

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455804	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2025
NAME OF PROVIDER OR SUPPLIER Northgate Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure the resident's right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 1 resident (Resident #6) reviewed for accommodations of needs. The facility failed to ensure Resident #6 had the proper Bariatric bed and overhead trapeze to facilitate self-positioning, self-transfer and bed safety. This failure could cause residents to lose independent functioning as related to Activities of Daily Living, loss of dignity, and overall well-being. Findings included: Record review of Resident #6's admission record dated 11/19/2025 reflected Resident #6 was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #6 had a diagnoses of Acute Respiratory Failure with Hypoxia (low levels of oxygen in muscle tissues); Muscle Weakness (Generalized); Difficulty in Walking, Not Elsewhere Classified; Unspecified Lack of Coordination, Mild Intermittent Asthma, Uncomplicated; Pain in Right Shoulder; Age-related Osteoporosis without Current Pathological Fracture (progressive bone density loss in aging adults); Body Mass Index (BMI) 70 or greater; Morbid (Severe) Obesity due to excess calories; Post-traumatic Stress Disorder, Chronic; Bipolar Disorder, Current Episode Mixed, Moderate, and Major Depressive Disorder, Recurrent, Moderate. Resident #6's annual MDS dated [DATE] reflected Resident #6 had a BIMS score of 15 indicating he was cognitively intact. Review of Resident #6's progress notes from 08/29/2025 reflected the therapy department's recommendations and the need for the larger bed and overhead trapeze. Review of Resident #6's orders revealed the order for the bed and trapeze had been given by the therapy department along with the rounding physician on 08/29/2025. Observation of Resident #6's bed on 11/19/2025 revealed Resident #6 still had a 48-inch bariatric bed and no overhead trapeze. An interview with Resident #6 on 11/19/2025 at 1:50PM revealed Resident #6 had asked the DON and Administrator to provide a larger bariatric bed and overhead trapeze since 08/29/2025 when the therapy department spoke with the rounding physician regarding Resident #6's need for the items to maintain his ability to self-position, self-transfer and for bed safety. Resident #6 stated he weighed 559 pounds, and it was difficult for him to re-position and transfer himself in his current bed which was 48 inches wide and had no overhead trapeze. He stated the therapy department had written an order for a 60-inch-wide bed with an overhead trapeze so Resident #6 could reposition and self-transfer to and from his bed. Resident #6 stated he had also spoken with the rounding physician regarding the bed and trapeze, and the physician had agreed with the therapy department's recommendations in August. An additional physician order for the equipment was given by the rounding physician on 11/20/2025 due to the equipment not being obtained. An interview with the Administrator, DON and Corporate RVP on 11/19/2025 at 5:22PM revealed the Administrator stated she had personally reviewed Resident #6's therapy and physician's orders and had placed the order for the equipment as soon as she became aware of the need. She was unable to produce a purchase order or a timeline for the delivery of the equipment. An interview with the Director of Rehabilitation Therapy on 11/20/2025 at 8:37AM revealed he had originally spoken with the rounding physician regarding Resident #6's need for a larger Bariatric bed and trapeze on 08/29/2025 and the physician had agreed with the recommendations and approved the orders along with the implementation of the equipment as soon as possible. He stated he had tried to follow up numerous times with the Administrator, DON and Corporate RVP to see if the order for the equipment had been placed but was unable to get either a purchase order or confirmation of purchase from any of these staff members. An interview with the DON on 11/20/2025 at 10:39AM revealed she had a copy of an order for the larger Bariatric bed and trapeze from the rounding physician bearing today's date. She stated she was unable to say why the bed and trapeze had not been purchased in August when the therapist and rounding physician had originally given the order due to Resident #6's medical necessity, other than the equipment was not available for purchase. The DON was unable to produce a purchase order for the equipment and stated today was the first time she had been notified of Resident #6's need for the equipment. An interview with the DON on 11/20/2025 at 2:22PM revealed a purchase order for the equipment was placed on 11/14/2025 but review of the purchase order did not confirm the equipment had actually been ordered or paid for by the facility. The purchase order showed the equipment in the cart of the Administrator, but there was no indication of a credit card being utilized for the purchase. Review of facility policy entitled Resident Rights dated October 2024 revealed the following: You have a right to request reasonable accommodation, which is a change in policy or practice, communication, or the physical space</p>		

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<p>F 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing.</p> <p>(continued on next page)</p>

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<p>F 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure residents had the right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. The facility failed to ensure door access to residents after 8:00PM daily for 1 of 10 residents (Resident #3) reviewed for visitation rights. This failure could lead to reduced communication and contact between residents, families and others, resident isolation and a decreased quality of life. Findings included: Record review of Resident #3's admission record dated 11/19/2025 revealed Resident #3 was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses of Alzheimer's Disease with late onset, Dysphagia, Oropharyngeal Phase (swallowing difficulties due to neurological or muscular impairments), Other Abnormalities of Gait and Mobility, Vascular Dementia (cognitive impairment due to loss of blood flow to the brain), moderate with other behavioral disturbance, Major Depressive Disorder, single episode, moderate; Other Specified Anxiety Disorders; Muscle Weakness, generalized; Cognitive Communication Deficit and Other Lack of Coordination. Resident #3's annual MDS dated [DATE] reflected Resident #3 had a BIMS score of 00 indicating severe cognitive impairment. An interview with Resident #3's POA on 11/19/2025 at 9:05AM revealed the POA had to come to the facility prior to 8:00PM to see Resident #3 due to the front door being locked and no one answering the doorbell after 8:00PM. She stated Resident #3 had an electronic surveillance device in her room and the POA had asked staff entering the room to come to the front door because she had been standing there and no one had answered the doorbell. The POA stated she had spoken with the DON, the Administrator and the Corporate RVP regarding the door not being answered after 8:00PM, but nothing had been done to rectify the situation. An interview with the DON and Administrator on 11/21/2025 at 10:15AM revealed the DON thought the door alarm for the front door was attached to the fire system, so the facility could not have a push button that could be used by families to enter through the front door at their leisure. She stated discussion had taken place regarding an on-call phone number being posted outside the front door for families to call to request entrance to the facility but had not been put into place by the leadership team. The Admn. stated the leadership team had discussed a schedule for the team to cover phone/door duty but the schedule had not been put into practice. She was unable to answer what families were to do when leadership team members were not in the building, particularly after regular business hours, but thought a solution might be to give one of the charge nurses a cordless phone so they could answer the phone or door if needed. Review of facility policy entitled Resident Rights dated February 2021 revealed the following: Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to: f. communication with and access to people and services both inside and outside the facility; aa. visit and be visited by others from outside the facility; bb. be informed of safety or clinical restrictions or limitations of visitation; cc. access to a telephone, mail and email; dd. communicate in person and by mail, email and telephone with privacy. Review of facility policy entitled Visitation dated September 2022 revealed the following: Policy Statement: Our facility permits residents to receive visitors subject to the residents' wishes and the protection of the rights of other residents in the facility. Policy Interpretation and Implementation: 1. Residents are permitted to have visitors of their choosing at the time of their choosing. 2. The facility provides 24-hour access to individuals visiting with the consent of the resident. 3. Family members are designated by the resident or resident representative. Immediate family is not limited to individuals related by blood, adoption, marriage or common law. 4. Visitors may include, but are not limited to: a. spouses (including same-sex and transgender spouses). b. domestic partners (including same-sex and transgender domestic partners). c. other family members; and d. friends.</p>		

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>(continued on next page)</p>

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure residents had the right to reasonable access to the use of a telephone and a place in the facility where calls can be made without being overheard. The facility failed to protect and facilitate residents' right to communicate with individuals and entities within and external to the facility, including reasonable access to a telephone, for 2 of 10 residents (Resident #4 and Resident #10) reviewed for Resident Rights. Resident #4 had a personal cell phone but was unable to use it due to decline in visual impairment. Resident #10 did not have a personal cell phone and the only means of outside communication was through a facility-provided telephone. These failures could lead to reduced communication and contact between residents, families and others, resident isolation, and decreased quality of life. Findings Included: Record review of Resident #4's admission record dated 11/19/2025 revealed Resident #4 was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4 had a diagnoses of Other Acute Osteomyelitis (infection of a bone), Right Femur; Presence of Right Artificial Hip Joint; Subacute Osteomyelitis (bone infection of more than 2 weeks), Right Femur; Generalized Anxiety Disorder; other Speech and Language Deficits following Cerebral Infarction (stroke); Difficulty in Walking, not elsewhere classified; Depression, unspecified; Major Depressive Disorder, recurrent, moderate; Anxiety Disorder, unspecified; other Chronic Pain; Hemiplegia and Hemiparesis (weakness on half the body) following Cerebral Infarction affecting left non-dominant side; Hemiplegia, unspecified affecting left non-dominant side; other Abnormalities of Gait and Mobility; other Lack of Coordination, and Muscle Weakness, generalized. Resident #4 had a BIMS score of 13, indicating she was cognitively intact. An interview with Resident #4's Emergency Contact on 11/20/2025 at 11:42AM revealed Resident #4 had a personal cell phone but was unable to understand how the phone was used at times, due to rapid decline in visual function. He stated he called the facility almost daily to inquire how Resident #4's day had been and to see how she was feeling. The Emergency Contact stated the telephone rang multiple times every time he called but was rarely answered. The Emergency Contact stated he inquired about Resident #4's use of a landline phone when he spoke with the Activities Director and was told there was a cordless phone that was used by residents on the hallway where Resident #4 lived. Record review of Resident #10 admission record dated 11/20/2025 reflected Resident #10 was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #10 had a diagnosis of Difficulty in Walking not Elsewhere Classified, Muscle Weakness (Generalized), Dysphagia, Oral Phase (swallowing disorder), Other Chronic Pain, Other Specified Anxiety Disorders, Other sequelae of Cerebral Infarction (loss of consciousness during a stroke), Vascular Dementia (cognitive impairment due to loss of blood to the brain), Moderate, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety, Other Atrioventricular Block (problem of heartbeat signal from top to bottom of heart), Chronic Diastolic (Congestive) Heart Failure and Other Speech and Language Deficits following Cerebral Infarction. Record review of Resident #10's Resident #10 had a BIMS score of 15 indicating she was cognitively intact. An interview with Resident #10 on 11/20/2025 at 1:18PM revealed she did not have a cell phone for her personal use and the cordless phone that could be used by residents who lived on the hallway was not in operating order. She stated she had asked the nursing staff many times about the cordless phone and had been told the phone needed charging or was not in working order. Observation of the cordless phone on the 300/400 hallway reflected it was not plugged into a power source, and the wiring had been pushed into a hole in the wall behind the phone. An interview with the DON on 11/20/2025 at 1:24PM while inspecting the phone revealed the phone worked fine and there were no issues with residents using the phone. She was shown the phone with the wiring not plugged into a power source and the cords pushed into a hole behind the phone and stated the maintenance man would have to look at it. The maintenance man approached during the conversation and stated the phone had not worked for an undetermined period of time and he would inquire about getting a new phone for the hallway. He stated the residents could have walked to the 100/200 hall and used their cordless phone but was unable to say how the bed bound residents were to access a phone if they did not possess a personal cell phone. An interview with the DON and Administrator on 11/21/2025 at 10:15AM revealed the DON thought the door alarm for the front door was attached to the fire system, so the facility could not have a push button that could be used by families to enter through the front door at their leisure. She stated discussion had taken place regarding an on-call phone number being posted outside the front door for</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 10 residents (Resident #1) reviewed for smoking safety. The facility failed to ensure that a resident did not keep cigarettes and a lighter in their personal possession. This failure could lead to risk of injury, potential fire incidents and a decreased quality of life. Findings included: Record review of Resident #1's admission record dated 11/18/2025 reflected a [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnosis: chronic obstructive pulmonary disease with (acute) exacerbation; other persistent atrial fibrillation; cough, unspecified; other hereditary and idiopathic neuropathies; other muscle spasm, and insomnia, unspecified. Record review of Resident #1's quarterly MDS dated [DATE] revealed Resident #1 had a BIMS score of 15, indicating she was cognitively intact. Resident #1 was fully ambulatory and required supervision to no assistance with ADLs. Resident #1's revised care plan dated 10/02/2025 reflected a Focus of Resident #1 was a smoker, Goals of no complications from smoking through next review and stop keeping cigarettes in her own possession in her room and Interventions of assess smoking safety quarterly and as needed; provide supervised smoking as needed; store cigarettes safely and store lighter safely. Resident #1's revised care plan dated 10/02/2025 also reflected a Focus of Resident was a safe smoker as determined through assessment, Goals of Resident will be allowed to smoke with supervision per facility policy, will follow the requirements of the facility smoking policy, will not be injured as a result of smoking and will not hide cigarettes and lighters in her room, through the next review date and Interventions of Assess resident's ability to smoke safely, observe resident for adherence to smoking policy, provide resident with copy of facility smoking policy and explain policy to resident/family and refer non-compliance with smoking policy to the administrator and social services. Record review of Resident #1's smoking assessment dated [DATE] reflected she was not required to wear a smoking vest and was deemed a safe smoker. An observation of Resident #1 on 11/18/2025 at 1:59PM revealed Resident #1 in her room, preparing to go outside for a smoking break with her cigarettes and lighter in her room atop her bedside table. In an interview on 11/18/2025 at 2:02PM Resident #1 stated she was allowed to keep her cigarettes and lighter in her room because she was a safe smoker and did not require anyone to keep them for her. Resident #1 stated she did not have to go outside with the other smokers in the facility and was allowed to smoke whenever she desired. She stated she knew what the facility policy was regarding smoking and keeping cigarettes and lighters in her room but did not have to follow the policy due to being a safe smoker. An interview with the Corporate RVP on 11/19/2025 at 12:07PM revealed it was against facility policy for residents to keep cigarettes and/or lighters in their rooms, regardless of safe smoker status. He stated Resident #1 should have given her cigarettes and lighter to whomever was supervising the smoke break, so they were locked in the smoking lock box with all other resident's cigarettes and lighters. He was unable to say why the cigarettes and lighter had not been confiscated from Resident #1 by the smoking attendant, other than it was against facility policy to search resident's persons or rooms, even if they were care planned for hiding their cigarettes. An interview with the DON on 11/19/2025 at 12:19PM revealed Resident #1 was a safe smoker and was allowed to smoke unsupervised. An interview with the Corporate RVP and DON on 11/19/2025 at 12:22PM revealed the DON stated to the Corporate RVP that all smokers were to be supervised while smoking and their cigarettes and lighters were to be given to the smoking attendant when they finished smoking. The Corporate RVP told the DON he would have to discuss this discrepancy with what she had told me, with the corporate team to ensure policy was being followed. Review of Resident #1's smoking assessment dated [DATE] reflected she was not required to wear a smoking vest and was deemed a safe smoker. Review of facility smoking in-service dated 04/08/2025 revealed 16 staff members who were designated as smoking attendants attended the in-service. Each staff member received a copy of the Smoking Policy, Staff Smoking Monitoring Reminders, a list of residents who smoked and their smoking vest/apron status and the smoking times along with which department would be in charge of supervision during those times. Review of the Staff Smoking Monitoring Reminders revealed the following: Designated smoking times are 8:30AM (Activities), 11:00AM (Housekeeping Staff), 2:00PM (Dietary Staff), 5:00PM (Nursing Staff) and 8:00PM (Nursing Staff). Please report at your designated time. Staff will ensure that residents who require smoking aprons/vests have them on and are properly placed. Each resident has</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>(continued on next page)</p>

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Resident #6 had a diagnoses of Acute Respiratory Failure with Hypoxia (low levels of oxygen in muscle tissues); Muscle Weakness (Generalized); Difficulty in Walking, Not Elsewhere Classified; Unspecified Lack of Coordination, Mild Intermittent Asthma, Uncomplicated; Pain in Right Shoulder; Age-related Osteoporosis without Current Pathological Fracture (progressive bone density loss in aging adults); Body Mass Index (BMI) 70 or greater; Morbid (Severe) Obesity due to excess calories; Post-traumatic Stress Disorder, Chronic; Bipolar Disorder, Current Episode Mixed, Moderate, and Major Depressive Disorder, Recurrent, Moderate. Resident #6's annual MDS dated [DATE] reflected Resident #6 had a BIMS score of 15 indicating he was cognitively intact. Record review of Resident #6's dietary orders dated 10/16/2024 reflected he was to receive a Regular diet; Regular texture, thin liquids; Double portions of protein at all meals and double portions of vegetables at lunch and dinner. An interview with the Ombudsman on 11/18/2025 at 4:36PM revealed Resident #6 had communicated with the Ombudsman concerning not receiving his prescribed meal portions. She stated Resident #6 had sent her several photos of his meal tray tickets and the accompanying meal. The Ombudsman stated in most of the photos, the tray tickets indicated Resident #6 was to receive double portions of protein at all meals and double portions of vegetables at lunch and dinner, but the accompanying photo of the meal tray did not depict portions prescribed by the physician. An interview with Resident #6 on 11/19/2025 at 1:50PM revealed Resident #6 was a Bariatric patient who weight approximately 559 pounds. Resident #6 was a good historian and produced several photos from an undetermined amount of time, that showed he had not received his prescribed diet. Resident #6 produced photos of the tray ticket from his lunch tray today and the accompanying entree. Photo #1 showed the tray ticket that was on the tray of food he received at lunch today. The tray ticket indicated he was allergic to fish and a tuna salad sandwich was on the menu. The substitution was a ham and cheese sandwich with French fries. The accompanying photo (photo #2) depicted the plate Resident #6 received, which consisted of 2 ham and cheese sandwiches and a serving of French fries. The prescribed double portion of protein was satisfied by the ham and cheese sandwiches, but the serving of French fries did not satisfy the double portion of vegetables which were prescribed. Photo #3 depicted the breakfast tray ticket from yesterday, 11/18/2025. The tray ticket showed Resident #6 should have received a 4-ounce glass of juice, 8 ounces of cereal of choice, 1 slice of bacon 8 ounces of scrambled eggs, 1 slice of bread of choice, 1 pat of margarine, 1 tablespoon of jelly, 8 ounces of milk and 8 ounces of another beverage of choice. The ticket showed Double Protein circled and the Resident's request for fried eggs. The accompanying photo (photo #4) depicted 1 serving of scrambled eggs, one slice of toast and one sausage patty. There was also a container of margarine on the tray. There was no cereal, juice, bacon, jelly, milk or another beverage. The text message that accompanied the photo of the breakfast place that was sent to this investigator by Resident #6 describe the following: Because of budget that are always running out of food, and you don't get your full meal. If you don't have family that can send you food, you're in bad shape. The facility gets paid to house, feed us and take care of our needs, but out of greed, the facility is trying to cut corners. Photo #5 showed the dinner tray ticket from 11/04/2025 which indicated Resident #6 should have received 3 ounces of glazed meatloaf, 4 ounces of roasted red potatoes, 4 ounces of green beans, a roll, margarine, a 4-ounce gelatin parfait and an 8-ounce beverage of choice. Again, Double Protein and Vegetables is circled on the ticket. The accompanying photo of the dinner plate Resident #6 received (photo #6) depicted 2 slices of meatloaf, 2 scoops of mashed potatoes with gravy and a serving of what appeared to be cooked red cabbage. Resident #6 also received vanilla pudding and iced tea. There were no red potatoes, green beans, roll or parfait on Resident #6's tray. An interview with the Dietary [NAME] on 11/20/2025 at 9:45AM revealed he did not think that French fries or mashed potatoes qualified as a vegetable. He stated both are starches. He also stated residents could receive fried eggs if requested. An interview with the Administrator and DON on 11/20/2025</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455804	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2025
NAME OF PROVIDER OR SUPPLIER Northgate Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455804	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to establish and maintain an infection control program designed to provide a safe sanitary, and comfortable environment for 6 of 10 residents (Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8 and Resident #10) reviewed for infection control. The facility failed to ensure residents who lived on the 300/400 hallway of the facility received showers in a room that was free of potentially infectious debris. The facility failed to ensure Resident #4, and Resident #6 were screened for tuberculosis prior to or upon admission to the facility and annually. These failures could cause the spread of infections from one resident to another, leading to sickness and a decreased quality of life. Findings included: Record review of Resident #3's admission record dated 11/18/2025 revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had a diagnosis of Alzheimer's Disease with Late Onset, Pressure-induced Deep Tissue Damage of Left Heel, Dysphagia, Oropharyngeal Phase (disruption or delay of swallowing), Vascular Dementia (decreased blood-flow to areas of the brain), Moderate, with Other Behavioral Disturbance, Major Depressive Disorder, Other Specified Anxiety Disorders, Muscle Weakness, Generalized, and Kidney Disease, Stage 3A (kidneys are working at about 49-52% of usual function). Resident #3's Annual MDS dated [DATE] revealed she had a BIMS score of 00 indicating severe cognitive impairment. Record review of Resident #4's admission record dated 11/19/2025 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4 had a diagnosis of Other Acute Osteomyelitis (bone infection), Right Femur, Generalized Anxiety Disorder, Other Speech and Language Deficits following Cerebral Infarction (stroke), Major Depressive Disorder, Hemiplegia and Hemiparesis (paralysis or muscle weakness) following Cerebral Infarction, Methicillin Susceptible Staphylococcus Aureus Infection (infection that is sensitive to Methicillin antibiotics) as the Cause of Diseases Classified Elsewhere, Muscle Weakness, and Other Abnormalities of Gait and Mobility. Resident #4's Quarterly MDS dated [DATE] revealed she had a BIMS score of 13 indicating she was cognitively intact. Resident #5's admission Record dated 11/19/2025 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5 had a diagnosis of Unspecified Dementia, Severe, with Other Behavioral Disturbance, Vascular Dementia, Moderate, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety, Dysphagia (difficulty swallowing), Oral Phase, Generalized Idiopathic Epilepsy and Epileptic Syndromes, Not Intractable, without Status Epilepticus (epilepsy that does not respond to treatment), and Chronic Embolism and Thrombosis of Unspecified Vein (blood clots that start in the veins of the lower extremities). Resident #5's Quarterly MDS dated [DATE] revealed she had a BIMS score of 06 indicating she was severely cognitively impaired. Resident #6's admission Record dated 11/19/2025 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #6 had a diagnosis of Acute Respiratory Failure with Hypoxia (respiratory failure with low levels of oxygen in body tissues), Muscle Weakness, Generalized, Difficulty in Walking, not Elsewhere Classified, Mild, Intermittent Asthma, Rash and Other Non-Specific Skin Eruption, Post-Traumatic Stress Disorder, Morbid Obesity (Severe), Body Mass Index of > 70, and Other Heart Failure. Resident #6's Annual MDS dated [DATE] revealed he had a BIMS score of 15 indicating he was cognitively intact. Resident #7's admission Record dated 11/20/2025 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #7 had a diagnosis of Parkinson's Disease without Dyskinesia (Parkinson's Disease without involuntary muscle movements), without mention of Fluctuations, Hypertensive Heart Disease (Heart issue caused by high blood pressure) without Heart Failure, Mild, Intermittent Asthma, Uncomplicated, and Diverticulitis of Intestine, Part Unspecified, without Perforation, Abscess, or Bleeding (inflammation or infection of the pockets in the lining of the intestine). Resident #7's admission MDS dated [DATE] revealed she had a BIMS score of 14 indicating she was cognitively intact. Resident #8's admission Record dated 11/24/2025 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #8 had a diagnosis of Cellulitis (Infection and swelling of the skin) of Left Lower Limb, Other Recurrent Depressive Disorders, Pressure Ulcer of the Sacral Region, Stage 4 (full-thickness tissue loss with exposure of underlying muscle, tendon, or bone at the base of the spine). Resident #8's admission MDS dated [DATE] revealed she had a BIMS score of 15 indicating she was cognitively intact. Resident #10's admission Record dated 11/24/2025 revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #10 had a diagnosis of (the body's inability to process sugar) without Complications</p>		