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	11/25/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to respect the residents right to personal privacy for 2 of 2 residents (Resident #2 and Resident #3) reviewed for privacy/dignity. The facility failed to ensure residents' privacy/dignity was maintained during wound care on (2) occasions. This failure could place residents at risk for poor self-esteem, decreased self-worth, and quality of life. Findings included: Record review of Resident #2's admission Record, dated 10/23/25, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: right femur fracture, Alzheimer's Disease (disease affecting memory and other important mental functions), Dementia (group of thinking and social symptoms that interferes with daily functioning). Record review of Resident #2's comprehensive MDS assessment, dated 9/5/25, revealed the resident's cognitive skills for daily decision making were severely impaired. An interview was attempted on 10/22/25 at 2:06 pm, Resident #2 did not respond to the state investigator's questions. During observation of wound care to Resident #2's right second toe, on 10/22/25 beginning at 4:44 pm, RN A entered the room and explained the procedure. Further observation revealed RN A completed wound care to Resident #2's right second toe without closing the door, privacy curtain, or blinds. Observation revealed Resident #2's roommate was in the room. During an interview on 10/23/25 at 9:35 am (translated from Spanish), Resident #2 said she did not have any wounds. Record review of Resident #3's admission Record, dated 10/23/25, revealed the resident was re-admitted to the facility on [DATE] with diagnoses which included: Cerebral Infarction/CVA (stroke - disrupted blood flow to the brain), Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities), Generalized Anxiety Disorder (severe and ongoing that is ongoing and interferes with daily activities), and Aphasia (disorder that affects a person's ability to communicate). Record review of Resident #3's quarterly MDS assessment, dated 9/16/25, revealed the resident's cognitive skills for daily decision making were severely impaired. During an interview on 10/22/25 at 2:00 pm, Resident #3 shook her head when asked if she had any wounds and was receiving wound care. During observation of wound care to Resident #3's left heel, on 10/22/25 beginning at 4:21 pm, RN A entered the room and explained the procedure. Further observation revealed RN A completed wound care to Resident #3's left heel without closing the door or privacy curtain. An interview was attempted on 10/22/25 at 4:39 pm, Resident #3 did not respond to the state investigator's questions. During an interview on 10/23/25 at 2:07 pm, RN A said the expectation was to always provide privacy to residents. RN A further stated the blinds, privacy curtain, and door should be closed when providing care for privacy. RN A said it was important to provide the residents with privacy to prevent others from seeing the residents receiving care to respect the residents' dignity. During an interview on 10/23/25 at 2:31 pm, the DON said staff were expected to knock on the residents' door, announce themselves, explain the procedure, close the door, privacy curtain, and blinds before providing care. The DON further stated this was to respect the residents' dignity and rights and that not doing so might lead the residents to feel that strangers were looking at them or feel devalued. Record review of the facility's policy, titled Resident Rights, undated, revealed: The resident has a right to a dignified existence. A facility must treat each resident with respect and dignity.The resident has a right to personal privacy.Personal privacy includes accommodations, medical treatment. Record review of the facility's validation checklist, titled Wound Care, dated 2022, revealed: .Upheld dignity principles for entry, permission to proceed, and privacy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 2 residents (Resident #2 and Resident #3) reviewed for infection control. The facility failed to ensure RN A followed infection control policy/procedures during wound care for Resident #2 and Resident #3. This deficient practice could place residents at risk for infection. Findings included: Record review of Resident #2's admission Record, dated 10/23/25, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: right femur fracture, Alzheimer's Disease (disease affecting memory and other important mental functions) , Dementia (group of thinking and social symptoms that interferes with daily functioning). An interview was attempted on 10/22/25 at 2:06 pm, Resident #2 did not respond to the state investigator's questions. During observation of wound care to Resident #2's right second toe, on 10/22/25 beginning at 4:44 pm, RN A entered the room and explained the procedure. RN A then placed the wound care supplies on Resident #2's bedside table without sanitizing it. RN A began to don a gown when Resident #2's roommate removed her covers and night gown, exposing her breasts. RN A approached Resident #2's roommate and replaced her covers, during which RN A's gown touched the resident and her bed. After assisting Resident #2's roommate, RN A continued to tie the ties on the gown and donned gloves without performing hand hygiene. RN A then pulled Resident #2's chair close to the resident, who was sitting in her wheelchair, sat down, placed a trash bag on the floor next to her (used to dispose of used wound care supplies) and removed Resident #2's sock. RN A then touched Resident #2's wound to the right second toe with her gloved hand without changing gloves or performing hand hygiene. After cleaning the wound, RN A removed her gloves, donned clean gloves without performing hand hygiene and applied the treatment to Resident #2's right second toe. RN A removed her gloves and washed her hands for 13 seconds. RN A exited Resident #2's room, removed her gown and placed the trash bag that was on the floor on top of the treatment cart. RN A then walked with the state investigator to the conference room without sanitizing the top of the treatment cart. During an interview on 10/23/25 at 9:35 am (translated from Spanish), Resident #2 said she did not have any wounds. During an interview on 10/23/25 at 2:07 pm, RN A said she should have removed her PPE after assisting Resident #2's roommate. RN A further stated she should have then washed her hands and donned new PPE before providing wound care to Resident #2's right second toe to avoid the spread of infection and cross contamination between residents. RN A said she should have made sure her hands were clean prior to touching Resident #2's wound. RN A further stated she must wash her hands the right way every time otherwise it put everyone at risk for infection. RN A said the trash bag should not have been placed on top of the treatment cart because the trash bag had germs and she was transferring germs from one surface to another, placing residents at risk for infection. RN A further stated all staff were responsible for following infection control policies and procedures. Record review of Resident #3's admission Record, dated 10/23/25, revealed the resident was re-admitted to the facility on [DATE] with diagnoses which included: Cerebral Infarction/CVA (stroke - disrupted blood flow to the brain), Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities), Generalized Anxiety Disorder (severe and ongoing that is ongoing and interferes with daily activities), and Aphasia (disorder that affects a person's ability to communicate. During an interview on 10/22/25 at 2:00 pm, Resident #3 shook her head when asked if she had any wounds and was receiving wound care. During observation of wound care to Resident #3's left heel, on 10/22/25 beginning at 4:21 pm, RN A entered the room and explained the procedure. RN A washed her hands for 4 seconds, removed Resident #3's boot from her left foot and donned a gown without performing hand hygiene. RN A then placed the wound care supplies on top of the bedside table without sanitizing it and moved the table close to the foot of the bed with her bare hands. RN A donned gloves without performing hand hygiene. RN A set Resident #3's left foot on top of a plastic trash bag, removed the dressing, placed it in the trash bag under the resident's foot and set Resident #3's left foot on the trash bag containing the dirty dressing. After RN A cleaned Resident #3's wound and set the resident's foot on top of the trash bag containing the dirty dressing and liquid used to clean the wound. RN A removed her gloves, leaned out the door to get a clean pair of gloves from the treatment cart without performing hand hygiene and donned the gloves. RN A then applied the ointment to Resident #3's wound