted by the facility and was accepted on 07/15/2026 at 2:25 PM. Facility:Date: 7/13/26Plan of RemovalF684 Quality of Care Interventions:Resident #1 was assessed by the DON for any further injuries or pain from fall on 7/6/26. No additional injuries or pain were noted. The assessment was documented in PCC. Completed 7/12/26.An audit of all residents who experienced a fall within the previous 30 days was completed by the Regional Compliance Nurse, DON, and ADON to ensure all incident reports, post fall assessments, neuro checks, and notifications to physician and responsible party were completed per facility policy. Completed 7/13/26.New Process: Effective immediately, the Administrator and DON (or designee) will be notified of all resident falls prior to the end of each shift. The DON or designee will review each fall to verify completion of the incident report, post-fall assessments, head-to-toe assessment, pain assessment, neurological assessments (when indicated), physician and responsible party notifications, and implementation of appropriate interventions. Any resident that complains of pain post fall will be sent to the emergency room to prevent a delay in treatment per MD orders. All residents' falls will be reviewed each morning during the clinical meeting to ensure all required documentation, notifications, physician orders, follow-up evaluations, care plan revisions, and interventions have been completed. Any identified concerns or deficiencies will be addressed immediately by the DON or designee. Completed 7/13/26The Administrator and DON were 1:1 in-serviced on the following by the Regional Compliance Nurse and Area Director of Operations. Completed 7/13/26.Abuse and Neglect Policy in-service will be provided to all staff to include that failure to timely assess a resident following a fall, delay in notifying the physician or responsible party, delay in obtaining treatment, or failure to implement physician orders may constitute neglect.Fall Prevention Policy in-service will be provided to all staff including documentation to be conducted after a fall to include the incident report, post fall assessment, head to toe assessment, neurological assessment, and pain assessment per policy.Neurological Assessment Policy in-service will be provided to all nurses- neurological assessments will be completed for all residents who experience an unwitnessed fall or a fall that results in the residents hitting their head or face area.Notification of Change in Condition in-service to be provided to all nurses to include notifying the physician immediately for signs and symptoms of a fracture, pain or injury after a fall for subsequent orders. All residents who complain of pain post fall will be sent to the emergency room to prevent a delay in treatment per MD orders. Also notifying the responsible party immediately after a change in condition and a fall.Shift to Shift Communication Expectations in-services to be provided to all nurses and CNAs to include any resident who experiences a fall will be included in shift-to-shift report for a minimum of 72 hours. The off-going licensed nurse will communicate the details of the fall, resident assessment, physician and responsible party notifications, pending diagnostic testing, current interventions, neuro checks (when indicated), pain status, and any changes in the resident's condition. The oncoming licensed nurse will acknowledge receipt of the report and assume responsibility for continued monitoring and completion of any outstanding interventions. The nurses will use the 24hr report in PCC for communication.5. Admin/designee will complete 10-15 abuse surveys for staff 5 days weeks x 4 weeks.6. Admin/designee will complete 10-15 abuse surveys for residents 5 days weeks x 4 weeks.7. The Medical Director was notified of the Immediate Jeopardy Citation on 7/13/26 by the Director of Nursing.8. An ADHOC QAPI meeting was conducted with the IDT Team and Medical Director to discuss the immediate jeopardy and plan of removal. Complete 7/13/26. In-servicesThe following in-services were initiated by Administrator, Regional Compliance Nurse, ADO, DON, and ADON to all staff. All staff not present or in-serviced as of 7/12/26 will not be (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	allowed to assume their duties until in-serviced. All new hires will be in-serviced during orientation. All PRN, agency staff, or staff on leave will in serviced prior to assuming their next assignment. A post-test will be provided to all staff to verify retention of education. Completion date 7/13/26. Abuse and Neglect Policy in-service will be provided to all staff to include that failure to timely assess a resident following a fall, delay in notifying the physician or responsible party, delay in obtaining treatment, or failure to implement physician orders may constitute neglect.Fall Prevention Policy in-service will be provided to all staff including documentation to be conducted after a fall to include the incident report, post fall assessment, head to toe assessment, neurological assessment, and pain assessment per policy.Neurological Assessment Policy in-service will be provided to all nurses-neurological assessments will be completed for all residents who experience an unwitnessed fall or a fall that results in the resident hitting their head or face area.Notification of Change in Condition in-service to be provided to all nurses to include notifying the physician immediately for signs and symptoms of a fracture, pain or injury after a fall for subsequent orders. All residents who complain of pain post fall will be sent to the emergency room to prevent a delay in treatment per MD orders. Also notifying the responsible party immediately after a change in condition and a fall.Shift to Shift Communication Expectations in-services to be provided to all nurses and CNAs to include any resident who experiences a fall will be included in shift-to-shift report for a minimum of 72 hours. The off-going licensed nurse will communicate the details of the fall, resident assessment, physician and responsible party notifications, pending diagnostic testing, current interventions, neuro checks (when indicated), pain status, and any changes in the resident's condition. The oncoming licensed nurse will acknowledge receipt of the report and assume responsibility for continued monitoring and completion of any outstanding interventions. The nurses will use the 24hr report in PCC for communication Monitoring:DON/DESIGNEE WILL VERIFY SHIFT TO SHIFT REPORT COMPLETED PER PCC 24 HR REPORT DAILY IN STAND UP BY ENSURING NURSES SIGN OFF ON 24 HR REPORT.DON/DESIGNEE WILL VERIFY CAN SHIFT TO SHIFT REPORT DAILY IN STAND UP BY ENSURING CNAS SIGN SHIFT TO SHIFT REPORT LOG.DON/DESIGNEES WILL REVIEW RISK MANAGEMENT DAILY IN STAND UP TO ENSURE REPORT IS COMPLETED TIMELY.DON/DESIGNEE WILL REVIEW ALL EVENTS IN RISK MANAGEMENT IN STAND UP TO ENSURE POST FALL FOLLOW UP/NEUROS ARE COMPLETED.DON/DESIGNEE WILL REVIEW ALL EVENTS IN RISK MANAGEMNT IN STAND UP TO ENSURE S/SX OF PAIN WAS ASSESSED AND TRANFERED TO ER FOR FURTHER EVALUATION. Verification of the POR was as follows: Record reviews as follows:a. Record review assessment had revealed post-fall assessment for Resident #1 dated 7/6/2026 at 8:55. No other assessments were entered into PCC until 07/12/2026 when staff asked about re-admission documentation. b. Record review 30-day incident report/assessments had revealed undated print out from PCC under Risk Management listing falls within facility from 6.9.2026 to current 07/15/2026. Initials on sheets from DON next to each listing is observed to show acknowledgement of the review by the facility. c. Record review of post in-service exams with questions identifying notification after falls effective immediately, to include the DON and the Administrator. The facility created a list to review the above listed documentation which includes halls and completion dates of 7.13.2026 and 7.14.2026. d. Record review of in-services dated 7/12/2026 titled Abuse Neglect Policy, Fall Prevention Policy, Neuro Assessment Policy, Notification/Change policy, shift to shift communication expectations were signed by the ADMIN and the DON. Record reviews of in-services titled ANE dated, 7/12/2026, revealed 112 of 119 staff signed acknowledgment of receipt. e. Record review of in-services, dated 07/12/2026, documented 112 of 119 staff members received the Fall Prevention in-service. f. Record review of in-services, dated 07/12/2026, documented 27 nursing employees received the Neurological (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Assessment In-service. g. Record review of in-services, dated 07/12/2026, documented 27 nursing employees received the Notification of Change of Condition In-service. h. Record review of in-services, dated 07/12/2026, documented 27 nursing employees received the Shift to Shift 24-hour report In-service. i. Record review of the completion of the staff abuse surveys for 15 staff members was completed on 7.13.2026, no findings. j. Record review of the completion of the resident abuse surveys for 35 residents within the facility was completed 7.14.2026. k. Record review of the QAPI sign-in sheet, dated 7/12/2026, revealed the MD signature along with the ADMIN, DON, and other members of the management team. l. Record review of the completion of the QAPI/ADHOC meeting completed and was signed on 7.13.2026. Notes of Meeting revealed a system failure identified during abbreviated self-report survey, which resulted in an immediate need for review for this system. The action plan created due to facility failure to ensure Resident #1 had received the necessary care post unwitnessed fall, that resulted in hip fracture. Interviews are as follows: a. Interview with the DON and ADMIN regarding Intervention 1 was as follows: They assessed for pain as well as asked her, Resident #1 had dermabond to surgical site and was in good spirits. This information was documented in clinical system. No other assessment was entered into clinical system, to include re-admission from hospital on [DATE], until staff was asked about missing documentation. b. Interview with the DON and the ADMIN regarding Intervention 2 was as follows: They looked back at Risk Management for the last 30 days to make sure the event notes were there, post assessments were completed, notifications were completed, and pain was identified. They did follow up if something was missing, and now in-services should be a cleaner and smoother process. c. Interview with the DON on 7/14/2026 at 12:45 PM regarding Intervention 3 was as foll		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 of 6 residents (Residents #2 and Resident #4), and the facility failed to ensure that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled for 5 of 5 medication carts (B Hall Carts #1, #2, and #3; A Hall Cart, and C Hall Cart) reviewed for pharmacy services. The facility failed to ensure Resident #4 received ordered insulin on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE].The facility failed to ensure Resident #2 received ordered medications on [DATE] after admission to the facility on the evening of [DATE].The facility failed to ensure narcotics logs were maintained and reconciled on B Hall Carts #1, #2, and #3; A Hall Cart; and C Hall Cart. These failures could lead to residents not receiving ordered medication, residents not receiving the intended therapeutic effect of medications, or the loss or misappropriation of residents' narcotic medications. Findings included: Record review of Resident #4's admission Record, dated [DATE], revealed an [AGE] year-old female, admitted [DATE], with diagnoses that included: Type 2 Diabetes (a chronic condition where your body resists insulin or doesn't make enough of it, causing blood sugar levels to spike), Cognitive communication deficit (an impaired ability to speak, listen, read, or write caused by disrupted thinking skills&mdash;such as attention, memory, and executive function&mdash;rather than a physical speech issue) and dementia (an umbrella term for a decline in cognitive abilities&mdash;such as memory, thinking, and reasoning&mdash;severe enough to interfere with daily life). Recorder review of Resident #4's Quarterly MDS, dated [DATE], revealed a BIMS score of 00, indicating severe cognitive impairment. Record review of Resident #4's Care Plan, dated [DATE], revealed the resident had diabetes mellitus that require insulin administration and was a wander-risk. Record review of Resident #4's MAR, dated [DATE], revealed that on: -[DATE] no documentation indicating administration of 18 units of insulin being administered on the overnight shift -[DATE] no documentation indicating administration of 18 units of insulin being administered on the overnight shift -[DATE] no documentation indicating administration of 8 units of insulin being administered on the day shift (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-[DATE] no documentation indicating administration of 8 units of insulin being administered on the day shift -[DATE] no documentation indicating administration of 8 units of insulin being administered on the day shift -[DATE] no documentation indicating administration of 18 units of insulin being administered on the overnight shift -[DATE] no documentation indicating administration of 8 units of insulin being administered on the day shift -[DATE] no documentation indicating administration of 8 units of insulin being administered on the day shift Record review of Resident #4's Order Summary Report, dated [DATE], revealed that Resident #4 had an order for Insulin Glargine Solution 100 UNIT/ML Inject 18 unit subcutaneously one time a day in the evening for diabetes, and an order for Insulin Glargine Solution 100 UNIT/ML Inject 8 unit subcutaneously one time a day in the morning for diabetes. Record review of Resident #4's Progress Notes, dated [DATE], revealed no documentation pertaining to the missed doses of insulin. Progress Notes also revealed no hypo or hyperglycemic incidents for the resident around the times of missed insulin doses. During an interview on [DATE] at 4:15 PM, the DON revealed that she is unsure why the insulin was not documented on the MAR for the resident. The DON stated that she believed that ADON C was covering the unit those days. The facility expectation is that all medications are administered, documented that they are administered, or it is documented why the medications could not be administered. The DON stated that failure to receive insulin could result in negative outcome to the resident. Attempted to contact ADON C on [DATE] at 3:50 PM, [DATE] at 4:45 PM, and again on [DATE] at 5:15 PM. Review of facility Documentation Policy, undated, revealed that the facility will ensure that information is comprehensive and timely. Policy also revealed that documentation is to be completed in timely manner in the clinical record. Review of facility Medication Administration Policy, undated, revealed that all medications are to be documented in clinical record by right medication, right time, right dose, right route, and right documentation. Policy revealed that medication 2. Record review of Resident #2's admission Record dated [DATE] reflected a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included end stage renal disease [severe kidney disease] and dependence on renal dialysis [artificial filtering of the blood by machine]. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's MDS dated [DATE] reflected Resident #2 expired at the facility. The admission MDS was in progress status during the survey. Record review of Resident #2's Order Summary Report dated [DATE] reflected the following orders: -Coreg Oral Tablet 3.125 MG (Carvedilol) Give 1 tablet by mouth two times a day for Hypertension [sic] [high blood pressure] HOLD [sic] if SBP less than 110 and/or HR: [sic] less than 60 Start Date [DATE] -Hydroxyzine HCl Tablet 25 MG Give 1 tablet by mouth every 8 hours for itching Start Date [DATE] -Lisinopril Tablet 2.5 MG Give 1 tablet by mouth one time a day for hypertension Hold [sic] for SBP less than 110/DBP less than 60/HR less than 60 Start Date [DATE] -Plavix Oral Tablet 75 MG (Clopidogrel Bisulfate) Give 1 tablet by mouth one time a day for prevent clot formation [sic] Start Date [DATE] Record review of Resident #2's MAR for [DATE] dated [DATE] reflected code UN was used by staff to indicate UNAVAILABLE (Contact the DON/ADON), and code 9 was used to indicate Other/ See Nurse Notes. The following was documented by facility staff for [DATE]: -Lisinopril Tablet 2.5 MG, code UN for morning administration documented by MA AM -Plavix Oral Tablet 75 MG, code UN for morning administration documented by MA AM -Coreg Oral Tablet 3.125 MG, code UN for morning administration documented by MA AM -Coreg Oral Tablet 3.125 MG, code UN for evening administration documented by MA AM -Hydroxyzine HCl Tablet 25 MG, code 9 documented by RN AB for 6:00 AM administration -Hydroxyzine HCl Tablet 25 MG, code UN documented by MA AM for 2:00 PM administration -Hydroxyzine HCl Tablet 25 MG, code 9 documented by RN AB for 9:00 PM administration Record review of Resident #2's progress notes did not reveal documentation from [DATE] associated with the above listed medications not administered for code 9. In an interview on [DATE] at 9:17 AM, RN AB said Resident #2 admitted to the facility on [DATE] and her medications had not yet arrived when he worked night shift on [DATE]. He said he was told by the day shift nurses that Resident #2's medication had not yet arrived and could not be taken from the emergency kit because nobody had access. He was unsure which nurse reported this to him. He said he was unsure what the facility policy was for obtaining medications for residents that are not in stock, and he said he attempted to borrow the medications from other residents' stock but was unsuccessful because he couldn't locate other residents with the same prescriptions. He said he did (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not have access to the facility's emergency medication storage, and he did not attempt to contact the ADON or DON because he was busy. He said he did not contact the physician to notify him/her that Resident #2 had not received her scheduled medications that day. In an interview with MA AM on [DATE] at 3:25 PM, she said she was not responsible for administering medications to Resident #2 on [DATE] because Resident #2 had a tracheostomy, so the nurse had to administer the medications. She said she signed off the medications for that shift because they appeared on her MAR task list, but she had told the nurse of the need for administration prior to signing them. She was unsure if the medications were available for administration, and she was unsure which nurse she told. In an interview with the DON on [DATE] at 10:36 AM, she said the staff should have informed her immediately that Resident #2's medication had not arrived in time for scheduled administration on [DATE]. She said she was unaware that the staff were unable to give Resident #2 her scheduled medications that day, and the medications could have been pulled from the emergency kit. She said RN AB did not have access to the emergency kit, but there was always at least one nurse during every shift who was able to log into the system to obtain medications. She said the facility policy included never using one resident's medication to administer to another resident, and the medication policies were covered with staff during orientation. She said there is not a document verifying that staff receive medication ordering and emergency medication retrieval during orientation. Record review of the facility policy titled Medication Administration and General Guidelines dated 2025, reflected the following: . 12. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g. resident not in facility at scheduled dose time, initial dose of antibiotic), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN documentation. The physician must be notified when a dose of medication has not been given. If an electronic medical record is being utilized than the caregiver administering the medication will enter the correct documentation that will then be electronically date/time stamped with their initials. 13. Medications supplied for one resident are never administered to another resident . A policy regarding medication ordering/ re-ordering was requested from the facility, and the facility provided a document titled Ordering and Receiving Medications from Non-Contracted Pharmacy dated 2025. Record review of this document did not reveal policy or procedure related to admission medication ordering or emergency medication supplies. 3. In an observation and record review on [DATE] at 12:22 PM, the medication cart for A Hall was observed to have a binder containing the reconciliation records for narcotic medication in the A Hall. Record review of the first page of the binder, titled Controlled Drugs- Audit Record dated [DATE] for Memory Care Station 1, reflected a form for two staff members to sign for each 12 hour shift period on a daily basis acknowledging the narcotic medications were reconciled. The following dates had incomplete documentation (4 shifts): -[DATE] 6:00 AM nurse on signature (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-[DATE] 6:00 AM nurse off signature -[DATE] 6:00 AM nurse on signature -[DATE] 6:00 PM nurse off signature In an observation on [DATE] at 12:26 PM, the medication cart for C Hall was also observed to have a binder containing narcotic medication reconciliation records. Record review of the first page of the binder, also titled Controlled Drugs- Audit Record dated [DATE] for Cart 1 Station C reflected 12 shifts from [DATE] through [DATE] in which the facility staff had not signed the form, including the following (13 total shifts): -[DATE] nurse off 6:00 AM -[DATE] nurse on 6:00 PM -[DATE] nurse on 6:00 AM -[DATE] nurse on 6:00 PM -[DATE] nurse on 6:00 AM -[DATE] nurse on 6:00 PM -[DATE] nurse on 6:00 AM -[DATE] nurse on and nurse off 6:00 AM -[DATE] nurse off 6:00 PM -[DATE] nurse on 6:00 AM -[DATE] nurse off 6:00 PM -[DATE] nurse on 6:00 AM -[DATE] nurse off 6:00 PM In an observation and interview on [DATE] at 1:49 PM, three medication carts located in the B hall were observed to also have binders containing narcotic medication reconciliation documents. The records contained in the binders were noted to have columns for three, eight-hour shifts, and the RDON said the facility did not utilize any MAs or nurses in eight-hour shifts during the month of [DATE]. He said the staff should have notated the correct shift start time and reconciled the cart with both staff members signing the form at the end/start of each 12-hour shift. (continued on next page)		

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Controlled Drugs-Audit Record dated [DATE] contained in B hall cart #1 reflected the record with three shift columns, as previously described. The following dates from [DATE] through [DATE] contained no signatures (16 total shifts): -[DATE] nurse on and nurse off for morning shift -[DATE] nurse off for evening shift -[DATE] nurse on for evening shift -[DATE] nurse off for morning shift -[DATE] nurse on for evening shift -[DATE] nurse off for morning shift -[DATE] nurse on for morning shift -[DATE] nurse on for morning shift -[DATE] nurse on and nurse off for evening shift -[DATE] nurse on and nurse off for evening shift -[DATE] nurse on and nurse off for morning shift -[DATE] nurse off for evening shift -[DATE] nurse off for morning shift -[DATE] nurse on for evening shift -[DATE] nurse off for morning shift -[DATE] nurse off for morning shift Record review of the Controlled Drugs-Audit Record dated [DATE] contained in B hall cart #2 reflected the record with three shift columns, as previously described. The following dates from [DATE] through [DATE] contained no signatures (2 total shifts): -[DATE] nurse off and nurse on for morning shift -[DATE] nurse off for evening shift Record review of the Controlled Drugs-Audit Record dated [DATE] contained in B hall cart #3 (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reflected the record with three shift columns, as previously described. The following dates from [DATE] through [DATE] contained no signatures (10 total shifts): -[DATE] nurse off morning shift -[DATE] nurse off evening shift -[DATE] nurse off and nurse on morning shift -[DATE] nurse on evening shift -[DATE] nurse off morning shift -[DATE] nurse off morning shift -[DATE] nurse on evening shift -[DATE] nurse off morning shift -[DATE] nurse off morning shift -[DATE] nurse off morning shift In an interview on [DATE] at 1:55 PM, LVN Y said she always signed the narcotic book and had signed the book for hall A that morning. She said not all staff followed the facility policy of reconciling the cart with two staff members, but she made sure to follow the procedure because she did not want to be responsible for any missing medications. In an interview with the DON on [DATE] at 3:00 PM, she said the facility policy was for the staff member whose shift was ending and the staff member arriving for shift to count the narcotic medications together and both sign the audit record. She said she was unaware the records for [DATE] were incomplete, and the ADONs were responsible for ensuring the logs were complete at the end of every month. She said not signing the logs could result in missing medications, but the facility had not had any instances of missing narcotics since she had assumed the position of DON in [DATE]. Record review of the facility policy titled Controlled Medications- Administration dated [DATE] reflected the following: .8. At each shift change, a physical inventory of all controlled medications is conducted by two licensed nurses and/or one nurse and a CMA, QMAP, Med Tech or equivalent as allowed by your State regulatory agency and documented on an audit record. Alternatively, the shift change audit may be recorded on the accountability record if there is a designated column for the audit. 9. Current controlled medication accountability records and audits records are kept on the medication card, either in the MAR or in a separate folder. When completed, audit and accountability records are submitted to the Director of Nursing and kept on file for three years at the facility .		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all alleged violations involving neglect are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation result in serious bodily injury for 1 of 6 residents (Resident #3) reviewed for neglect. The facility failed to report the unexpected death with signs of potential neglect for Resident #3. This failure could lead to lack of oversight and neglect of residents. Findings included: Record review of Resident #3's admission Record dated [DATE] reflected a [AGE] year-old male admitted to the facility on [DATE] and discharged on [DATE]. Relevant diagnoses included cerebral infarction, unspecified (interrupted blood flow to the brain causing brain damage). Record review of Resident #3's MDS dated [DATE] reflected Resident #3 expired at the facility. Record review of Resident #3's quarterly MDS dated [DATE] reflected a BIMS score of 13, which indicated intact cognition. Section J0100 reflected Resident #3 received a scheduled pain medication regimen. Section GG0115 reflected Resident #3 had impairment to one side of both upper and lower limbs. Section N0415 reflected Resident #3 was taking opioid medication. Record review of Resident #3's Order Summary Report dated [DATE] reflected the following orders: -fentaNYL [sic] Transdermal patch 72 Hour 25 MCG/HR (Fentanyl) Apply 25 mcg/hr transdermally [sic] [to skin] one time a day every 3 day(s) for pain and remove per schedule Start date [DATE] -HYDROcodone-Acetaminophen [sic] Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 8 hours for pain Start date [DATE] Record review of Resident #3's Care Plan Report undated/ printed [DATE], reflected the following: . Resident is a Full Code [sic] Date Initiated: [DATE] . and . The resident has a terminal prognosis and/or is receiving hospice services with [hospice provider] Date Initiated: [DATE] . Further record review of Resident #3's Care Plan Report did not reveal findings related to pain monitoring or pain medication. Record review of Resident #3's progress notes reflected the following documentation: -Progress note by LSW dated [DATE] 1:01 PM: SW contacted legal guardian to inform of incident where resident stated he was not receiving his pain medication but then resident proceeded to remove medication from his sock. Legal guardian was informed that staff has checked MAR and that resident is receiving his medications. Legal guardian states that he is concerned about this because of resident's past issues with substances. Legal guardian states he would prefer resident be put on a patch rather than oral tablets for his pain medication. SW to contact hospice for this request. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Progress note by RN AN dated [DATE] at 2:18 PM: This nurse was notified at 1326 [1:28 PM] resident was slumped over in his bed sitting at the side of the bed with visible blood at the mouth, this nurse entered the room [ROOM NUMBER] [1:28 PM] 911 services were called immediately for assistance in distress. Assistance was called for ADON, DON entered the room with crash cart resident was being suctioned when he was noted with no pulse and CPR was initiated immediately AED applied indicating no shock needed, 2 rounds of 2-minute CPR performed and then EMS arrived on seen and took over. Guardian and family were notified, MD was notified, Hospice was notified. TOD was called by EMS and [police department] @ 1357 [1:57 PM]. Police cleared resident for release to funeral home. Record review of Resident #3's Postmortem [after death] assessment dated [DATE] reflected Resident #3 was found unresponsive with no respirations or pulse while in bed. Resident #3 was pronounced and released to the funeral home on [DATE] at 5:00 PM. Record review of EMS Run Report dated [DATE] at 1:29 PM for Resident #3 reflected EMS was dispatched to the facility for reported cardiac arrest [heart not beating]. EMS performed advanced life-saving support interventions, including the administration of Naloxone (also known as narcan, a medication used to reverse the effects of opiate overdose). EMS documentation indicated the Naloxone had no effect, and the resident was unable to be resuscitated. Records from the police department were requested on [DATE] at 3:33 PM (reference number W804485-071626), but the request remained in progress as of [DATE]. In an interview with ADON D on [DATE] at 11:17 AM, she said she was present at the time Resident #3 was found unresponsive, and she was present when EMS and the police department declared Resident #3 deceased. She said the police department located a bag containing multiple pills on Resident #3's body that she identified as Resident #3's opiate pain medication. She said Resident #3 had also been discovered hiding opiate pain medication in his sock recently. She said she had notified the DON of both instances, but no investigation or action had occurred as a result of the notification. In an interview with the DON on [DATE] at 3:30 PM, she said she was aware of the incident in which Resident #3 was discovered to have hidden pain medication in his sock. She said the incident was brought to the attention of hospice, his legal guardian, and the IDT during a care plan meeting shortly after the incident. She said the determination was made to modify the pain regimen for safety and better pain control. She said she was unaware that additional pills were located on Resident #3's body after he died, and she did not feel Resident #3's death was suspicious or required reporting to the SSA because the police department had released Resident #3's body for funeral arrangements and not required an autopsy. She said she did not suspect Resident #3 had died as a result of overdose. In an interview with the ADM on [DATE] at 3:30 PM, she said she was not told by staff that Resident #3 had been in possession of suspected narcotics at the time he died. She said she had not reported Resident #3's death to the SSA because he was on hospice and because the police had released his remains without requiring an autopsy. In an interview with CNA A on [DATE] at 6:24 PM, she said she brought Resident #3 coffee at lunch (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 07/17/2026
NAME OF PROVIDER OR SUPPLIER Normandy Terrace Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 841 Rice Road 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.			
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time on [DATE], at which time he was acting normally. She said she found him unresponsive with blood near his nose approximately 10 minutes later. She said he displayed signs of an overdose, including drooling and a slumped position. She said she immediately notified the nurse that Resident #3 was unresponsive and looked like he had overdosed, and the nurse responded right away. She said she observed a bag of pills discovered on Resident #3's body by the police department after he died. In an interview with the MD on [DATE] at 9:10 PM, he said he was aware Resident #3 had expired and that he had been found with pills. He said he did not suspect Resident #3 died of an overdose because the Narcan was ineffective, and he suspected Resident #3 died from a heart attack. Record review of the facility's policy titled, Abuse/Neglect, undated, revealed Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. If an allegation involves serious bodily injury, the reporting of incident should be made within 2 hours of the allegation. Further review revealed, E. Reporting . 3. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 2024-14 dated [DATE] .		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure, in response to allegations neglect, have evidence that all alleged violations are thoroughly investigated for 2 of 6 residents (Residents #2 and #3) reviewed for neglect. The facility failed to have evidence of investigation into the unexpected death with signs of potential neglect for Resident #3. The facility failed to have evidence of thorough investigation of the unexpected death with signs of potential neglect for Resident #2. These failures could lead to lack of oversight and/or neglect of residents. Findings included: 1. Record review of Resident #3's admission Record dated [DATE] reflected a [AGE] year-old male admitted to the facility on [DATE] and discharged on [DATE]. Relevant diagnoses included cerebral infarction, unspecified (interrupted blood flow to the brain causing brain damage). Record review of Resident #3's MDS dated [DATE] reflected Resident #3 expired at the facility. Record review of Resident #3's quarterly MDS dated [DATE] reflected a BIMS score of 13, which indicated intact cognition. Section J0100 reflected Resident #3 received a scheduled pain medication regimen. Section N0415 reflected Resident #3 was taking opioid medication. Record review of Resident #3's Order Summary Report dated [DATE] reflected the following orders: -fentaNYL [sic] Transdermal patch 72 Hour 25 MCG/HR (Fentanyl) Apply 25 mcg/hr transdermally [sic] [to skin] one time a day every 3 day(s) for pain and remove per schedule Start date [DATE] -HYDROcodone-Acetaminophen [sic] Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 8 hours for pain Start date [DATE] Record review of Resident #3's Care Plan Report undated/ printed [DATE], reflected the following: . Resident is a Full Code [sic] Date Initiated: [DATE] . and . The resident has a terminal prognosis and/or is receiving hospice services with [hospice provider] Date Initiated: [DATE] . Further record review of Resident #3's Care Plan Report did not reveal findings related to pain monitoring or pain medication. Record review of Resident #3's progress notes reflected the following documentation: -LSW dated [DATE] 1:01 PM: SW contacted legal guardian to inform of incident where resident stated he was not receiving his pain medication but then resident proceeded to remove medication from his sock. Legal guardian was informed that staff has checked MAR and that resident is receiving his medications. Legal guardian states that he is concerned about this because of resident's past issues with substances. Legal guardian states he would prefer resident be put on a patch rather than oral tablets for his pain medication. SW to contact hospice for this request. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-RN AN dated [DATE] at 2:18 PM: This nurse was notified at 1326 resident was slumped over in his bed sitting at the side of the bed with visible blood at the mouth, this nurse entered the room [ROOM NUMBER] [1:28 PM] 911 services were called immediately for assistance in distress. Assistance was called for ADON, DON entered the room with crash cart resident was being suctioned when he was noted with no pulse and CPR was initiated immediately AED applied indicating no shock needed, 2 rounds of 2-minute CPR performed and then EMS arrived on seen and took over. Guardian and family were notified, MD was notified, Hospice was notified. TOD was called by EMS and [police department] @ 1357 [1:57 PM]. Police cleared resident for release to funeral home. In an interview with ADON D on [DATE] at 11:17 AM, she said she was present at the time Resident #3 was found unresponsive, and she was present when EMS and the police department declared Resident #3 deceased. She said the police department located a bag containing multiple pills on Resident #3's body that she identified as Resident #3's opiate pain medication. She said Resident #3 had also been discovered hiding opiate pain medication in his sock recently. She said the DON had been notified of both instances, but no investigation or action had occurred as a result of the notification. In an interview with the DON on [DATE] at 3:30 PM, she said she was unaware that additional pills were located on Resident #3's body after he died, and she did not feel Resident #3's death was suspicious or required reporting to the SSA because the police department had released Resident #3's body for funeral arrangements and not required an autopsy. She said no further investigation regarding the circumstances of Resident #3's death had been done after he died because she was unaware of the pills. She said the facility had not performed a search of Resident #3's body or belongings after he was discovered to have hidden a narcotic pill in his sock because she felt it was a violation of his rights. She said Resident #3 could have potentially obtained the pills found on his body from a source outside of the facility because he occasionally left the facility on pass. She said the facility did not have established monitoring in place for Resident #3 to determine if Resident #3 had returned from pass exhibiting signs or symptoms of intoxication or substance abuse, but she was not aware of any instances in which Resident #3 had seemed intoxicated or altered after returning to the facility. In an interview with the ADM on [DATE] at 3:30 PM, she said she was not told by staff that Resident #3 had been in possession of suspected narcotics at the time he died. She said the facility had not further investigated Resident #3's death because she was not aware that any potential neglect had occurred. In an interview with CNA A on [DATE] at 6:24 PM, she said she brought Resident #3 coffee at lunch time on [DATE] and found him unresponsive with blood near his nose approximately 10 minutes later. She said he displayed signs of an overdose, including drooling and a slumped position. She said she immediately notified the nurse that Resident #3 was unresponsive and looked like he had overdosed, and the nurse responded right away. She said she observed a bag of pills discovered on Resident #3's body by the police department after he died. She said she had not been questioned by the DON or ADM regarding the pills. 2. Record review of Resident #2's admission Record dated [DATE] reflected a [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE]. Relevant diagnoses included (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tracheostomy [an artificial opening in the airway to allow for oxygenation] status. Record review of Resident #2's MDS submitted [DATE] reflected Resident #2 had expired in the facility. Record review of Resident #2's MAR for [DATE] dated [DATE] reflected code UN was used by staff to indicate UNAVAILABLE (Contact the DON/ADON), and code 9 was used to indicate Other/ See Nurse Notes. The following was documented by facility staff for [DATE]: -Lisinopril Tablet 2.5 MG, code UN for morning administration documented by MA AM -Plavix Oral Tablet 75 MG, code UN for morning administration documented by MA AM -Coreg Oral Tablet 3.125 MG, code UN for morning administration documented by MA AM -Coreg Oral Tablet 3.125 MG, code UN for evening administration documented by MA AM -Hydroxyzine HCl Tablet 25 MG, code 9 documented by RN AB for 6:00 AM administration -Hydroxyzine HCl Tablet 25 MG, code UN documented by MA AM for 2:00 PM administration -Hydroxyzine HCl Tablet 25 MG, code 9 documented by RN AB for 9:00 PM administration Record review of Resident #2's progress notes from [DATE] did not reveal documentation from [DATE] associated with the above listed medications not administered for code 9. Further record review of Resident #2's progress notes reflected the following documentation from RN AB dated [DATE] at 7:24 AM: At approximately 0400hrs, resident was found in prone position [face down] on fall mat. Resident was unresponsive to verbal and painful stimuli. Resident repositioned to supine and found to have absent lung sounds and heartbeat. CPR was initiated and code blue initiated. At 0407 fire department arrived and took over CPR. Unable to revive resident after exhausting all efforts, time of death was called at 0426am by EMS and [EMS MD] on phone. [Police department] was contacted by EMS and arrived shortly thereafter. After initial [sic] [Police Department] investigation and conferring [sic] with the M.E., the decision was made to end the investigation citing resident past medical history. Family member was notified at 0600 hrs, spoke to [family member] who stated funeral arrangements would be through [funeral home]. Resident was transferred [sic] to bed, bed bath provided, and family enroute to visit. Record review of document EMS Run Report dated [DATE] at 3:59 AM reflected EMS was notified of cardiac arrest by the facility and arrived at 4:10 AM, and the resident was already receiving CPR from an additional fire department team who arrived several minutes earlier. The documentation reflected the facility staff could not relay a time at which Resident #2 was last seen at her baseline status. The documentation also reflected Resident #2's jaw showed signs of rigor [the natural stiffening of muscles that happens hours after death] when EMS attempted to place an artificial airway in Resident #2's mouth, and that Resident #2's body was very cold to the touch. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of TULIP intake #1103796 reflected the facility reported Resident #2 was found unresponsive on [DATE] , on the ground on a fall mat in the prone position at approximately 4:00 AM and facility staff initiated CPR. Resident #3 expired, and the facility had notified the MD, Resident #3's family, contacted the police department, interviewed staff, and initiated in-services regarding abuse and neglect. Record review of the facility binder identified as the investigation for intake #1103796 reflected a document titled Self-Reporting Protocol/ Ad Job QAPI- Neglect and/or Injury of Unknown Origin dated [DATE] that reflected the incident had been reported to the SSA on [DATE]. The item if camera system used and applicable to the area, review was blank. The item suspend known perpetrators immediately pending investigation was documented as completed on [DATE]. The item take statements from everyone who cares for the resident in the 24 hours preceding the discover of the injury was documented as completed on [DATE]. The item interview other interviewable residents regarding staff treatment was indicated as complete by a checkmark but no date of completion was documented. The item begin abuse/neglect in-service and/or assign an abuse related [computer] course was documented as started on [DATE] for emergency codes and cpr policy. An entry into the EMR was documented as completed on N/A and the MD was documented to have been notified on [DATE]. The document reflected because of the above actions, the likelihood for serious harm to any resident no longer exists as of [DATE] and reflected 2 code blue drills per shift per week could be performed, as well as 10 ADL actions per week to ensure sufficient staffing. The binder included written staff statements from CNA AJ dated [DATE], CNA AO dated [DATE], and LVN P dated [DATE]. In an interview with CNA AJ on [DATE] at 7:41 AM, he said he rounded on resident at approximately 11:00 PM on [DATE] and again at an unknown time after 3:00 AM on [DATE]. He said he noticed Resident #2's bed looked like it was in an elevated position, and he felt that she would benefit from a fall mat, so he left her room to obtain one and returned to put it in place. He said he then attempted to speak to Resident #2, and he determined she was unresponsive. He then attempted to perform CPR but could not effectively initiate chest compressions, so he attempted to assist her to the ground, at which time she slipped down onto the fall mat. He then left the room to obtain assistance and notify the nurse of Resident #2's condition. CNA AJ then said he whispered to RN AB that Resident #2 was dead, but RN AB did not respond or move towards Resident #2's room. He said several minutes later he again notified RN AB that he thought Resident #2 was dead, and at that time RN AB went to Resident #3's room and they initiated CPR and called EMS. In an interview with RN AB on [DATE] at 9:17 AM, he said Resident #2 had not received any medications on [DATE] except her pain medication because the medications had not been delivered. He said he did not notify the doctor or facility leadership of the missed doses. He said he administered the pain medication to Resident #2 around 9:30 PM on [DATE] and was unable to check on her again because he was very busy. He said CNA AJ whispered something to him at an unknown time before 4:00 AM, but he has difficulty hearing and could not understand what CNA AJ had said. He said approximately 5-10 minutes later, CNA AJ whispered to him again, and this time he understood that CNA AJ had told him Resident #2 was not breathing. He said he went to Resident #2's room with CNA AJ and they had to reposition her onto her back from the prone position, at which time he attempted to stimulate her and obtain vital signs, but he discovered she had no heartbeat or breathing activity. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	He said he then left the room to obtain the crash cart but he then felt that he did not need any items from the crash cart, so he returned to Resident #2's room and CPR was initiated at that time. He was unsure of the amount of time that lapsed between CNA AJ initially attempting to notify him of Resident #2's condition and when CPR was initiated. He said he had not been given training regarding the procedure for initiating a code blue at the facility. In a joint interview with the DON and ADM on [DATE] at 10:36 AM, the ADM said the incident had initially been reported to the SSA because it was reported by staff that the resident was found unresponsive on the floor, but their interview with CNA AJ revealed CNA AJ had assisted Resident #2 to the floor, so she didn't feel the incident should have been reported. She said the facility investigation was nearly complete and had not reflected any indications of neglect. She said the facility had reviewed the camera footage and found the footage to be consistent with CNA AJ's account of the incident, but the footage was unavailable for surveyor review due to technical issues. She said when she interviewed CNA AJ, he did not tell her that there was a delay in initiating assistance from the nurse. She said she had not yet interviewed RN AB, and she was unaware RN AB had left the room again prior to initiating CPR. She said she was aware Resident #2 had not received any of her scheduled medication on [DATE] but had not yet interviewed staff to determine the cause. In an interview with the DCS on [DATE] at 11:30 AM, the DCS said she had assisted the facility with investigating the death of Resident #2. She said she had not yet interviewed RN AB as part of the investigation, but RN AB would be suspended beginning [DATE] until the investigation was complete. Review of facility Abuse/Neglect Policy, undated, revealed that Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. If an allegation involves serious bodily injury, the reporting of incident should be made within 2 hours of the allegation. Further review revealed: .4. With an allegation of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property, the employee will immediately be suspended pending an investigation. The employee will have an opportunity to present a written statement to answer the allegation(s) of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property 6. The Abuse Preventionist and/or administrator will conduct a thorough investigation of the incident(s). A copy of the written report will accompany any personnel action deemed necessary .		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable and, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for 2 of 5 medication carts (A Hall cart and C Hall cart) reviewed for storage of drugs and biologicals. The facility failed to ensure the carts for A Hall and C Hall were locked and secured or labeled and dated. This failure could place residents at risk of medication misuse, medication errors, drug diversion or harm due to accidental ingestion of unprescribed medications. The findings include: 1. During an observation on 07/11/2026 at 11:37 AM, revealed the medication cart on A Hall, secured unit, was left unlocked and unattended. The medication cart was against the nurses station with drawers facing out towards residents. Three unknown resident ambulated within 10 feet of the unlocked medication cart. MA Q exited from a resident room several doors down from the nurses station and approached the medication cart. MA Q noticed the cart was unlocked and rushed to secure the medication. During an interview on 07/11/2026 at 11:39 AM, MA Q stated she should not leave the medication cart unlocked and she was running around like crazy and must have missed it. MA Q stated the medication cart should be locked if she was not using it and residents could be negatively affected by the medication cart being unlocked as they could take medications that they were not prescribed. MA Q stated that she did not have a charge nurse on her hall so she was doing everything. 2. During an observation on 07/16/2026 at 6:03 AM, medication cart on C hall was left unlocked and unattended. The medication cart was halfway down the hallway, facing outward. Two unknown aides were in a room two doors down transferring a resident. RN AW exited a room several doors down from the medication cart. There were no residents near the medication cart. During an interview on 07/16/2026 at 6:05 AM, RN AW stated the policy was that the medication carts were to be locked when staff walked away and that the negative outcome for residents could be they take something that was not prescribed. During an interview on 07/16/2026 at 2:57 PM, ADON D stated medication carts should be locked when staff were not next to them. The negative outcome could be a resident taking something they were not prescribed and being injured. 3. During an observation on 07/17/2026 at 12:07 PM, revealed the medication cart on A hall had one bottle of Latanoprost eye drops without an open date on the bottle or box and two bottles of Fluticasone nasal spray without an open date on the bottles or boxes. During an interview on 07/17/2026 at 12:07 AM, LVN Y stated all three bottles on the medication cart should have an open date either on the bottle or on the box. LVN Y stated failure to do this could affect medication potency and hinder affects to residents utilizing the medications. During an interview on 07/17/2026 at 5:35 PM, the DON stated all medication carts should be locked, medications labeled, medications signed out, and medications monitored per policy or professional standards to prevent accidents to residents. Record review of the facility's undated, Medication Storage in the Facility Policy, reflected all medications should be stored safely, securely and properly following manufacturer's recommendations or those of the supplier. Policy also revealed that medication rooms, carts and medication supplies are locked or attended to by persons with authorized access and that medications should have open dates, or use by dates, where		