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	05/31/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131 Based on observation, interview, and record review, the facility failed to residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 of 8 residents (Resident #21) reviewed for reasonable accommodations, in that: The facility failed to ensure Resident #21's call light was within reach. This failure could place residents at risk of not having their needs met Findings include: Record review of Resident #21's face sheet dated 5/28/24 revealed a [AGE] year-old male admitted to the facility 3/14/24 with diagnoses that included: End stage renal disease (disorder when kidneys no longer function on their own), Post Traumatic Stress Disorder (disorder that develops in some people who have experienced a shocking, scary, or dangerous event), and Diabetes Type II (disorder in which body doesn't produce enough insulin or does not use it properly, resulting in high blood sugar levels). Record review of Resident #21's Admission MDS, dated [DATE], revealed a BIMS score of 15, which indicated intact cognition. Review of Resident #21's Admission MDS, dated [DATE], reflected under section G, G0300, option # 3, which stated that the patient was unsteady on his feet and required assistance X 1. Review of Resident # 21's care plan, dated 3/14/24, revealed, The resident has impaired vision with interventions to place call light within reach at all times. Observation on 5/28/24 at 10:45 a.m. revealed the call light was not visible. Resident #21's call light was wrapped on the call light box on the wall. In an interview with Resident #21 on 5/28/24 at 10:25 a.m., he stated, They always move that call light away from me, So I don't call. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/2024 at 10:58 a.m. CNA D, stated she was the assigned nursing assistant for Resident #21, and the call light was wrapped on the wall call light box. CNA D stated, I must have forgotten to move it back to Resident #21's reach when I provided incontinent care this morning. CNA D noted that the lack of accessibility of a call light could negatively affect any resident if they needed assistance. In an interview with the DON on 5/28/24 at 11:05 a.m., she stated it was her expectation call lights should be within arm's length of all residents, she added the lack of a call light could possibly lead to a fall if a resident needed something. The DON stated charge nurses were responsible for overseeing call lights were within residents' reach, which was monitored daily during administration rounding. She did not have a policy to address call lights.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 41651 Based on interview and record review, the facility failed to promote the residents' right to receive mail, for all facility residents, in that: Facility staff did not distribute mail received on Saturdays to the residents. This deficient practice could result in residents not receiving mail in a timely manner and a diminished quality of life. The findings were: During a confidential group meeting on 05/30/2024 at 1:30 p.m., members of the resident group stated that they do not receive mail on Saturdays and stated they feel this practice is disrespectful. During an interview with the AD on 05/31/2024 at 3:15 p.m., the AD stated mail is not delivered to resident on Saturdays. During an interview with the ABOM on 05/31/2024 at 3:18 p.m., the ABOM stated she and BOM do not work on Saturdays, and that the mail received at facility on Saturdays was left for them to sort and is given to residents on Mondays. During an interview with the Weekend Receptionist on 05/31/2024 at 3:42 p.m., the Weekend Receptionist stated she receives the mail from the postman/woman on Saturdays and was instructed to leave all of it, including resident mail, for the ABOM and BOM to sort and distribute on Mondays. During an interview with the DON on 05/31/2024 at 3:54 p.m., the DON stated that residents should receive their mail on Saturdays. Record review of the facility policy, Resident Mail Delivery and Distribution, undated, revealed The health care facility will develop a system to deliver and distribute resident mail in accordance with privacy and confidentiality regulations.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131 Based on the interview and record review, the facility failed to transmit the resident assessment within the required time frame for 1 of the 2 discharged residents (Resident # 89) reviewed for data encoding and transmission, in that: The facility did not submit a discharge not anticipated MDS for Resident #89. This failure could put residents discharged from the facility at risk of not having their assessments transmitted accurately. Findings included: Record review of Resident #89's face sheet, dated 5/31/2024, revealed a [AGE] year old male admitted to the facility on [DATE] and discharged on [DATE] with the diagnoses that included: Alzheimer's Disease (a brain disorder that gradually destroys memory, thinking, and learning skills), General Anxiety Disorder (is a condition that causes people to experience excessive, persistent, and unrealistic worry about everyday things), and Hypertension (when the pressure in your blood vessels is too high (140/90 or higher). Record review of Resident #89's discharge MDS, dated [DATE], revealed that discharge MDS was completed and submitted for a return anticipated. Record review of Resident #89's nurses' notes for 03/12/2024 revealed 1:00 p.m. that Resident #89 was picked up by ambulance and transferred to hospital. During an interview on 05/29/24 at 10:11 a.m., MDS Nurse A stated Resident #89 was discharged from the facility on 03/14/24. MDS Nurse A stated the discharge MDS was marked as return anticipated because, at times, discharged residents return before 30 days. During an interview on 05/29/24 at 11:57 a.m., the DON stated the MDS was transmitted within the required timeframes and was unaware of marking it return anticipated and he was unable to provide a copy of a policy for transmitting MDS as the facility uses the RAI manual. During an interview on 05/29/24 at 03:30 p.m., the Administrator said the MDS was transmitted within the required timeframes and was unaware of marking it return anticipated. CMS's RAI Version 3.0 Manual CH 2: Assessments for the RAI, Resident Transfers: It has been determined that the resident will not return to the evacuating facility, the evacuating provider will discharge the resident return not anticipated, and the receiving facility will admit the resident.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131 Based on interview and record review, the facility failed to ensure all Pre-Admission Screening and Resident Review (PASRR) Level I residents with mental illness were provided with a PASRR Evaluation assessment for 1 of 2 residents (Residents #21) reviewed for PASRR screening, in that: Resident #21's PASRR Level 1 assessment did not accurately capture the resident's diagnosis of mental illness. These failures could put residents with inaccurate PASRR Level 1 Evaluations at risk of not receiving care and services to meet their needs. The findings were: Record review of Resident #21's face sheet, dated 5/28/24, revealed a [AGE] year-old male admitted to the facility 3/14/24 with diagnoses that included: End stage renal disease (disorder when kidneys no longer function on their own), Post Traumatic Stress Disorder (a disorder that develops in some people who have experienced a shocking, scary, or dangerous event), and Diabetes Type II (disorder in which body doesn't produce enough insulin or does not use it properly, resulting in high blood sugar levels). Record review of Resident #21 Admission MDS, dated [DATE], revealed a BIMS score of 15, which indicated intact cognition. Record review of Resident #21's care plan, dated 03/14/3024, revealed requires anti-psychotic medications, interventions administer medication as ordered. Record review of Resident #21's PASRR I screening, completed by the referring entity and dated 03/12/24, before admission on 03/14/24 indicated in Section C PASRR Screen questions C0100 asks, is there evidence or an indicator this individual has Mental Illness? The answer was 0 (0. No). During an interview with the MDS Coordinator A on 5/29/24 at 3:08 p.m., MDS Coordinator A stated, I work together with the local mental health authority to discuss PASRRs. The local authority can often give us the history of the person. MDS Coordinator A acknowledged Resident #21 had a diagnosis of bipolar disorder and post-traumatic stress disorder and the resident's PASSR 1 screening should have been redone as positive. MDS Coordinator A stated Resident #21 risked the opportunity to be screened by the local health authority for possible services offered, and she would get the PASSR 1 corrected and resubmitted. During an interview with the DON on 5/29/24 at 4:10 p.m., the DON stated it was her expectation that MDS Coordinator A reviewed all residents' medication orders to ensure no possible PASSR positive resident was missed, as Resident #21,risked the possibility of not receiving valuable services offered by the local health authority. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's policy titled, PASRR Maintenance in the Active Paper Medical Record, dated , January 2018, revealed, If the Resident is PASRR positive the following forms will follow: Local Health Authority PASRR Evaluation form for all confirmed Negative or Positive, obtained from local health authority.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36232 Based on observations, interviews, and record reviews, the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities for 3 of 22 residents (Residents #14, #48 and #73) reviewed for activities in that: 1. The facility failed to provide Resident #14 activities designed to meet her interests and promote physical, mental, and psychosocial well-being. 2. The facility failed to provide Resident #48 activities designed to meet his interests and promote physical, mental, and psychosocial well-being. 3. The facility failed to provide Resident #73 activities designed to meet her interests and promote physical, mental, and psychosocial well-being. This deficient practice could affect residents at the facility who require assistance to activities to decline in mental acuity due to lack of stimulation, boredom, and depression. The findings included: 1. Record review of Resident #14's face sheet, dated 05/31/2024, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Neurocognitive Disorder with Lewy Bodies, Depression, and Anxiety Disorder. Record review of Resident #14's quarterly MDS assessment dated [DATE] revealed a BIMS of 00, indicating severe cognitive impairment. Record review of Resident #14's comprehensive care plan, revised 04/30/2024, revealed a focus, [Resident #14] needs out of room social, spiritual, and stimulus activities and mental stimulation and interventions, activity director will encourage and remind the resident of current activities. The Activity Director will provide the resident reading material for mental stimulation. The activity will praise the resident for attending activities of their choice. Record review of Resident #14's clinical record revealed a progress notes, dated 05/22/2024, This resident received mail today via [activity volunteer]. Counted as a one-to-one activity. [Resident #14] was observed to be asleep during mail delivery. Mail was left at this resident's bedside. 2. Record review of Resident #48's face sheet dated 05/31/2024 revealed the resident was a [AGE] year old male admitted to the facility on [DATE] with diagnoses that included: Dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), cognitive communication deficit (difficulty with any aspect of communication that is affected by disruption of cognition), epilepsy (a brain disorder that causes recurring, unprovoked seizures) and psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality). (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #48's quarterly MDS assessment dated [DATE] revealed a BIMS of 02, indicating severe cognitive impairment. This assessment further revealed Resident #48 had unclear speech, was rarely/never understood by others, and sometimes understood others. Record review of Resident #48's quarterly MDS assessment dated [DATE] revealed a BIMS of 02, indicating severe cognitive impairment. This assessment further revealed Resident #48 had unclear speech, was rarely/never understood by others, and sometimes understood others. Record review of Resident #48's comprehensive care plan revealed a focus area Activities, indicating Resident #48 preferred independent activities or spending time with family rather than doing things in groups but was willing to give joining group activities a chance (initiated: 06/18/2019). Interventions included inviting the resident to sit in during activity programs he might enjoy, allowing him to join in at his own comfort level, offering activities and supplies for things he could do in his room and activities he and his family could do together, assisting the resident in participating in his favorite activities at his highest level and reviewing his participation level in independent activities with him to ensure he could still participate at a high level with no signs of decline. Record review of Resident #1's EHR revealed a progress note from the Assistant Activity Director dated 05/22/2024, 6:06 PM, Type: Activity: This resident received mail today via activity volunteer. Counted as a one to one activity. Informed Resident #48 his mail would be held and given to his daughter. Further review of Resident #48's EHR revealed there were no Activity Assessments completed for this resident since his initial admission of 06/17/2019. One Activity assessment dated [DATE] was blank. Observation on 05/28/2024 at 1:30 PM revealed Resident #48 was sitting in the common area in the secure unit with several other residents watching a movie. He was eating a muffin and he did not respond to questions during an interview attempt. During an interview on 05/31/24 at 03:19 PM with the Activity Director (AD) she stated that the provision of mail was not considered an activity. She further stated Resident #48 should have received an initial activity assessment and quarterly assessments thereafter, and the AD did not have an explanation as to why no assessments were completed. 3. Record review of Resident #73's face sheet, dated 05/31/2024, revealed an admitted [DATE] with diagnoses including: Mild Cognitive Impairment, Chronic Kidney Disease, and Cognitive Communication Deficit. Record review of Resident #73's annual MDS, dated [DATE], revealed a BIMS of 11 which indicated mild cognitive impairment. Record review of Resident #73's care plan, revised 04/30/2024, revealed a focus, [Resident 73] has little interest in activities but does enjoy at times participating in bingo also likes to work on crosswords and coloring at her leisure and interventions, Establish and record the resident's prior level of activity involvement and interests by talking with the resident caregivers, and family on admission and as necessary; Explain to the resident the importance of social interaction, leisure activity time. Encourage the resident's participation; Invite/encourage the resident's family members to attend activities with resident in order to support participation; Remind the resident that the resident may leave activities at any time and is not required to stay for entire activity. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #73's clinical record revealed a progress notes, dated 05/22/2024, This resident received mail today via [Activity Volunteer]. Counted as a one to one activity. [Resident #73] was observed to be happy to receive her mail. Resident opted to open mail at a later time. During an interview on 05/31/24 at 03:19 PM with the Activity Director (AD) she stated that the provision of mail was not considered an activity and stated she would re-educate the activity aide who authored the notes stating that mail delivery counted as a one-to one activity. Record review of facility policy Activity Documentation - General Guidelines, 2011, revealed: Standard: A qualified Activity professional will complete all required medical record documentation per state and federal regulations. The Activity Director shall coordinate and supervise all documentation and be ultimately responsible for all areas of documentation, according to required timeframes and practice guidelines. Practice Guidelines: The following areas are considered documentation responsibilities of the Activity Director and staff and should be completed in a comprehensive and timely manner. 1. Comprehensive Activity assessments within 14 days of admission or identification of significant change. 2. Comprehensive Activity assessments annually. 3. Interdisciplinary team will assess the need for activities and reflect on the resident of care. A. Problem(s) or need(s) B. Goal(s) C. Appropriate approaches in related problems. 4. Progress notes at least quarterly. 5. Subsequent or intervention notes, when necessary. 8. General guidelines when completing any of the above area of required documentation include: D. If any person writing in the medical record is not qualified, the documentation is reviewed and co-signed by a qualified professional. 41651

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36232 Based on observation, interview, and record review, the facility failed to ensure residents received proper treatment and care to maintain mobility and good foot health for 1 of 1 resident (Resident #1) reviewed for foot care. The facility failed to provide Resident #1 with access to a podiatrist. The deficient practice placed residents at risk of discomfort, poor foot hygiene, and a decline in resident's physical condition. The findings were: Review of Resident #1's face sheet dated 05/28/2024 revealed an [AGE] year old female admitted on [DATE] and readmitted on [DATE] with diagnoses that included: Dementia (impaired ability to remember, think, or make decisions that interfere with doing everyday activities), rheumatoid arthritis (an autoimmune disorder that affects the lining of the joints, causing painful swelling), depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and diabetes mellitus (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of Resident #1's quarterly MDS dated [DATE] revealed she scored a 00 on her BIMS, indicating severe cognitive impairment. Review of Resident #1's comprehensive care plan, updated 02/21/2024, revealed a focus area of ADL self-care performance deficit related to, Impaired balance, limited ROM, and pain (joint pain). The goal was to maintain current level of function. An intervention was, Bathing/Showering: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Further review of this care plan revealed there was no mention of behaviors or resistance to care. Observation on 05/28/2024 at 1:20 PM revealed Resident #1 was standing in the doorway of her room. She was not wearing shoes or socks. The toenail plates (the visible part of the nail) on both her feet were longer that the nail bed (the skin beneath the nail plate). The left toenail plates were overgrown, thick, curved, ragged, chipped, uneven, cracked, and had a yellowish color. The toenails were approximately 1/4 inch to 3/4 inch past the nail bed and had reddened areas around the nail bed. The big toenail plate was yellow and approximately 1/2 inch long and had curled almost completely around the big toe. The second toenail plate was approximately 1/2 inch long, was growing sideways and stabbing into the big toe. The third toenail plate was approximately 3/4 inch long. The fourth toenail plate was approximately 3/4 inch long and curved down in front of the toe and under the 2nd toe. The little toenail plate was approximately 1/2 long. The right foot toenail plates were overgrown, thick, curved, ragged, chipped, uneven, cracked, and had a yellowish color. The big toenail plate was yellow and approximately 1/2 inch long. The second toenail bed was approximately 3/4 inch long and curved down in front of the toe. The third toenail plate was approximately 1/2 inch long and curved sideways under the second toe. The fourth toenail plate was 1/2 long. The little toenail plate was approximately 1/2 inch long. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/28/2024 at 1:23 PM with ADON E, she stated the social worker compiles the list of residents who need to be seen by the consultant podiatrist and Resident #1 had been resistant to staff providing foot care. During a later interview, ADON E stated the contract podiatrist comes every two months, the facility did not know the podiatrist would visit the facility that day, Resident #1 was in need of foot care, she was eligible for care, she would not receive care from the podiatrist that day because she was not on the list of residents to be seen by the podiatrist, and she was unable to find any notes indicating the resident had ever resisted care or had ever been seen by a podiatrist. During an interview on 05/28/2024 at 2:05 PM with the social worker, he stated some providers come every few weeks, some every few months, and getting residents on the list for specialty care providers was critical because they would not be seen otherwise. It was his responsibility to ensure residents who needed care were on the lists to be seen prior to the providers coming to the facility. The consultant podiatrist had visited that day, 05/28/2024, no one in the facility knew she would be there, Resident #1 was not on the list of residents to be seen and was not seen. During an interview on 05/31/2024 at 4:04 PM with the DON, she stated there was no documentation in Resident #1's EHR she had ever received care from a podiatrist. She had seen the resident's toenails after the staff had soaked and cut them, and they are still a bit long, but better. Resident #1 did not resist care from the staff. Review of the facility's policy and procedure for Foot Care dated 2003 revealed: Foot management is the daily assessment, bathing, lubrication, and protection of the feet. It is done to promote cleanliness and peripheral circulation of the feet. Foot care is especially important in those residents with diabetes mellitus or peripheral circulatory conditions because of the susceptibility to infection and skin breakdown. If required, trimming of the toenails is performed by a podiatrist. Goals: The resident will maintain intact skin integrity, be free from infection, and remain free from injury to the feet. The procedures included Daily assessment of the feet should be done when care is given. Any breaks in skin, blisters, cracks, or other abnormalities should be noted and reported to the primary nurse immediately. The primary nurse will advise the physician and obtain a referral to the wound care nurse or the podiatrist.