

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 12/02/2025
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)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (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: 455804	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2025
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 0688</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 observation, interview and record review the facility failed to ensure that a resident with limited mobility receives appropriate services and equipment to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is unavoidable for 1 of 1 Resident (Resident #1) whose records were reviewed for motorized wheelchairs. The facility failed to obtain Resident #1's motorized wheelchair's specifications, to assess and ensure Resident #1 had a wheelchair that met his weight capacity for at least 3 months. This violation could place residents at risk of utilizing an unsuitable motorized wheelchair and contribute to unsafe mobility. The findings were: Review of Resident #1's face sheet, dated 10/24/25, revealed he was admitted to the facility on [DATE] with diagnoses including acute respiratory failure with hypoxia, muscle weakness (generalized), difficulty in walking not elsewhere classified, unspecified lack of coordination, adult morbid (severe) obesity due to excess calories and other heart failure. Review of Resident #1's annual MDS assessment, dated 9/11/25, revealed his BIMS score was 15 of 15 reflective of no cognitive impairment (cognitively intact). He did not have mood or behavior indicators; he used a motorized wheelchair, his weight was 560 pounds; he received oxygen therapy; he was not receiving rehabilitation services and his discharge plan was to return to the community. Review of Resident #1's Care Plan, updated 7/11/25, revealed Resident #1 used a motorized wheelchair (MWC) for mobility. One of the interventions included therapy as indicated. Review of Resident #1's consolidated physician orders for October 2025 revealed an order PT, OT, ST to eval and treat as indicated Verbal Active 08/29/2025. Review of Resident #1's EHR revealed the following documented weights: 09/05/2025 11:25 560 Lbs (Digital/ wheelchairScale)08/27/2025 13:52 556 Lbs (Digital/ wheelchairScale)07/09/2025 09:20 556 Lbs06/17/2025 11:16 552 Lbs (Standing)05/13/2025 12:41 567 Lbs04/02/2025 11:14 561 Lbs03/14/2025 14:35 563.5 Lbs03/12/2025 13:11 574 Lbs03/05/2025 13:16 567.3 Lbs Review of a letter from Resident #1's insurance company in response to the facility BOM r/t DME, dated 1/22/25, read in relevant part any equipment is part of the (insurance name) unit rate and the facility provides the equipment. The NF unit care include daily care services such as medical supplies and equipment. Review of a letter written by the MWC vendor to Resident #1's insurance case manager, dated 10/3/25, read Pursuant to letter received via fax today referencing the above-named member (Resident #1), (Insurance name) asked the following questions: An assertion was made by the client that the power wheelchair provided has a weight capacity of 450 lbs. This information is incorrect. The weight capacity of the chair he received is 550 lbs. Additionally, the letter states that the patient received the power wheelchair on June 24, 2025; this is also factually incorrect, he received the chair on 6/24/2024. 1. Please: provide written explanation of the process for ensuring a wheelchair is correctly sized for each individual. Please provide supportive documentation. In accordance with Texas Health and Human Services Commission NF CPWC policy in Section 11100 of the (Insurance provider) handbook, on 5/10/2024, a licensed Physical Therapist (PT) and Qualified Rehabilitation Professional (QRP) conducted a comprehensive wheelchair assessment for (Resident #1). As part of this comprehensive wheelchair assessment, the patient's current weight is obtained from medical records and actual anatomical physical measurements of his body were taken. These measurements are used to ensure proper fit of the recommended equipment. See attached written and signed assessment including relevant measurements on page 7.2. Please provide specific details about the power chair (Resident #1) received on June 2024, including but not limited to its weight limit. (Resident #1) received his customized power wheelchair on 6/24/2024. The weight rating for this chair is 550lbs. He received the following equipment: Manufacturer: (name). Model: (name) HD3 Pwr Wchair item # ATHD3-3VHD-MP, Serial number: 2406152434012 - (Resident #1) See attached Manufacturer build sheet/ chair specifications that specifies weight rating on line 4. This information can also be found on the manufacturer's website for the model chair in question both on the order form and in the owners manual. 3. What type, if any, service, maintenance, or warranty came with the power wheelchair June 21, 2024 and how was this information communicated to (Resident #1) Please provide supportive documentation. (Resident #1) was provided with the owners manual at the time of delivery which detailed warranty specifications for the provided equipment. See attached United States Limited Warranty available on (manufacturer's) website and as part of the owners manual. Please note that physical damages due to impacts, abuse, misuse, accident, negligence or improper operation of the equipment are exclusions stated in the warranty details. Additionally, see attached signed delivery confirmation</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 12/02/2025
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 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>

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 12/02/2025
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 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 observation, interview and record review the facility failed to ensure:each resident received adequate supervision and assistive devices to prevent accidents for 1 of 2 Residents (Resident #2) whose records were reviewed. Nursing staff failed to ensure Resident #2's bed was in the lowest position and staff provided Resident #2 with adequate supervision. This violation could place residents at risk for experiencing avoidable falls. The findings were:Review of Resident #2's face sheet, dated 10/26/25, revealed she was admitted to the facility on [DATE] with diagnoses including neurocognitive disorder with Lewy bodies (a progressive neurocognitive disorder characterized by the accumulation of Lewy bodies in the brain, leading to cognitive decline, movement issues, and various other symptoms), psychotic disorder with delusions due to known physiological condition (a psychotic disorder characterized by the presence of delusions that arise as a direct consequence of a known physiological condition), generalized anxiety disorder (when you worry a lot and have a hard time controlling) and dementia in other diseases classified elsewhere severe with other behavioral disturbance (a condition where Dementia is associated with other underlying conditions, characterized by significant cognitive decline and severe behavioral disturbances). Review of Resident #2's quarterly MDS assessment, dated 9/28/25, revealed her BIMS score was 0 of 15 reflective of severe cognitive impairment; she had behaviors not directed at others such as hitting and scratching self and she was dependent on staff for most ADL's including chair/bed-to-chair transfer. Further review revealed Resident #2 had not had any falls since the prior assessment. Review of Resident #2's Care Plan, revised on 7/23/25, revealed Resident #2 had a history of falling related to Lewy Body Dementia and one of the approaches included keep bed in lowest position with brakes locked and observe frequently and place in supervised area when out of bed. Review of the facility incident/accident log from July to October 2025 revealed Resident #2 had not had any falls during this time period. Observation and attempted interview on 10/26/25 at 12:25 PM with Resident #2 revealed she was lying in bed with the head of bed at about 30 degrees. Further observation revealed the bed was positioned about 3 1/2 feet off the floor. There was a mat next to the bed closest to the door. Resident #2 was moving and wiggling around in bed, turning from side to side, kicking her feet and reaching for the blankets which were on the floor. Attempted interview with Resident #2 revealed she was non-verbal. She would make eye contact but did not answer any questions. Observation on 10/26/25 at 12:30 PM revealed LVN A walking away from the nurse's station. Further observation revealed there were no other staff in sight. Observation and interview on 10/26/25 at 12:50 PM revealed CNA D walking up 100 hall picking up lunch trays. Surveyor intervened and called CNA D over for fear Resident #2 would fall. CNA D stated she transferred Resident #2 into bed after lunch about 15 to 20 minutes ago (12:30 PM). CNA D stated, it was her fault, she forgot to lower the bed to the lowest position. CNA D stated Resident #2 was a fall risk, she had falls in the past but had not had any falls most recently. CNA D stated Resident #2 was alert to self with confusion, but she did not follow directives. CNA D stated Resident #2 would also get out of bed without asking for assistance. She stated she should have lowered the bed so that Resident #2 did not fall and get hurt. Interview on 10/26/25 at 4:06 PM with the DON revealed Resident #2 was a fall risk. She stated Resident #2 had fallen before due to confusion and she was very impulsive. The DON stated if Resident #2 was in bed, the bed should be in the lowest position because Resident #2 would get out of bed without assistance. The DON stated Resident #2 would try to walk and could fall because she was very unsteady. Review of facility policy, Falls and Fall Risk Managing revised March 2018, read in relevant part Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Fall Risk Factors: 1. Environmental factors that contribute to the risk of falls include: c. incorrect bed height or width.</p>		