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	01/16/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to maintain a sanitary, orderly, and comfortable interior by housekeeping and maintenance services, which were necessary to maintain a sanitary, orderly, and comfortable interior for 1 of 8 residents (Resident #3) reviewed for homelike environment. The facility failed to maintain Resident #3's bathroom with dry clean drywall without damage and without stains. This failure could place residents at risk for diminished self-worth.The findings included: A record review of Resident #3's admission record dated 1/13/2026 revealed an admission date of 8/29/2025 with diagnoses which included mid back spine fractures at T7-T8 and T11-T12 (spine fractures), bladder cancer, and muscle weakness. A record review of Resident #3's quarterly MDS assessment dated [DATE] revealed Resident #1 was a [AGE] year-old male admitted for long term care supports for activities of daily life (ADLs). Resident #1 was assessed with the need for assistance with hygiene and toileting. A record review of Resident #3's care plan dated 1/13/2026 revealed, the resident has an ADL self-care performance deficit . the resident will maintain or improve current level of function . bathing requires staff x1 for assistance . discharge from the facility is not feasible as evidenced by inability to care for self independently . During an interview and observation on 1/16/2026 at 9:28 AM revealed Resident #3 in his bed, in his room. Resident #3 stated he was demoralized by his poorly maintained bathroom. Observation of the bathroom revealed a toilet, sink, and shower. The bathroom walls were stained in 5 to 10 areas and damaged, and had holes. During an interview on 1/16/2026 at 5:00 PM the Administrator stated he and the Maintenance Director had discussed repairs to Resident #1's room but the repairs had not yet begun. A record review of the facility's undated Residents Rights policy revealed, The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy . respect and dignity . the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences.

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

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 01/16/2026
NAME OF PROVIDER OR SUPPLIER Normandy Terrace Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 841 Rice Rd San Antonio, TX 78220	

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart, for 1 of 8 residents (Resident #2) reviewed for misappropriation of property, in that: Housekeeper F (HK F) took Resident #2's money to purchase herself meals. This failure could place residents at risk for harm by exploitation which could result in psychosocial harm and mistrust of the staff. The findings included: Record review of the facility's undated Freedom from Abuse Notice to Employees Resident / Patient Abuse, Neglect, and Mistreatment of Belongings policy revealed, Gratuities and Loans . gratuities and gifts are any type of denomination of currency, items, of monetary value or could be exchanged for monetary value, services that are typically of monetary value, and items that have been designated to an individual that may have monetary value. It is the policy of the facility not to accept gratuities of any kind from residents, their families, relatives, acquaintances, associates or individuals acting on their behalf. Record review of Resident #2's admission record dated 1/14/2026 revealed an admission date of 8/27/2025 with diagnoses which included chronic obstructive pulmonary disease (COPD; a progressive, incurable, yet treatable lung disease that causes severe breathlessness, chronic coughing, and limited airflow). Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed Resident #2 was a [AGE] year-old male admitted for long term care supports for COPD and activities of daily life (ADL). Resident #2 was assessed with a BIMS score of 12 out of 15 which indicated moderate cognitive impairment. Resident #2 was assessed with adequate hearing and impaired vision and used glasses. Resident #2 was assessed with the ability to understand others and could usually make himself understood. Record review of Resident #2's care plan dated 1/16/2025 revealed, the resident has mood problem related to diagnosis of depression the resident will have improved mood state . monitor / record / report to medical doctor as needed risk for harm to self: . risky actions . giving away possessions . Record review of HK F's human resources training records dated 8/24/2025 revealed HK F acknowledged and signed she received training which included, Gratuities and Loans . gratuities and gifts are any type of denomination of currency, items, of monetary value or could be exchanged for monetary value, services that are typically of monetary value, and items that have been designated to an individual that may have monetary value. It is the policy of the facility not to accept gratuities of any kind from residents, their families, relatives, acquaintances, associates or individuals acting on their behalf. During an interview on 1/14/2026 at 2:20 PM HK F stated she had taken Resident #2's debit card to buy food and never bought cigarettes and or vapes. HK F stated she met Resident #2 in August 2025, and since then Resident #2 asked her to buy fast food for herself and himself. HK F stated she was counseled by an unnamed charge nurse to not get close to the residents and HK F stated she then decided to stop buying stuff for the Residents. HK F stated Resident #2 was targeting her aggressively and would call her racial slurs and yell out loud She's a liar! . She stole $40. HK F stated Resident #2 would video her while making allegations of theft. During an interview on 1/14/2026 at 2:40 PM the SW and Resident #2 stated Resident #2 was working with the SW to pay his credit card bill. Resident #2 demonstrated his wallet to include a debit card and cash around $50. Resident #2 stated he was upset at HK F because she stole $40 cash and stated, She went through my wallet. Resident #2 stated he never gave HK F his debit card but had purchased small cigarettes from her with cash. Resident #2 denied he gave HK F any money to buy food. During an interview on 1/14/2026 at 3:48 PM the Administrator stated he had suspended her today and prepared to terminate HK F related to HK F admitted she had used Resident #2's money to purchase herself and Resident #2 food. The (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator stated he had reported the allegation of misappropriation of property to the S.A. because the incident violated the facility's policy.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the basis for discharge was documented in the resident's medical record for 1 out of 3 residents (Resident #1) reviewed for inappropriate discharges. 1.The facility failed to provide and document sufficient preparation and orientation for Resident #1 to ensure safe and orderly discharge from the facility to another facility. 2.The facility failed to develop and implement an effective discharge planning process and involve Resident #1 and the resident representative in the development of the discharge plan and inform Resident #1 and resident representative of the final plan. 3.The facility failed to have a discharge summary that included a post-discharge plan of care for Resident #1 that was developed with the participation of the resident representative(s), which would assist the resident to adjust to his or her new living environment. These failures could place residents at risk of diminished continuity of care and unsafe and/or improper transfers or discharges.The findings included: Review of Resident #1's admission record dated 1/15/2026 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included unspecified dementia, unspecified severity, with agitation (diagnosis indicating cognitive decline without a specific cause, often accompanied by behavioral symptoms like restlessness and aggression), unspecified dementia with behavioral disturbance (type of cognitive decline that lacks a clear diagnosis and is characterized by various behavioral changes, including agitation, aggression, and mood swings), and major depressive disorder. Review of the annual MDS for Resident #1 dated 7/6/2025 reflected a BIMS score of 06, indicating severely impaired cognition. It reflected that she was diagnosed with medically complex conditions including Non-Alzheimer's Dementia and depression and was taking antidepressants. It reflected Resident #1 was independent with functional abilities of self-care and mobility. Further review of the annual MDS reflected Resident #1 had no physical or behavioral symptoms directed towards others identified and no impact on others identified. Review of the care plan for Resident #1 dated 7/8/2022 reflected the following: revision date 3/23/2023 [Resident #1] has diagnosis of Dementia Unspecified. Due to cognitive loss, diminished decision-making capabilities and safety and security issues. [Resident #1] placement in the secure Memory Care unit with programs designed for this population is needed as evidenced by: Vascular dementia. Resident's freedom of movement will be enabled through the secure prosthetic environment until next review. Care plan revision 9/12/2025 reflected [Resident #1] has a behavior problem aggression r/t Dx: Dementia, Resident has short term memory related to Dementia and does not remember she has a roommate, resident will become aggressive and with roommate. At this time resident does not have a roommate at this time. Pushed another resident to the floor when they wandered into her room resident to resident altercations with a male resident – no injuries. [Resident #1] will have fewer evidence of behavior problems aggression towards other by review date. Interventions included: Administer medications as ordered. Observe/document for side effects and effectiveness. Assist the resident to develop more appropriate methods of coping and interacting. Encourage the resident to express feelings appropriately. Review of Resident #1's care plan conference dated 6/17/2025 reflected the following: Resident #1 did not attend due to cognitive impairment, the RP was not able to be reached, and a voicemail was left regarding the conference. Focus, goals and interventions were reviewed. Care plan (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conference completed with interdisciplinary team where they went over medications, diagnoses and behaviors. No changes made to plan, [Resident #1] remains stable. Review of Resident #1's Weekly Summary Nursing Note dated 9/8/2025, 8:10 PM completed by LVN E, reflected the following: In the last week, the resident wandered daily. No verbal behavior directed toward others in the last week. No physical behavior directed toward others in the last week. In the last week, the resident experienced other behaviors not directed toward others daily. In the last week, the resident rejected evaluation or care 1-3 days. Review of Resident #1's Social Service Note dated 9/9/2025, 3:30 PM completed by LMSW, reflected the following: [LMSW] called [Family Member A] and asked about solutions for the most recent incident with another resident. She said.she would be okay with a facility closer to her if it came to that alternative to help her [Resident #1] have more room to move around. Review of Resident #1's QRR Summary dated 9/10/2025, 11:05 AM completed by LVN D reflected the following: Behavior Patterns In the last 7 days has the resident exhibited any of the behaviors below: Verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) 0. Behavior not exhibited Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) 0. Behavior not exhibited. Review of Resident #1's Psychiatric Subsequent assessment dated [DATE] completed by psychiatrist reflected the following: Reason for Referral: Confusion, Memory Loss, Physical Aggression Assessment/Plan: DAILY. patient remains well at her baseline with baseline cognitive impairment, no behavioral disturbances reported recently. Review of Resident #1's Discharge summary, dated [DATE], 10:42 AM completed by the DON reflected the following: Reason for discharge: requires locked unit that allows more space to move around Date of discharge: [DATE] discharged to: Other Staffed Facility Physician signature: [not completed] Date: [not completed] (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's nursing progress note dated 9/11/2025, 11:21 AM completed by LVN D reflected the following: Resident left facility via wc clean dry and with no distress noted or voiced activity personal accompanied resident to new facility. all of resident clothing and medication where sic[were] given to transportation personal sic[personnel]. Review of an email notification dated 9/11/2025, 11:49 AM from the LMSW addressed to Family Member A reflected the following: Email notification with information of skilled nursing facility that Resident #1 would be going to [transferring] including the name of the new facility, address, and contact information for admission Coordinator. The LMSW also informed Family Member A, I left you a voicemail and [new facility] is a larger locked facility for her [Resident #1] to walk and plenty of activities so that may help with her [Resident #1] territorial disputes. Review of an email notification dated 9/12/2025, 12:41 PM from the LMSW addressed to Family Member B reflected the following: My [LMSW] apologies for not contacting you [Family Member B] on this matter as well as her [Resident #1's] [Family Member A]. Since you [Family Member B] and [Family Member A] were both listed as Emergency Contacts and Dual POAs, and resident representatives, [Family Member A] was listed first on our contact list, and she was contacted (see attached screen shot of progress note) about this possible move and had said if it was needed, then it was okay to do. I too [LMSW] regret that this [transfer/discharge] happened so quickly and it wasn't to your [Family Member B] liking but we did contact [Family Member A] on this and explained that getting her [Resident #1] to a larger, more open environment would be better for her overall well-being. If you feel that we [facility staff] still violated state and federal laws, I [LMSW] have cc'd our Ombudsman, on this email if you [Family Member B] have any further questions on that matter specifically. On the notification; A 30-day notice of eviction requires notification, not a transfer from one nursing home to another. It's a move, not an eviction and [Family Member A] was informed of this possibility. Review of an email notification dated 9/12/2025, 1:37 PM from Family Member A addressed to LMSW reflected the following: I [Family Member A] do not agree with the remarks regarding our conversation. I [Family Member A] was asked if I [Family Member A] would consider moving her [Resident #1]. I [Family Member A] never agreed to anything the 3 incidents were never mentioned. When the [potential facility] was suggested I [Family Member A] said no I [Family Member A] would only consider a move closer to me. I [Family Member A] never agreed to a move only to consider it. I [Family Member A] don't appreciate the games you [LMSW] are playing and trying to put the blame on others. You [LMSW] wanted her [Resident #1] gone and made sure it happened. The new place is not much different from your [current facility] place. Review of email notification dated 9/12/2025, 2:19 PM from the LMSW addressed to Family Member A reflected the following: I [LMSW] asked if you [Family Member A] would consider moving her [Resident #1] as an option to (continued on next page)

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F 0627

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

resolve the territorial disputes, you [Family Member A] agreed, and specifically said, if we have to move her [Resident #1] than I [Family Member A] guess we have to I [LMSW] took that to mean you [Family Member A] were okay with a transfer if needed. Please reach out to Ombudsman (cc'd on this email) for any further concerns.

Review of Resident #1's clinical record from 1/15/2025 indicated there was no valid basis for discharge documented.

Review of Resident #1's clinical record from 1/15/2025 indicated there was no documented evidence of notification prior to the transfer provided to the POA.

Review of Resident #1's clinical record from 1/15/2025 indicated there was no documented evidence of sufficient preparation and orientation for Resident #1 to ensure safe and orderly transfer or discharge from the facility to the new facility.

Review of Resident #1's clinical record from 1/15/2025 indicated there was no documented evidence of implemented and effective discharge planning process that involved Resident #1 and resident representative to include a final plan.

Review of Resident #1's clinical record from 1/15/2025 indicated there was no documented evidence of a discharge summary that included post-discharge plan of care for Resident #1.

In a phone interview on 1/16/2026 at 9:32 AM Family Member B stated she didn't know why Resident #1 was transferred to another facility, she could only make assumptions. She stated Family Member A told her that facility staff thought Resident #1 would be better suited at another facility to roam around, would be better at new facility as she had exhibited violence at the facility. She stated she was aware there were incidents involving other residents in the nursing home because Resident #1 was diagnosed with severe dementia. She stated she was notified of the incidents, she and Family Member A talked about a plan of action with facility staff. She stated she could not recall the last incident that occurred, but to them [Family Members A and B] the incidents were handled, and Resident #1 was stable. She stated the decision to move Resident #1 seemed abrupt, especially since the last incident was a while back. She stated Family Member A was informed by the LMSW on 9/09/2025 that the transfer initially was to provide Resident #1 with more space. She stated Family Member A made it clear that she did not want Resident #1 moved further from her home and was only given information as to potential facilities. She stated Family Member A was trying to process the information, she was not in agreement to transfer Resident #1 at the time. She stated the day after Family Member A spoke with LMSW about a potential facility, 9/10/2025 she received a telephone call from the Admissions Coordinator of the new facility introducing himself and notifying her of the transfer arrangements. She stated she made it clear to the admission Coordinator that she was not aware of a transfer from Resident #1's current facility and she was not approving the transfer. She stated she immediately reached out to the LMSW by phone and informed him that she never approved Resident #1 to be transferred to another facility. She stated the following day on 9/11/2025 Resident #1 was transferred to the new nursing facility despite her making it clear she didn't want her transferred. She stated there was no notification of the transfer/discharge, there was no planning, and no approval.

In an interview on 1/16/2026 at 11:46 AM the LMSW stated he was responsible for the facility's transfer/discharge process. He stated he would talk to the resident or the POA/guardian, to get permission for transfer/discharge. The LMSW stated he would coordinate with the admissions coordinator from the transferring facility, facility was typically closer to family, and the nursing staff handled

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F 0627

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

and coordinated logistics of transport/discharge, medications, and physician orders. He stated the notification of transfer was provided to the resident or POA. He stated if transfer needed to happen, he would explain and if the POA agreed or didn't agree he would provide a 30-day discharge notice. He stated typically if the transfer/discharge was due to safety concerns and the resident or the POA did not agree then he would proceed with a notice of eviction and provide information for the appeal process and Ombudsman. The LMSW stated if the resident or the POA disagreed with the transfer/discharge he would get them in contact with the Ombudsman, and they could start the conversation for appeal. He stated typically a resident or POA will have 14 days from notification to Ombudsman whether verbal, by phone or by email to file an appeal. He stated the impact of not transferring/discharging a resident by the facility's process could be traumatizing and there could be trust issues with nursing facility or staff. The LMSW stated on 9/9/2025 he notified the POA, [Family Member A] that Resident #1 would benefit from more space to walk around and not be distracted by territorial disputes, safety concerns as she was having conflicts with residents. He stated Family Member A initially agreed with the arrangements to locate a nursing facility to meet Resident #1's needs. He stated on 9/10/2025 Family Member B called him the day following the facility's efforts of securing a nursing facility to meet Resident #1's needs. He stated Family Member B was also a POA for Resident #1 and he assured her that Resident #1 was going to a safe place and if she was not okay with the transfer, he told her to contact the Ombudsman and file an appeal and provided contact information. He stated on 9/11/2025 he provided an email notification of the transfer to both POAs [Family Members A and B] and included the Ombudsman. He provided the surveyor with a printed email dated 9/11/2025 at 11:49 AM providing the family notification of Resident #1's transfer with new facility information. He stated he was aware the transfer of Resident #1 occurred the morning of 9/11/2025 and after reviewing the progress note in Resident #1's clinical record the nursing staff documented the transfer at 9/11/2025, 11:21 AM, which was prior to his notification email. The LMSW stated Family Member B was upset as she was not contacted and stated there were no policies that he would have to contact the secondary POA, and family did not reach out to the Ombudsman to start the appeal. He stated since Family Member B was not the primary POA he didn't have to accept her request to stop the transfer since he was coordinating efforts with Family Member A. The LMSW stated he did not get notification back that the transfer was being challenged, just that Family Member B was unhappy she wasn't notified. He stated a transfer/discharge from one day to the next was unusual as they typically took several days as people need to review clinicals. He stated Resident #1's transfer was quicker as the DON knew someone at the new facility who was able to expedite the process. He stated the standard process was to get the POA to agree to the transfer/discharge, he worked on looking for a facility that met the resident's needs and notified the POA if one was found and the date of transfer. He stated he left Family Member A a voicemail on 9/10/2025 regarding the new facility located for Resident #1. He stated she returned the call, and he discussed with her that Resident #1 was on one-on-one supervision, and he was under some pressure, and he was to get her transferred to another facility. He stated quick transfers like that one could cause a family harm as they were not given time to discuss as a family and the notifications did come after the fact, which was not something normally done by the facility.

In an interview on 1/16/2026 at 5:00 PM the ADM stated the facility followed the discharge transfer policy.

Review of policy dated 2/12/2025, titled Discharge or Transfer reflected the following:

This facility will ensure the discharge planning process addresses each resident's discharge goals and needs, including caregiver support and referrals to local contact agencies, as appropriate, and involves the resident and if applicable, the resident representative and the

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interdisciplinary team in developing the discharge plan. Notification of Discharges For a facility-initiated non-emergent transfer or discharge of a resident, the facility will notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand with at least 30 days' notice prior to discharge. Additionally, the facility will send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman. Discharge Planning Discharge planning is the process of creating an individualized discharge care plan, which is part of the comprehensive care plan. It involves the interdisciplinary team working with the resident and resident representative, if applicable, to develop interventions to meet the resident's discharge goals and needs to ensure a smooth and safe transition from the facility to the post-discharge setting. Post-Discharge Plan of Care The post-discharge plan of care details the arrangements that facility staff have made to address the resident's needs after discharge, and includes instructions given to the resident and his or her representative.