STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675823	A. BUILDING _____ B. WING _____	05/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, for 1 of 4 residents (Resident #1) whose care plans were reviewed in that: Resident #1's care plan was not reviewed and revised to include all of the resident's falls with interventions necessary for the resident's care. This deficient practice could place residents identified as being at risk for falls at risk for inadequate care and insufficient interventions implemented to prevent future falls. The findings were: Record review of Resident #1's face sheet, undated, revealed the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's Discharge MDS, dated [DATE], revealed the resident had a BIMS score of 99, which indicated the resident was severely cognitively impaired. Record review of Resident #1's care plan revealed the following: Focus: At risk for falls related to: History of falls, new environment, decrease safety awareness due to [DIAGNOSES REDACTED]. Revision on: 4/02/2020. Focus: The resident has had an actual fall AEB: Fall in room [ROOM NUMBER]/16/20. AEB: 3/20 Fall in room. AEB 3/22 Fall in Bathroom. AEB: 3/23 Fall in room from the bed. AEB 3/27/20 Fall in bathroom. Date initiated [DATE]20. Revision on: 3/27/2020. Record review of Incidents By Type, provided by facility, date range from 0[DATE]20 to 05/26/2020, revealed the facility's Fall Incidents, Date and Time. Further review revealed that in addition to the falls documented in Resident #1's care plan, the resident also sustained falls on the following dates: [DATE], 0[DATE]3/2020, 04/27/2020, 05/01/2020 at 4:05 p.m., 05/01/2020 at 11:13 p.m., 05/03/2020, and 05/04/2020. Record review of Progress Notes, dated 04/02/2020, revealed: IDT fall sub committee convened today to discuss resident fall on [DATE]/20. Our investigation reveals a root cause in which resident was observed on the restroom floor. Resident was toileted prior to fall. Denies pain or discomfort. Immediate intervention initiated by center include toileting schedule after dinner and bedtime. MD and RP are in agreement with plan of care. Record review of Progress Notes, dated 0[DATE]6/2020, revealed: IDT fall subcommittee convened today to discuss resident fall on [DATE]3/20. Our investigation reveals a root cause in which resident was observed laying on floor in the hallway. Resident was saying he was looking for his wife. No injuries at the time of incident. Resident prior to call spoke to his wife over the phone. Resident intermittently calls out for his wife and redirected and staff call his wife. Immediate intervention initiated by center include redirection, calling wife for resident to speak with him couple of times throughout the day. MD and RP are in agreement with plan of care. Record review of Progress Notes, dated 04/27/20, revealed: IDT fall subcommittee convened today to discuss resident fall on 4/27/20. Our investigation reveals a root cause in which resident was observed on the floor laying on the ground in the restroom stating he was looking for his casa and his wife. No injuries at the time of the incident. Made aware by staff that he has made several calls to his wife throughout the day and it was in the middle of the night and would call first thing in the morning. Resident requires extensive redirection on his wife not being in the facility and that calls have been made to his wife throughout the day. Redirection ineffective. Immediate intervention initiated by center include redirection, calling wife for resident to speak with him couple of times throughout the day and hospice med review for increased anxiety. MD and RP are in agreement with plan of care. Record review of Progress Notes, dated 05/04/2020 at 11:01 p.m., revealed: IDT fall subcommittee convened today to discuss resident 2 falls on 5/1/20. Our investigation reveals a root cause analysis in which resident was on first fall was in TV room and on the floor in a fetal position and second fall resident was noted faced down trying to get self up. Immediate intervention initiated by center include continue with monitoring with redirection, continue with non-skid socks and keep in visual sight, toileting. MD and RP are in agreement with plan of care. Record review of Progress Notes, dated 05/04/2020, revealed: IDT fall subcommittee convened today to discuss resident fall on 5/3/20. Our investigation reveals a root cause analysis in which resident was witnessed getting up from wheelchair and started walking and fell immediately due to his unsteadiness, nurse unable to get to him in time. Immediate intervention initiated by center include continue with redirection, keep in visual sight, non-skid socks, hospice to do med review, which revealed [MEDICATION NAME] and [MEDICATION NAME] increase [MEDICATION NAME] initiated. MD and RP are in agreement with plan of care. Further review of Resident #1's care plan revealed that none of the information in the progress notes detailing Resident #1's falls from [DATE] to 05/03/2020 were listed in the resident's care plan. During an interview with the DON on 05/26/2020 at 5:27 p.m., the DON confirmed that although the additional falls were documented in Resident #1's progress notes and the IDT met after each, discussed the potential root causes and decided on immediate interventions, Resident #1's care plan was not updated with the falls he sustained in the months of April and May 2020, the goals for the resident to resume his usual activities without further incident and the interventions necessary to reduce his risk of sustaining further falls. During an interview with the Administrator on 05/26/2020 at 5:30 p.m., the Administrator confirmed Resident #1's care plan was not revised with the falls from the months of April and May 2020 added. The Administrator further stated the MDS nurse and Social Worker were responsible for updating residents' care plans. Record review of the facility's policy Falls, undated, revealed, Post fall: The fall event and intervention is recorded on 24 Hour Report, patient's care plan and caregiver guide.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE