STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455804	A. Building B. Wing	06/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northgate Health and Rehabilitation Center	5757 N Knoll San Antonio, TX 78240

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse, to the administrator of the facility and to other officials including to the State Survey Agency where state law provides for jurisdiction in long-term care facilities in accordance with State law through established procedures for 2 of 4 residents (Residents #1 and #2), reviewed for freedom from abuse, neglect, and exploitation. 1. Facility failed to report incident of suspected abuse from Monday 04/12/2025 when Resident #1 stated she had been fondled by man. 2. Facility failed to report an incident of suspected physical abuse from Monday 04/12/2025 when Resident #2 stated he had been hit by a female resident. These failures could put the residents at risk of abuse, allegations of abuse not being reported immediately, and could result in physical and psychosocial harm. The findings were: Record review of Resident #1's face sheet, dated 06/21/2025, revealed she was admitted on [DATE] and the latest admission being 04/02/2025 with diagnoses which included: muscle weakness (generalized), cognitive communication deficit, and paranoid schizophrenia (subtype of schizophrenia characterized by prominent symptoms of paranoia, including delusions and hallucinations, particularly those involving persecution or conspiracy). Record review of Resident #1's Quarterly MDS assessment, dated 06/05/2025, revealed the resident's BIMS score was 15, which indicated intact cognitive impairment. The Quarterly MDS assessment further revealed Resident #1 required substantial/maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) for sit to lying, chair/bed to chair transfer, was dependent (helper does all of the effort. Resident does none of the effort to complete the activity) for toileting hygiene, upper body dressing, and lower body dressing. Record review of Resident #1's care plan, problem start date of 02/05/2025, revealed Resident #1 had a problem of [Resident's name] has a hx of calling the police to report false allegations. (continued on next page)

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
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident record review of Resident #1's LVN progress notes, dated 04/12/2025, revealed Res. was heard yelling out and crying in dayroom and res. was asked what wrong. Res. crying and mumble something in low tone. Nurse was unable to hear and asked res. to speak up. Res. blurted out he put his hands on me and tried to touch my breasts, he put his hands on me! Res. Was comforted and asked if she could wait there so nurse could get help. Res. said she didn't want to leave the dayroom anyway. DON was walking towards rosewood nurses' station when she was called and asked to come to dayroom to speak to res. DON was made aware as she also repeated her statement about another res. to DON. Res. was asked by DON if going to her room or nurses' station would help her feel safe. Res. agreed and went to nurses' station then just a few min. later she asked to be taken to her room. Res. asked if I have to talk to the police, will they come to my room? Nurse assured if needed they would be escorted to her room. During an interview on 06/21/2025 at 12:30 PM Resident #1 stated Resident #2 put his hands on her body and he fondled her. Resident #1 further stated he had only bothered her once. Record review of Resident #2's face sheet, dated 06/21/2025, revealed he was admitted on [DATE] with diagnoses which included: vascular dementia (a type of dementia caused by reduced blood flow to the brain, often due to strokes or other conditions affecting blood vessels. This impaired blood flow damages brain cells, leading to problems with memory, thinking, and behavior), unspecified severity, with other behavioral disturbance, alcohol abuse, and generalized anxiety. Record review of Resident #2's admission MDS assessment, dated 04/15/2025, revealed the resident's BIMS score was 04, which indicated severe cognitive impairment. The Quarterly MDS assessment further revealed Resident #2 was independent with toileting hygiene, upper body dressing, lower body dressing and personal hygiene. Record review of Resident #2's care plan, problem start date of 06/13/2025, revealed Resident #2 had a problem of [Resident's name] presents with agitation and verbal behavioral symptoms and racial slurs directed toward staff regarding smoke breaks. Resident record review of Resident #2's progress notes, dated 04/12/2025, revealed Res. came from dayroom and said, that lady is crazy, she just started hitting me for no reason, so I left and I'm not gonna help her anymore. Res. said he was ok and just waiting to go smoke. DON gave instruction to have this res. be moved to [NAME] (hall on opposite side of building) now. Res. and belongings were moved at this x. During an interview on 06/21/2025 at 12:23 PM with Resident #2 stated he had never touched anyone, but a lady had said he had once. Resident #2 stated she was crazy. Resident #2 did not recall having been hit by another resident. Record review of TULIP on 06/21/2025 revealed the facility had not made reports regarding Resident #1 or Resident #2's allegations of abuse. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/21/2025 at 3:58 PM the DON stated when she reviewed the LVN's note from Resident #1's chart that it was the account from the LVN, but it was not the account of what she believed happened. The DON stated she had passed the small dining room where Resident #1 was sitting and spoke to the LVN. The DON reported after she spoke to the LVN she went to talk to Resident #1. The DON stated Resident #1 was not distressed when they spoke Resident #1 did not report to her having been touched and stated she was fine. The DON stated she did not think it was reportable because Resident #1 had a high BIMS and Resident #1 did not express anything to her. The DON further stated she did not feel it should have been reported due it only being something the LVN had said and when she visited Resident #1, she did not mention it. The DON reviewed Resident #2's notes for 04/12/2025 and stated Resident #2's allegation of being hit by another resident had not been reported to her and it was the first time she was hearing abut it. The DON further stated she was not sure why Resident #2 was moved to the other unit. During an interview on 06/21/2025 at 4:30 PM the Administrator stated she was aware of the allegations made by Resident #1. The Administrator stated if it was true, it should have been reported. The Administrator stated according to the LVN's note there was no one in the room with Resident #1 and further stated Resident #1 had a history of coming to her telling her that she saw things. The Administrator stated she had not talked with Resident #1 regarding the alleged incident. The Administrator stated it had been mentioned it was Resident #2, but it was not witnessed. The Administrator stated she did not think the LVN had witnessed Resident #2 coming from the day room. The Administrator stated the two alleged incidents regarding Resident #1 and Resident #2 had been related to each they would have been reported. The Administrator stated Resident #1 had history of making allegations that were untrue and Resident #2 was known to become upset and just say things. The Administrator stated they could have reported the alleged incidents but there were no eyewitnesses, and Resident #2 couldn't tell if he was truly in the room. The Administrator stated only the LVN would have been able to tell if she witnessed it. The Administrator stated she was there the day of the alleged incidents however she did not hear any screaming. The Administrator stated Resident #1 would sometimes sleep in the day room and would wake up startled. During an interview on 06/21/2025 at 5:19 PM the LVN stated Resident #2 came to her while she was standing at the medication cart and told her the woman was crazy and the woman had hit him then further told her this would be the last time, he tried to help the woman. The LVN stated while Resident #2 was talking to her she could hear a female yelling. The LVN stated she did go to talk to the female who was yelling in the day room and Resident #1 told her a man had touched her all over. The LVN stated Resident #1 was upset and had tears in her eyes. The LVN stated there was no one else in the room. The LVN stated she had passed the day room prior to Resident #2 coming to her upset and reported both Resident #1 and Resident #2 were in the day room with Resident #2 standing by a table and Resident #1 sitting in front of a table like she normally did. The LVN further stated the two residents were not near each other when she walked past the day room. The LVN stated she got the DON and stated Resident #1 told the DON the exact thing she told the LVN and when Resident #1 would say the man touched her, she would motion to her chest. The LVN stated Resident #1 was taken to her room and Resident #2 was moved to the other side of the facility. During an interview on 06/21/2025 at 5:52 PM the DON stated the residents BIMS was the determining factor for reporting abuse allegations. The DON further stated she believed Resident #1's BIMS was a 15 and that she was not aware of Resident #2's allegation and further stated the note did not say who hit him. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/21/2025 at 6:00 PM the Administrator stated she was aware of Resident #2's allegation of being hit. The Administrator stated she did not receive report regarding Resident #2's allegation of having been hit but she did see the nursing note. The Administrator stated when she spoke to Resident #2, he did not remember anything regarding his having said he was hit by another resident. The Administrator stated they could have reported the allegation Resident #2 had made and investigated it, but it was just a statement made and there were no witnesses. The Administrator stated she guessed she could have reported the allegations made by Resident #1 and Resident #2 with an unknown perpetrator to HHSC. The Administrator stated regarding the facility's policy if a statement is made regarding alleged abuse they will interview and get information to start the allegation (investigation). The Administrator stated by not reporting the alleged allegations could have led to a resident being abused. Review of the facility policy, Abuse/Reportable Events effective 1/10/2017, read: Policy: All residents have the right to free from abuse, neglect, misappropriation of resident property, and exploitation .The facility will provide and ensure the promotion and protection of resident rights. It is everyone's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents .that may constitute abuse or neglect in the facility. Prevention: All reports of abuse or suspicion of abuse/neglect or potentially criminal behavior will be investigated as per facility protocol. Investigations will be reviewed by the facility administrator and/or Abuse Preventionist with 24 hours of complaint. Appropriate notification to state and home office will be the responsibility of the administrator. Identification: The facility will identify and investigate events that may constitute abuse/neglect. The facility will determine the direction of the investigation based on a through examination of events. Opportunities to prevent abuse/neglect will be managed accordingly. Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect, exploitation must report this to the DON, administrator, and state. State law mandates that citizens report all suspected cases of abuse, neglect or financial exploitation of the elderly and incapacitated persons. When suspected abuse, neglected, exploited, misappropriation of property comes to the attention of any employee, that employee will make an immediate verbal report to the Abuse Preventionist or designee . Reporting: Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report the allegation of HHSC. If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews the facility failed to have evidence all allegations of abuse, neglect or mistreatment were thoroughly investigated and documented for 2 of 4 residents (Resident #1 and Resident #2) reviewed for abuse. 1. The Facility failed to ensure an allegation of Resident #1 being fondled by a man was thoroughly investigated. 2. The Facility failed to ensure an allegation of Resident #2 having been hit by a female resident was thoroughly investigated. These failures could place residents at risk for abuse and neglect by not investigating allegations of abuse, neglect, exploitation, or mistreatment. The findings were: Record review of Resident #1's face sheet, dated 06/21/2025, revealed she was admitted on [DATE] and the latest admission being 04/02/2025 with diagnoses which included: muscle weakness (generalized), cognitive communication deficit, and paranoid schizophrenia .(subtype of schizophrenia characterized by prominent symptoms of paranoia, including delusions and hallucinations, particularly those involving persecution or conspiracy. Record review of Resident #1's Quarterly MDS assessment, dated 06/05/2025, revealed the resident's BIMS score was 15, which indicated intact cognitive impairment. The Quarterly MDS assessment further revealed Resident #1 required substantial/maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) for sit to lying, chair/bed to chair transfer, was dependent (helper does all of the effort. Resident does none of the effort to complete the activity) for toileting hygiene, upper body dressing, and lower body dressing. Record review of Resident #1's care plan, problem start date of 02/05/2025, revealed Resident #1 had a problem of [Resident's name] has a hx of calling the police to report false allegations. Record review of Resident #1's psychiatry progress note dated 04/29/2025, revealed Resident #1's Patient reveals: I'm alright. Appearance/behavior The patient did not appear uncomfortable. Patient was smiling. The appearance was normal and decreased eye-to-eye contact was observed. Orientation: Orientation to person, place, time and situation, Mood: The mood was euthymic. The affect was reactive. Affect is appropriate. Thought Process were not impaired, and a thought disorder was not noted. The thought content revealed no impairment. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident record review of Resident #1's LVN progress notes, dated 04/12/2025, revealed Res. was heard yelling out and crying in dayroom and res. was asked what wrong. Res. crying and mumble something in low tone. Nurse was unable to hear and asked res. to speak up. Res. blurted out he put his hands on me and tried to touch my breasts, he put his hands on me! Res. Was comforted and asked if she could wait there so nurse could get help. Res. said she didn't want to leave the dayroom anyway. DON was walking towards rosewood nurses' station when she was called and asked to come to dayroom to speak to res. DON was made aware as she also repeated her statement about another res. to DON. Res. was asked by DON if going to her room or nurses' station would help her feel safe. Res. agreed and went to nurses' station then just a few min. later she asked to be taken to her room. Res. asked if I have to talk to the police, will they come to my room? Nurse assured if needed they would be escorted to her room. During an interview on 06/21/2025 at 12:30 PM Resident #1 stated Resident #2 put his hands on her body and he fondled her. Resident #1 further stated he had only bothered her once. Record review of Resident #2's face sheet, dated 06/21/2025, revealed he was admitted on [DATE] with diagnoses which included: vascular dementia (a type of dementia caused by reduced blood flow to the brain, often due to strokes or other conditions affecting blood vessels. This impaired blood flow damages brain cells, leading to problems with memory, thinking, and behavior), unspecified severity, with other behavioral disturbance, alcohol abuse, and generalized anxiety. Record review of Resident #2's admission MDS assessment, dated 04/15/2025, revealed the resident's BIMS score was 04, which indicated severe cognitive impairment. The Quarterly MDS assessment further revealed Resident #2 was independent with toileting hygiene, upper body dressing, lower body dressing and personal hygiene. Record review of Resident #2's care plan, problem start date of 06/13/2025, revealed Resident #2 had a problem of [Resident's name] presents with agitation and verbal behavioral symptoms and racial slurs directed toward staff regarding smoke breaks. Resident record review of Resident #2's LVN progress notes, dated 04/12/2025, revealed Res. came from dayroom and said, that lady is crazy, she just started hitting me for no reason, so I left and I'm not gonna help her anymore. Res. said he was ok and just waiting to go smoke. DON gave instruction to have this res. be moved to [NAME] now. Res. and belongings were moved at this x. During an interview on 06/21/2025 at 12:23 PM with Resident #2 stated he had never touched anyone, but a lady had said he had once. Resident #2 stated she was crazy. Resident #2 did not recall having been hit by another resident. During an intervewi on 06/20/2025 at 10:50 PM CNA stated he remembered Resident #2 being placed on 1 to 1 observation for a few day and having been askekd to assist with the 1 to 1. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/21/2025 at 3:58 PM the DON stated when she reviewed the LVN's note from Resident #1's chart that it was the account from the LVN, but it was not the account of what she believed happened. The DON stated she had passed the small dining room where Resident #1 was sitting and spoke to the LVN. The DON reported after she spoke to the LVN she went to talk to Resident #1. The DON stated Resident #1 was not distressed when they spoke Resident #1 did not report to her having been touched and stated she was fine. The DON stated she did not think it was reportable because Resident #1 had a high BIMS and Resident #1 did not express anything to her. The DON further stated she did not feel it should have been reported due it only being something the LVN had said and when she visited Resident #1, she did not mention it. The DON reviewed Resident #2's notes for 04/12/2025 and stated Resident #2's allegation of being hit by another resident had not been reported to her and it was the first time she was hearing about it. The DON further stated she was not sure why Resident #2 was moved to the other unit. During an interview on 06/21/2025 at 4:30 PM the Administrator stated she was aware of the allegation made by Resident #1. The Administrator stated if it was true, it should have been reported. The Administrator stated according to the LVN's note there was no one in the room with Resident #1 and further stated Resident #1 had a history of coming to her telling her that she saw things. The Administrator stated she had not talked with Resident #1 regarding the alleged incident. The Administrator stated it had been mentioned it was Resident #2, but it was not witnessed. The Administrator stated she did not think the LVN had witnessed Resident #2 coming from the day room. The Administrator stated the two alleged incidents regarding Resident #1 and Resident #2 had been related to each they would have been reported. The Administrator stated Resident #1 had history of making allegations that were untrue and Resident #2 was known to become upset and just say things. The Administrator stated they could have reported the alleged incidents but there were no eyewitnesses, and Resident #2 couldn't tell if he was truly in the room. The Administrator stated only the LVN would have been able to tell if she witnessed it. The Administrator stated she was there the day of the alleged incidents however she did not hear any screaming. The Administrator stated Resident #1 would sometimes sleep in the day room and would wake up startled. During an interview on 06/21/2025 at 5:19 PM the LVN stated Resident #2 came to her while she was standing at the medication cart and told her the woman was crazy and the woman had hit him then further told her this would be the last time, he tried to help the woman. The LVN stated while Resident #2 was talking to her she could hear a female yelling. The LVN stated she did go to talk to the female who was yelling in the day room and Resident #1 told her a man had touched her all over. The LVN stated Resident #1 was not unclothed in anyway but upset and had tears in her eyes. The LVN stated there was no one else in the room. The LVN stated she had passed the day room prior to Resident #2 coming to her upset and reported both Resident #1 and Resident #2 were in the day room with Resident #2 standing by a table and Resident #1 sitting in front of a table like she normally did. The LVN further stated the two residents were not near each other when she walked past the day room. The LVN stated she got the DON and stated Resident #1 told the DON the exact thing she told the LVN and when Resident #1 would say the man touched her, she would motion to her chest. The LVN stated Resident #1 was taken to her room and Resident #2 was moved to the other side of the facility. LVN stated she did do an assessment as much as Resident #1 would allow with no discolorations or bruising noted. LVN further stated Resident #1 was monitored for 72 hours for any changes. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/21/2025 at 5:52 PM the DON stated the residents BIMS was the determining factor for reporting abuse allegations. The DON further stated she believed Resident #1's BIMS was a 15 and that she was not aware of Resident #2's allegation and further stated the note did not say who hit him. During an interview on 06/21/2025 at 6:00 PM the Administrator stated she was aware of Resident #2's allegation of being hit. The Administrator stated she did not receive report regarding Resident #2's allegation of having been hit but she did see the nursing note. The Administrator stated when she spoke to Resident #2, he did not remember anything regarding his having said he was hit by another resident. The Administrator stated they could have reported the allegation Resident #2 had made and investigated it, but it was just a statement made and there were no witnesses. The Administrator stated she guessed she could have reported the allegations made by Resident #1 and Resident #2 with an unknown perpetrator to HHSC. The Administrator stated regarding the facility's policy if a statement is made regarding alleged abuse they will interview and get information to start the allegation (investigation). The Administrator stated by not reporting the alleged allegations could have led to a resident being abused. Review of the facility policy, Abuse/Reportable Events effective 1/10/2017, read: Policy: All residents have the right to free from abuse, neglect, misappropriation of resident property, and exploitation .The facility will provide and ensure the promotion and protection of resident rights. It is everyone's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents .that may constitute abuse or neglect in the facility. Prevention: All reports of abuse or suspicion of abuse/neglect or potentially criminal behavior will be investigated as per facility protocol. Investigations will be reviewed by the facility administrator and/or Abuse Preventionist with 24 hours of complaint. Appropriate notification to state and home office will be the responsibility of the administrator. Identification: The facility will identify and investigate events that may constitute abuse/neglect. The facility will determine the direction of the investigation based on a thorough examination of events. Opportunities to prevent abuse/neglect will be managed accordingly. Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect, exploitation must report this to the DON, administrator, and state. State law mandates that citizens report all suspected cases of abuse, neglect or financial exploitation of the elderly and incapacitated persons. When suspected abuse, neglected, exploited, misappropriation of property comes to the attention of any employee, that employee will make an immediate verbal report to the Abuse Preventionist or designee . Investigation: Comprehensive investigations will be the responsibility of the administrator and/or Abuse Preventionist. Allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injuries of unknown source will be investigated. After receipt of the allegation the Abuse Preventionist and/or administrator will immediately evaluate the resident's situation using the criteria as stated in this policy. Determination will be made for required reporting to HHSC reporting guidelines.