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	03/20/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure the environment was as free of accident hazards as is possible and each resident receives adequate supervision to prevent accidents for 1 of 1 resident (Resident #1) reviewed for accidents hazards and supervision: Resident #1 left the facility without supervision or staff knowledge on 3/19/26 from 11:35 p.m. to 11:57 p.m. Resident #1 was found approximately 0.1 miles away at a local fast-food restaurant. This failure could place residents at risk of accidents that could result in serious injury, harm, impairment, or death.The findings included: Record review of Resident #1's face sheet dated 3/20/26 reflected a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke, caused by loss of blood flow to part of the brain), COPD (Chronic Obstructive Pulmonary Disease; long-term lung condition that makes it hard to breathe), abnormal posture, muscle weakness, lack of coordination, dementia with agitation, heart failure, asthma, and fracture to the right wrist. Record review of Resident #1's most recent quarterly MDS assessment dated [DATE] reflected the resident had adequate vision, was cognitively intact for daily decision-making skills, and was independent with mobility. Record review of Resident #1's comprehensive care plan dated 1/13/26 reflected that the resident had impaired cognitive function or impaired thought processes related to disease process, forgetful at times, and dementia with agitation. Record review of Resident #1's Elopement Risk assessment dated [DATE] reflected the resident ambulated independently or with a device, understood and verbalized acceptance of the need for nursing home care, was cognitively consistent and reasonable with decision-making skills, did not have previous attempts of leaving her own residence/facility, recognized stop lights and signs, knew precautions when crossing streets, and knew the location of current residence. Record review of Resident #1's hospital visit summary dated 3/19/26 and time stamped 12:27 a.m., reflected the resident was transferred to the hospital by EMS for an unwitnessed fall at 7:00 p.m. and the resident complained of right sided head pain. The report reflected Resident #1 had a chest x-ray, a CT of the abdomen and pelvis, and a CT of the head all showing negative results. Record review of Resident #1's progress note dated 3/19/26, time stamped 6:45 a.m. and authored by LVN A revealed Resident #1 was seen in her room during the medication pass around 9:40 p.m., was alert and oriented and expressing grievance that she was supposed to be in a private room. LVN A documented he had talked to the Administrator about Resident #1's grievance. LVN A documented he then received a call from an EMS and was asked if Resident #1 lived in the facility. LVN A documented he instructed staff to go to Resident #1's room to look for her and was informed she was not in her room. LVN A documented he walked to the corner and Resident #1 was acting confused and denied knowing who LVN A was. LVN A documented that the resident was transferred to the emergency department related to confusion. LVN A documented that the nurse in the emergency department stated Resident #1 reported she had fallen at 7:00 p.m. and had hit her head. LVN A documented that Resident #1 returned to the facility at 4:00 a.m. (3/20/26) and apologized to LVN A for leaving. Record review of Resident #1's electronic record reflected the resident did not have any documented falls since the time of admission, 10/21/25. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's electronic record reflected the resident admitted to the facility on [DATE] with a diagnosis of right radius closed fracture with routine healing. During an interview on 3/20/26 at 8:14 a.m., the Administrator stated Resident #1 eloped from the facility at 11:35 p.m. on 3/19/26 and was transferred back to the facility from the hospital on 3/20/26 at 4:30 a.m. The Administrator stated, Resident #1 was observed on the video surveillance camera using the keypad to input the door code to the front entry to open the door. The Administrator stated Resident #1 had a history of going out to the local fast-food restaurant but was always accompanied by staff. The Administrator stated Resident #1 was upset because she had a roommate and wanted her own room. The Administrator stated Resident #2 was moved into Resident #1's room because she required closer monitoring and Resident #1 was offered to be moved to another room but Resident #1 rejected the idea. The Administrator stated, Resident #1 was unsupervised for about 20 minutes from 11:35 p.m. and up until LVN A received the phone call from EMS at 11:55 p.m. The Administrator stated Resident #1 was upset because another resident was placed in her room, and Resident #1 didn't sign out, she didn't tell anybody, and she somehow got the code to leave the facility. During an observation and interview on 3/20/26 at 9:00 a.m., Resident #1 was seen sitting up on the side of the bed with a walker in front of her. Resident #1 was observed with a wrist immobilizer to her right wrist, due to past injury. Resident #1 stated she was able to ambulate with the walker to go to the bathroom or to get something out of her closet and could stand long enough to do it. Resident #1 stated she used to have frequent blackouts when she lived at home but stated she could not remember the events from 3/19/26 in which she walked out of the facility and was found at the local fast-food restaurant. Resident #1 stated she was upset because they put a lady in her room when the Administrator had promised she would not have a roommate. Resident #1 stated she did not remember leaving the facility and stated, I was told I pushed the buttons on the door, but I don't even know the code, but I guess I got it open by pushing a bunch of numbers. Resident #1 stated nobody had given her the code to the front door and had only left the facility for doctor appointments, or when she obtained permission to go with family or friends. Resident #1 stated she recalled LVN A giving her medications at 8:00 p.m. (3/19/26), then she fell asleep and could not remember anything else. During an observation and interview on 3/20/26 at 10:08 a.m., Resident #1's room was located on B Hall next to the shower room and toilet on the right, and the nurse's station was next to the shower room on the left. The Administrator stated, according to his estimation, Resident #1's room was approximately 15 yards (45 feet) from her room to the dining room and a total of approximately 100 yards (300 feet) from her room to the facility front door [85 yards or 255 feet from the dining room to the front door of the facility]. Observation from Resident #1's room in the B Hall required Resident 1 to walk past three resident rooms, into the dining room, and then to the front lobby to gain access to the front door. The Administrator stated, Resident #1 was seen on the facility camera footage walking from her room, through the dining room, and to the lobby and was clearly not stumbling. During an interview on 3/20/26 at 10:16 a.m., Resident #2 stated she was moved to a room closest to the dining room because of issues related to difficulty with walking. Resident #2 stated she was moved to the same room as Resident #1 and was told by Resident #1 that she (Resident #1) wanted the room to herself and had been promised to have the room to herself. Resident #2 stated she received medications on 3/19/26 at approximately 8:30 p.m. and recalled Resident #1 had received her medication at the same time. Resident #2 stated Resident #1 did not say anything to her about leaving or about having the code, or getting the code to the door, other than she wanted the room to herself. Resident #2 stated she didn't usually go to sleep until 10:30 p.m. but recalled Resident #1 leaving the room at around 8:30 p.m. when medications were given, but was not in the room when I went to sleep. Resident #2 stated she was sure she went to sleep at 10:30 p.m. because that was the time she turned off her tv. Resident #2 stated, typically nobody checks on me after the last medication. I leave my door open a little bit if I need to get their attention. Observation of the facility video footage on 3/20/26 at 10:35 a.m. revealed Resident #1 was observed in the B Hall unit accompanied by CNA B and CNA C on 3/19/26 from 11:00 p.m. to 11:15 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	p.m. in the shower room. Resident #1 was observed exiting the shower room at approximately 11:30 p.m. with CNA C and Resident #1 was seen using her walker to go back into her room. The facility video footage shows there were two aides (CNA B and CNA C), one unidentified housekeeping staff, LVN A and LVN D in the unit. At approximately 11:35 p.m., Resident #1 was observed at the front door, activating the code on the keypad and exiting onto the sidewalk. The facility video footage showed LVN A walk out of the facility from the front door at 12:00 a.m. An attempt at a telephone interview with CNA B on 3/20/26 at 11:22 a.m. was unsuccessful. An attempt at a telephone interview with CNA C on 3/20/26 at 11:24 a.m. was unsuccessful. An attempt at a telephone interview with LVN D on 3/20/26 at 11:25 p.m. was unsuccessful. During a telephone interview on 3/20/26 at 11:29 a.m., LVN A stated he had administered medications to Resident #1 at approximately 9:40 p.m., and recalled the resident being upset because she had Resident #2 for a roommate. LVN A stated he told Resident #1 he would make her grievance known to the Administrator and placed a call to the Administrator at approximately 9:30 p.m., with Resident #1 witnessing the telephone exchange, and told the resident the Administrator would look into the matter of having a private room. LVN A stated Resident #1 seemed satisfied and never indicated to me that she was planning on making a run for it. LVN A stated he continued with medication pass and CNA B and CNA C assisted Resident #1 into the shower room. LVN A stated he received a phone call at approximately 11:58 p.m. from EMS staff about Resident #1 and asked LVN D to go to the resident's room to see if she was there. LVN A stated he was told by LVN D that Resident #1 was not in her room. LVN A stated it took him approximately 3 minutes to get from the facility to the local fast-food restaurant where Resident #1 was found. LVN A stated when he arrived at the local fast-food restaurant, Resident #1 was observed sitting on a stretcher and she acted like she didn't know me. LVN A stated, Resident #1 told him she had fallen and hit her head at 7:00 p.m. LVN A stated, if Resident #1 had fallen we would have known, and there was no way she would have been able to get up by herself. She has a lot of attention seeking. LVN A stated EMS staff took Resident #1 to the hospital because she appeared confused. LVN A stated he did not now how Resident #1 obtained the code to the front door but she is very observant. LVN A stated the facility had a lot of observant patients, a lot of smokers, and it's been a battle trying to keep the door codes a secret. Record review of the facility policy titled Resident Rights, undated reflected in part, .The resident has a 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.A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.Safe environment - The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.

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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 properly in the cart for 1 of 3 medication carts (300 hallway medication cart) reviewed for storage: he facility failed to ensure Resident #2's insulin Lispro was stored appropriately in a locked medication cart. This failure could place residents at risk of not receiving prescribed medications as ordered and drug diversions. The findings included: Record review of Resident #2's face sheet dated 3/18/26 reflected a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included type 1 diabetes (a chronic autoimmune disease in which the body's immune system destroys the insulin-producing cells of the pancreas, leading to an absolute deficiency of insulin), and dependence on renal dialysis (medical treatment that replaced some functions of the kidneys when they are no longer able to work effectively). Record review of Resident #2's most recent MDS assessment dated [DATE] reflected the resident was cognitively intact for daily decision-making skills and was treated with insulin. Record review of Resident #2's Order Summary Report dated 3/18/26 reflected the following:- Insulin Lispro Subcutaneous Solution Pen-injector 100 unit/ML, inject 4 units subcutaneously as needed for Diabetes before each session of dialysis with order date 3/3/26 and no end date.-Insulin Lispro Subcutaneous Solution Pen-injector 100 unit/ML, inject as per sliding scale subcutaneously with meals for diabetes with order date 3/5/26 and no end date. During an observation on 3/18/26 at 2:15 p.m., three medication carts on the 300 Hall were seen next to each other in front of the nurse's station facing the hallway. The middle medication cart was observed with an insulin Lispro pen on top of the medication cart counter with a pharmacy label with Resident #2's name. During an interview on 3/18/26 at 2:17 a.m., LVN E stated she had obtained the insulin Lispro pen for Resident #2 and stated she had given the resident a dose of insulin at approximately 11:30 a.m. and stated she had written the open date on the insulin cap with a black marker. LVN E stated she believed Resident #2's insulin Lispro pen may have been left on top of the medication cart by the previous shift because the medication cart counter where the insulin pen was seen was not hers. LVN E stated she could not recall if she had forgotten to lock the insulin pen in her medication cart. LVN E stated, all medications should always be locked in the medication cart because somebody could take it and if used could cause a drug reaction and it could also cause hypoglycemia (low blood sugar). During an interview on 3/18/26 at 3:02 p.m., the DON stated medications, including insulin, should be locked in the medication cart immediately after use. The DON stated, if someone took it, and it did not belong to them, they could inject themselves not knowing what it was and they could become hypoglycemia, or the insulin pen could go missing, or if the patient did take it and they were not diabetic, they could fall into a coma. The DON stated that an unlocked insulin pen was considered a safety concern. The DON stated, only nursing staff were allowed to administer insulin to the residents. Record review of the facility document titled Medication Storage in the Facility, dated 2025 reflected in part, .Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 6 residents (Resident #3) reviewed for accuracy of records: The facility failed to document wound care treatments on the TAR for Resident #3 on 3/1/25, 3/6/26, 3/7/26, 3/11/26, 3/13/26, 3/14/26, 3/15/26, and 3/16/26. These failures could affect residents whose records were maintained by the facility and could place the residents at risk of errors in care and treatment.The findings included: Record review of Resident #3's face sheet dated 3/19/26 reflected a [AGE] year-old male admitted to the facility on [DATE], and re-admitted on [DATE] with diagnoses that included diabetes, muscle weakness, lack of coordination, retention of urine, and pain. Record review of Resident #3's most recent quarterly MDS assessment dated [DATE] reflected that the resident was cognitively intact for daily decision-making skills and was at risk for pressure ulcer/injury. Record review of Resident #3's Order Summary Report dated 3/19/26 reflected the following:- Apply TRIAD to buttocks one time a day for wound healing with order date 2/15/26 and no end date. Record review of Resident #3's MAR for March 2026 reflected the following:- Apply TRIAD to buttocks one time a day for wound healing. The TAR was missing documentation for the TRIAD treatment for Resident #3 on 3/1/25, 3/6/26, 3/7/26, 3/11/26, 3/13/26, 3/14/26, 3/15/26, and 3/16/26. Record review of Resident #3's comprehensive care plan with revision date 10/9/25 reflected the resident was at risk for alteration in skin integrity related to impaired mobility with interventions that included to use lifting device, draw sheet, etc. to reduce friction. During an interview on 3/17/26 at 4:12 p.m., Resident #3 stated he had complained about the nursing staff not administering medications for his blood pressure. Resident #3 stated he had been receiving a treatment to his buttocks with a cream every morning, and was sure of that because he did not want the area to get worse. Resident #3 stated he often refused to take medications and stated he was part of the problem. During an interview on 3/19/26 at 2:34 p.m., the ADON stated Resident #3 often refused medications and the expectation was for nursing staff to document on the MAR/TAR when a medication was refused. The ADON stated, when a resident refused medications, the MAR/TAR prompted the nurse to input a numeric code which indicated if the resident refused, or if the resident was not in the building, but the MAR/TAR should not have any blanks because it could be interpreted as the medication not being given or treatment not being done. The ADON stated the nurse who documented on the MAR/TAR should also be auditing the document daily. The ADON stated, any medications or treatments not documented on the MAR/TAR were reviewed the following day during the morning meeting. The ADON stated, I know in the nursing world, if it wasn't documented it wasn't done. The ADON stated, in Resident #3's case, she was aware he often refused medications, but the treatment of the buttocks with TRIAD was something he did not refuse. During an interview on 3/19/26 at 4:20 p.m., LVN E stated the floor nurses were responsible for providing treatments to those residents who had physician's orders for wound care. LVN E stated there should not be any blank spaces on the MAR/TAR because it looked like the medication or treatment was not given or done. LVN E stated if treatment was not done as ordered, the area could deteriorate. LVN E stated, documentation of the situation whether the medication was refused, not given, or withheld should be documented at that time. During a joint interview with the Administrator and DON on 3/20/26 at 12:54 p.m., revealed the DON stated, it was her expectation that there should not be any blanks on the MAR/TAR because it could be considered the medication was missed or the treatment was not done. The Administrator stated it was important to keep an accurate medication record otherwise there could be mistakes due to double dosing or frequency isn't maintained. The DON and the Administrator stated the clinical management team generated a report that flagged missed medications that were reviewed daily. The DON stated, she and nursing management audited (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the MAR/TAR for missing documentation. The DON stated, in Resident #3's case, he had a history of medication refusals, but there was no way Resident #3 refused the TRIAD treatment to his buttocks. The DON stated, it was her expectation, once a medication or treatment was completed, it would be documented immediately after completed. Record review of the facility document titled, Documentation, undated reflected in part, .Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident and or soft resident file. It may include observations, investigations, and communications of the residents involving care and treatments. It has legal requirements regarding accuracy and completeness, legibility and timing. Special forms in the clinical record are utilized in nursing documentation, such as.nursing progress notes.medication sheets.The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets.The facility will ensure that information is comprehensive and timely and properly signed.