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	02/23/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of needs and preferences for three (3) of twelve (12) residents (Resident #1, Resident #2, Resident #3) reviewed for reasonable accommodation of needs. 1. The facility failed to ensure the call light system in Resident #1's room was in a position accessible to the resident on 02/20/2026.2. The facility failed to ensure the call light system in Resident #2's room was in a position accessible to the resident on 02/20/2026.3. The facility failed to ensure the call light system in Resident #3's room was in a position accessible to the resident on 02/23/2026. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.The findings included: 1. Record review of Resident #1's admission Record, dated 02/20/2026, revealed an [AGE] year-old female admitted on [DATE]and re-admitted on [DATE]. Record review of Resident #1's Diagnosis Report, dated 02/23/2026, revealed diagnoses including unspecified dementia (a decline in cognitive function, impacting memory, thinking, behavior, and the ability to perform everyday activities), unspecified lack of coordination, and unspecified osteoarthritis (a condition where the protective layer that cushions the ends of the bones wears down over time leading to pain, stiffness, and reduced mobility). Record review of Resident #1's Annual MDS, dated [DATE], reflected Resident #1 had a BIMS score of 7, indicating she was severely cognitively impaired. She used a wheelchair, required setup or clean-up assistance with toileting hygiene, and was independent for her mobility needs. Record review of Resident #1's Care Plan, undated and accessed 02/20/2026 at 03:07 p.m., reflected Resident #1 had a problem related to diagnoses of dementia and impaired cognition causing the resident to sometimes not understand staff and family, date initiated and revised 02/07/2025. An intervention included Ensure/provide a safe environment: Call light in reach, ., date initiated 02/07/2025. Resident #1 had an ADL Self Care Performance Deficit (a condition where an individual has difficulty performing self-care activities such as dressing, grooming, and toileting due to physical or mental impairment), date initiated 01/06/2025. An intervention included Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed., date initiated 01/06/2025. During an observation and attempted interview on 02/20/2026 at 10:16 a.m., Resident #1, was observed lying in her bed with a walker at bedside, located close to the room door. Her call light was observed wrapped and hooked onto the wall situated behind Resident #1's headboard and towards the center of the room, away from the room door. Resident #1 stated she just got here when asked how long she had lived at the facility and when asked if she could reach her call light, she was observed to reach over her shoulder but could not touch the call light. Resident #1 stated she did not know how long her call light was in that position. Resident #1 did not answer when asked how she felt about the call light being out of reach or if she used it. During an observation and interview on 02/20/2026 at 10:18 a.m., MA A was observed standing at a medication cart two (2) doors down (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

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	02/23/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from Resident #1's room. MA A stated Resident #1 had moved onto her current hall around three (3) days prior but had been a resident at the facility for a while. MA A stated Resident #1 was able to perform some self-care activities independently and used a walker for mobility; however, she needed some assistance and cueing for certain tasks. MA A stated Resident #1 was confused and needed redirection. MA A stated Resident #1 did use her call light. MA A stated Resident #1's current roommate would sometimes pack up all the possessions in the room and might have possibly put Resident #1's call light on the wall. MA A stated staff were to give the call light back to Resident #1 and clip it onto Resident #1's bed. MA A stated the call light was supposed to be within Resident #1's reach. She stated staff were supposed to check throughout the day, during the two-hour rounds, and when she was passing medications to ensure the call lights were within reach of the residents. MA A stated she had observed the call light having been hooked on the wall that morning, 02/20/2026 and had not placed it at Resident #1's bedside due to providing care to another resident. 2. Record review of Resident #2's admission Record, dated 02/20/2026, revealed an [AGE] year-old female admitted on [DATE] and re-admitted on [DATE]. Record review of Resident #2's Diagnosis Report, dated 02/23/2026, revealed diagnoses including neurocognitive disorder with Lewy bodies (a brain disorder caused by a gradual buildup of proteins in the brain resulting in cognitive decline, movement difficulties, and visual hallucinations), lack of coordination, and anxiety disorder (a mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life). Record review of Resident #2's Quarterly MDS, dated [DATE], reflected Resident #2 was unable to complete the BIMS interview and was moderately impaired regarding making decisions for tasks of daily life and required cues or supervision. She used a wheelchair and was dependent on an assistant for moving from sitting to lying, from lying to sitting on the side of the bed, and from transferring to and from bed to a chair. Record review of Resident #2's Care Plan, undated and accessed 02/20/2026 at 01:12 p.m., reflected Resident #2 had an ADL Self Care Performance Deficit, date initiated 07/05/2022 and revised on 02/28/2025. An intervention included Encourage the resident to use bell to call for assistance, date initiated 01/06/2025. Resident #2 had oxygen therapy (the administration of supplemental oxygen to someone who cannot get enough oxygen naturally) as needed, date initiated 03/30/2023 and revised on 09/20/2023. An intervention included Provide reassurance and allay (relieve or alleviate) anxiety (a feeling of worry or nervousness): Have an agreed-on method for the resident to call for assistance (e.g., call light, bell)., date initiated 03/30/2023. During observations on 02/20/2026 at 10:25 a.m. and 10:47 a.m., Resident #2, was observed in her bed asleep. Her call light was observed to be lying under her bed and against the wall. Resident #2 was unrousable and did not wake up enough to follow directions or attempt to demonstrate if she could have reached the call light. During an observation and interview on 02/20/2026 at 10:49 a.m., CNA B and CNA C stated Resident #2 did not use her call light. CNA B walked to Resident #2's bed, pick up the call light, and clip it onto the bed within Resident #2's reach. CNA B and CNA C stated the call light was on the floor, out of reach, and stated that though Resident #2 did not use the call light, it was still supposed to be within the resident's reach. 3. Record review of Resident #3's admission Record, dated 02/23/2026, revealed a [AGE] year-old female admitted on [DATE]. Record review of Resident #3's Diagnosis Report, dated 02/23/2026, revealed diagnoses including cerebral palsy (a condition caused from damage or abnormal development to a part of the brain which is responsible for muscle movement and leads to movement disorders and may result in developmental delays and sensory impairments), severe intellectual disabilities (a condition characterized by significant limitations in intellectual functioning such as reasoning, problem solving, planning and learning), and lack of coordination. Record (continued on next page)

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	02/23/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of Resident #3's Quarterly MDS, dated [DATE], reflected Resident #3 was rarely or never understood. She used a wheelchair and was dependent for her mobility needs. Record review of Resident #3's Care Plan, undated and accessed 02/23/2026 at 11:00 a.m., reflected Resident #3 had a communication problem, was non-verbal, had a diagnosis of cerebral palsy, and made sounds or gestures, date initiated 04/05/2023 and revised on 08/13/2024. An intervention included Ensure/provide a safe environment: Call light in reach. During an observation and interview on 02/23/2026 from 08:51 a.m. to 09:25 a.m., Resident #3, was initially observed in bed asleep. During medication administration, she woke up and was observed to be non-verbal. Upon entering Resident 3's room, her call light was observed to be out of Resident #3's reach, wrapped and hooked onto the wall situated along the wall toward the center of the room, past Resident 3's footboard. At 09:20 a.m., LPN D stated she did not know why Resident #3's call light was hooked onto the wall. LPN D stated she did not have a chance to check Resident #3's room earlier that morning. LPN D stated Resident #3 normally did not use or could not use the call light, but it was usually clipped to Resident #3's bed. LPN D stated housekeeping, night shift, or anyone could have put the call light there. LPN D stated the call light having been out of Resident #3's reach could definitely impact her if Resident #3 was able to use it. LPN D clipped the call button to the bed prior to leaving the room. During an interview on 02/23/2026 at 04:00 p.m., the DON stated she had always been taught that call lights were to be in reach of the residents. The DON stated the expectation was for call lights to be in reach of the residents. She stated the impact of a call light out of reach was that it could result in the residents' needs not being addressed in a timely manner. She stated at shift change or start of shift, the nurses were expected to check the more critical residents, and the CNAs, should have been completing a walkthrough on all their assigned residents, which would include checking the location of the call lights. The DON stated the facility did not have a policy on call lights. During an interview on 02/23/2026 at 04:27 p.m., the ADMIN stated his expectation was for the call lights to be within reach of the residents. He stated that even if a resident was comatose, the call light should still be within reach. He stated the impact on a resident of a call light having been out of reach was that they resident might not be able to have timely assistance. Record review of the facility's policy, Fall Policy, undated, reflected: Preventing falls requires an interdisciplinary program that focuses on modifying the extrinsic factors, correcting intrinsic factors, and educating the resident and family.Environmental .- Position call bells within reach.

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	02/23/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments and permit only authorized personnel to have access to the keys for one (1) of twelve (12) residents (Resident #4) reviewed for medication storage. The facility failed to ensure Resident #4 did not have two (2) velphoro oral tablets (a phosphate binder, a medication used to control phosphorus levels in the blood) at the bedside. This deficient practice could place residents at risk of medication misuse or drug diversion.The findings included: Record review of Resident #4's admission Record, dated 02/20/2026, revealed a [AGE] year-old male admitted on [DATE] and re-admitted on [DATE]. Record review of Resident #4's Diagnosis Report, dated 02/23/2026, revealed diagnoses including end stage renal disease (the final stage of chronic kidney disease, where the kidneys lose nearly all their ability to filter waste in the blood), and dependence on renal dialysis (condition where patients are reliant on dialysis treatment due to the inability of their kidneys to adequately filter waste from the blood). Record review of Resident #4's Quarterly MDS, dated [DATE], reflected Resident #4 had a BIMS score of 15.0, indicating he was cognitively intact. He had range of motion impairment on one side for his upper extremities and both sides for his lower extremities, used a wheelchair, and was dependent on assistance when transferring to and from a bed to a chair. Record review of Resident #4's Order Summary Report, dated 02/20/2026, reflected the order Velphoro Oral Tablet Chewable 500 MG (Sucroferric Oxyhydroxide) Give 2 tablet [sic] by mouth with meals related to END STAGE RENAL DISEASE give [sic] with meals. May crush, chew or swallow, noted as active and dated as ordered 10/10/2025. There was not an order stating Resident #4 could self-medicate. Record review of Resident #4's Self Medication Program Assessment of Skills, effective date 01/23/2025, reflected Resident #4 was Fully Capable of demonstrating the correct route of medication(s) administration, knowledge of dose (strength) of medication(s), correct frequency (time) of medication(s), could verbalize the basic reason why he was taking the medication, and the knowledge of common side effects of his medication. Record review of Resident #4's Care Plan, undated and accessed 02/20/2026 at 12:36 p.m., reflected Resident #4 had impaired cognitive function/dementia (a decline in cognitive function, impacting memory, thinking, behavior, and the ability to perform everyday activities) or impaired thought processes as evidenced by a BIMS score of 8.0, date initiated and revised on 12/25/2024. An intervention included Engage the resident in simple, structured activities that avoid overly demanding tasks., date initiated 12/25/2024. There was not a focus or intervention stating Resident #4 could self-medicate. Observation and interview on 02/20/2026 at 10:28 a.m., two 2 orangish-brown, disk-like pills were observed in a disposable plastic cup on Resident #4's side table. Resident #4 stated he had just come back to his room from dialysis (provided in the facility). He stated the pills were his binders (phosphate binders) for his dialysis. He stated that they [did not identify staff member(s)] gave it to him this morning, 02/20/2026. He stated, those I chew, referring to the binders, and the rest they watch me, referring to the other medications he was administered. During an interview on 02/20/2026 at 10:51 a.m., MA E stated she did not administer Resident #4 his medications yet that morning, 02/20/2026. She stated staff were supposed to watch residents take their medications. During an interview on 02/20/2026 at 10:52 a.m., RN F stated the impact for Resident #4 if he did not want to take his phosphate binder, was that his phosphate levels could be high. She stated the dialysis staff took their own labs on the dialysis residents and they would notice if Resident #4's phosphate levels were high. RN F stated the phosphate (continued on next page)

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	02/23/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	binders were supposed to be watched by staff when administered and swallowed. During an interview on 02/23/2026 at 04:00 p.m., the DON stated her expectation, if a resident refused to take a medication during administration, was for the staff to take the medication back and never leave a medication at a resident's bedside. She stated if a resident had a high enough BIMS, the resident would need to be assessed prior to being permitted to self-administer medications. She stated, as far as she was aware, the facility did not have any residents that were allowed to self-administer medications. She stated if a resident voiced that they wanted to self-administer medications, an assessment would have to be completed, the task could be care-planned with the resident, and the task would reflect on the resident's care plan. She stated the impact of a medication having been left at a resident's bedside was that the resident could overmedicate by taking the medication too close to the administration of the same medication from a different shift, double up on the phosphate binder, or another resident could find and take the medication, thinking the medication was candy or something. During an interview on 02/23/2026 at 04:27 p.m., the ADMIN stated that if Resident #4 was assessed to be capable of self-medicating, he should still have been care planned for that task. He stated his expectation was for a mention of self-medication to be the resident's care plan. The ADMIN stated that he would defer to the clinical staff to theorize on the impact a medication could have if left at a resident's bedside. Record review of the facility's policy, Medication Administration and General Guidelines, dated 2025, reflected: PolicyMedications are administered as prescribed, in accordance with State Regulations using good nursing principles and practices and only by persons legally authorized to do so.Procedure1. Medications are prepared, administered, and recorded only by licensed nursing, medical, pharmacy, or other personnel authorized by state laws and regulations to administer medications.4. Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with policy and procedure for self-administration of medications.Checklist for completing proper steps in the administration of medications .- Observes the resident take the medications. Record review of the facility's policy, Self-Administration of Medications by Residents Policy, undated, reflected: Each resident who desires to self-administer medication is permitted to do so if the facility's interdisciplinary team and/or facility policy allows or has determined that the practice would be safe for the resident and other residents of the facility.Procedure1. Each resident is offered the opportunity to self-administer his or her medications during the routine assessment by the facilities interdisciplinary team.2. If the resident desires to self-administer medications an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility.3. The interdisciplinary team determines the residents' ability to self-administer medications by means of completing the Self Administration of Medication assessment in PCC.4. The results of the interdisciplinary team assessment are recorded.8.The resident requests each dose from the medication nurse, who provides the medication to the resident in the unopened package for the resident to self-administer. The nurse then records such self-administration on the MAR in the manner described above.