

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  12/18/2025
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 0550  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.  (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  12/18/2025
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interviews, and record reviews the facility failed to ensure the resident had a right to a dignified existence, self-determination, and communication with and access to people and services inside and outside the facility for 1 resident (Resident #3) of 10 residents reviewed for dignity. The facility failed to ensure Resident #3 was checked on frequently and kept clean and dignified. This failure could affect residents who have incontinence and unsanitary behaviors and could result in diminished self-esteem. The findings included: Record review of Resident #3's electronic face sheet dated 12/17/2025 reflected he was a [AGE] year-old-male who was admitted to the facility on [DATE]. His diagnoses included: chronic obstructive pulmonary disease (condition involving constriction of the airways and difficulty or discomfort in breathing), muscle weakness (reduction in strength in one or more muscles, making it harder to move or perform tasks), major depressive disorder (serious mood disorder, causing persistent sadness, loss of interest, fatigue, and difficulty with daily activities), vascular dementia (decline in thinking skills from conditions damaging brain blood vessels, reducing oxygen, causing issues with memory, planning, reasoning, and focus), type II diabetes mellitus (chronic condition where the body either doesn't use insulin effectively or can't produce enough insulin to manage blood sugar) and paranoid schizophrenia (brain creates a false, scary reality, feeling of being watched, plotted against or harmed, often hearing voices that are not there) . Record review of Resident #3's quarterly MDS dated [DATE] reflected he could usually understand and usually be understood. He scored 07 of 15 on his BIMS which indicated his cognitive status was severely impaired. He required maximum assistance with his ADLs except for eating. He was always incontinent with bowel and bladder. He required 1-2 people to assist him with using the restroom. No behavior issues were noted. Record review of Resident #3's comprehensive person-centered care plan dated 11/16/2025 reflected Focus, has urinary incontinence, bowel incontinence r/t dementia, Interventions, check the resident frequently for incontinence. Change clothing PRN after incontinence episodes [sic] Further review reflected Focus, resistive to care r/t adjustment to new environment, at risk of fall due to trash and clothes being on floor, Interventions, housekeeping will make rounds and keep room clean, Focus, at risk for falling r/t unsteady gait, Interventions, staff to perform frequent rounding for bowel incontinence, Focus, on diuretic therapy r/t edema. Record review of Resident #3's Active Orders as of 12/17/2025 reflected Furosemide (diuretic) (medications that help the kidneys remove extra salt and water from the body, increasing urine output), 40mg tablet orally one time a day, start date 10/01/2025 r/t chronic ischemic heart disease (happens when narrowed arteries reduce blood flow and oxygen to the heart muscle, causing chest pain, shortness of breath or fatigue, and can lead to heart failure). Further review reflected he was prescribed Spironolactone (diuretic) oral tablet 25mg, give one tablet orally one time a day, start date 10/01/2025, r/t chronic ischemic heart disease. Observation and interview of Resident #3 in his room on 12/17/2025 at 09:00 am, accompanied by the DON revealed Resident #3's door was closed. After knocking and gaining entry into the room, Resident #3 was observed sitting in his wheelchair. There were wet pants lying on the floor near him. His call light was hooked to the privacy curtain within his reach. He was naked from the waist down, and the bathroom door was ajar with the light on, and smeared dried feces could be seen on the floor extending from the toilet to the sink. The air in the room was warm and smelled of urine and feces. The floor tiles were sticky and adhered to the bottom of shoes when walking. Near the window in his room was a pool of liquid approximately 2 ft by 2 1/2 foot. When asked by the surveyor what the pool of liquid was, he stated pee. He stated he waited, and no one had come into the room, and he could not hold the pee. When asked if he knew how to use his call light, he looked at it and did not respond. During an interview on 12/17/2025 at 09:05 am with Resident #3, he acknowledged that no one had checked on him since breakfast at 07:00 am. He stated he felt bad, sitting in the room with the soiled floors and urine and it bothered him. He stated the brown substance in the restroom was poop and had been there for awhile. He shrugged his shoulders and turned his head. During an interview on 12/17/2025 at 2:51 pm, CNA A, who was assigned to Resident #3, stated she did not enter his room or do rounds as she was supposed to and thought he could take himself to the restroom. She stated she did not always work in the hallway where he resided and should have checked his care plan or asked the nurse what he required. She stated she cleaned his room, and with the smell, urine and feces on the floor and no pants, he must have felt embarrassed. She stated he was left in an undignified position, and it could cause decreased self-esteem. She stated she was trained to do rounds at</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  12/18/2025
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 0584</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 a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</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  12/18/2025
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews and record reviews the facility failed to ensure the resident had a right to a safe, clean, comfortable, and homelike environment to receiving treatment and support for daily living safety for 1 resident (Resident #3) of 10 residents reviewed for safe and clean environment. The facility failed to ensure Resident #3's room which had urine and feces on the sticky floor was cleaned as required to provide a safe and clean environment. This failure could affect residents who have incontinence and unsanitary behaviors and could result in disease spread and accidents. The findings included: Record review of Resident #3's electronic face sheet dated 12/17/2025 reflected he was a [AGE] year-old-male who was admitted to the facility on [DATE]. His diagnoses included: chronic obstructive pulmonary disease (condition involving constriction of the airways and difficulty or discomfort in breathing), muscle weakness (reduction in strength in one or more muscles, making it harder to move or perform tasks), major depressive disorder (serious mood disorder, causing persistent sadness, loss of interest, fatigue, and difficulty with daily activities), vascular dementia (decline in thinking skills from conditions damaging brain blood vessels, reducing oxygen, causing issues with memory, planning, reasoning, and focus), type II diabetes mellitus (chronic condition where the body either doesn't use insulin effectively or can't produce enough insulin to manage blood sugar) and paranoid schizophrenia (brain creates a false, scary reality, feeling of being watched, plotted against or harmed, often hearing voices that are not there) . Record review of Resident #3's quarterly MDS dated [DATE] reflected he could usually understand and usually be understood. He scored 07 of 15 on his BIMS which indicated his cognitive status was severely impaired. He required maximum assistance with his ADLs except for eating. He was always incontinent with bowel and bladder. He required 1-2 people to assist him with toileting. Record review of Resident #3's comprehensive person-centered care plan dated 11/16/2025 reflected Focus, has urinary incontinence, bowel incontinence r/t dementia, Interventions, check the resident frequently for incontinence. Change clothing PRN after incontinence episodes. Further review reflected Focus, resistive to care r/t adjustment to new environment, at risk of fall due to trash and clothes being on floor, Interventions, housekeeping will make rounds and keep room clean, Focus, at risk for falling r/t unsteady gait, Interventions, staff to perform frequent rounding for bowel incontinence, Focus, on diuretic therapy r/t edema. Record review of Resident #3's Active Orders as of 12/17/2025 reflected Furosemide (diuretic) (medications that help the kidneys remove extra salt and water from the body, increasing urine output), 40mg tablet orally one time a day, start date 10/01/2025 r/t chronic ischemic heart disease (happens when narrowed arteries reduce blood flow and oxygen to the heart muscle, causing chest pain, shortness of breath or fatigue, and can lead to heart failure). Further review reflected he was prescribed Spironolactone (diuretic) oral tablet 25mg, give one tablet orally one time a day, start date 10/01/2025, r/t chronic ischemic heart disease. Observation and interview of Resident #3 in his room on 12/17/2025 at 09:00 am, accompanied by the DON revealed Resident #3's door was closed. After knocking and gaining entry into the room, Resident #3 was observed sitting in his wheelchair. There were wet pants lying on the floor near him. His call light was hooked to the privacy curtain within his reach. He was naked from the waist down, and the bathroom door was ajar with the light on, and smeared dried feces could be seen on the floor extending from the toilet to the sink. The air in the room was warm and smelled of urine and feces. The floor tiles were sticky and adhered to the bottom of shoes when walking. Near the window in his room was a pool of liquid approximately 2 ft by 2 1/2 foot. When asked by the surveyor what the pool of liquid was, he stated pee. He stated he waited, and no one had come into the room, and he could not hold the pee. When asked if he knew how to use his call light, he looked at it and did not respond. During an interview on 12/17/2025 at 09:05 am with Resident #3, he shook his head no when asked if anyone had come in to check on him since breakfast which was at 07:00 am. When asked how sitting in the room in the present condition and how he felt about it, he stated I feel bad, not good, it bothered me. When asked what the brown substance was in the restroom, he stated poop and said it was there for a while. When asked if staff came in frequently to check him, he shrugged his shoulders and turned his head. During an interview on 12/17/2025 at 2:45 pm with Housekeeper D, he stated he was assigned to Resident #3's hall. He stated the housekeeper for that hall does not come in to work until 10:00 am. He stated he mopped Resident #3's floor two times a day because of his poop and pee, and the feces were not there the day prior. He stated he tried to clean the sticky substance on Resident #3's floor but had not succeeded. During an interview on 12/17/2025 at 2:51 pm</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  12/18/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</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  12/18/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record reviews, the facility failed to ensure all allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 2 residents (Resident #1 and #2) of 10 residents reviewed for neglect and misappropriation.</p> <p>1. The facility failed to report Resident #1's missing Tramadol and Tylenol #3 while he was out on leave on Thanksgiving to the ADM who was the abuse and neglect prevention coordinator. When Resident #1 returned the narcotic cards were missing which resulted in the possible misappropriation of the narcotics.</p> <p>2. The facility failed to report that Resident #2 stated she was neglected for the first week of her admission, which was the week of December 8, 2025, and the SW failed to immediately report this to the ADM. This facility failure could affect residents who take narcotics for pain and residents who require care at the facility resulting in loss of medications and lack of appropriate care. The findings included: 1. Record review of Resident #1's electronic face sheet dated 12/16/2025 reflected he was a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included: acute respiratory failure with hypoxia (a condition where there is insufficient oxygen delivery to the tissues leading to low oxygen in the blood), muscle weakness (lack of muscle strength), schizoaffective disorder (a mental health condition that is marked by a mix of symptoms such as hallucinations (hearing things not there) and delusions (seeing things not there) and age-related osteoporosis (loss of bone density and strength), anxiety (feeling of worry, nervousness or unease), heart failure (chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs) and major depressive disorder (persistent feeling of sadness and loss of interest). Record review of Resident #1's annual MDS assessment dated [DATE] reflected he scored a 15 of 15 on his BIMS which signified his cognitive status was intact. He required minimal to no assistance with most of his ADLs. He utilized a motorized wheelchair and was taking opioid (class of drugs that include prescription pain killers) medications. Record review of Resident #1's comprehensive care plan dated 11/13/2025 reflected Focus, has osteoporosis and pain, interventions, give medications as ordered. Record review of Resident #1's Active Orders as of: 12/16/2025 reflected, he was ordered Acetaminophen with codeine (opioid), one tablet every 8 hours as needed for pain, start date 09/21/2025 and he received tramadol (opioid) 50mg tablet, 2 tablets by mouth three times a day for pain, start date 12/09/2025. During an interview on 12/16/2025 at 10:00 am, Resident #1 stated he went out on Thanksgiving and the agency nurse who signed him out gave him a bag with medications, and he asked her if they needed to count and sign, and she said that it was all taken care of. He stated he knew that was not the procedure and was out on pass for one night and came back with the medications he had left (tramadol and Tylenol #3's). He said he told LVN E that the nurse did not count with him when he left. He stated LVN E and LVN F counted the medication he had returned with which were 115 Tramadol and 27 Tylenol #3's. He stated he was not given the narcotic sheets with his medications when he left on pass. He stated he did not miss any of his medications but was concerned about the lack of accountability for the narcotics that the facility demonstrated. During an interview on 12/17/2025 at 2:24 pm, LVN E stated Resident #1 returned from his pass on Thanksgiving and brought his medications up to her and stated they were never counted when he left. She stated LVN F, and she counted his medications and LVN F went to get the narcotic sheets and stated the sheets were missing. She stated at that time, we created more sheets and accounted for what he brought into the facility. She stated that the agency nurse should have counted the narcotics with him and only provided him with what he needed while gone. She stated they reported the incident to the DON. An interview was attempted by phone on 12/17/2025 at 2:30 pm, with LVN F and Agency Nurse G with no response, phones were not accepting messages or calls. During an interview on 12/18/2025 at 08:40 am, the DON stated when she questioned Agency Nurse G about Resident #1's narcotics, she stated she gave him the narcotic sheets and the narcotics. She stated she contacted pharmacy, and they gave her what they had, but they were not able to figure out how many narcotics Resident #1 should have had left. She stated she did</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  12/18/2025
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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews and record reviews, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the residents that meet professional standards of quality care for 1 resident (Resident #2) of 10 residents reviewed for care plans. The facility failed to complete a baseline care plan within 48 hours of admission for Resident #2 that reflected she had a colostomy and required monitoring and care. This facility failure could affect residents who require care in the facility and could result in missed or inappropriate care. The findings included: Record review of Resident #2's electronic face sheet dated 12/17/2025 reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: type 2 diabetes mellitus (condition in which the body cannot use insulin correctly and sugar builds up in the blood), acute pain due to trauma (sudden or urgent pain that occurs as a result of an injury or trauma), acquired absence of left and right legs above knees (legs missing both right and left above knees), adult failure to thrive (significant decline in overall health and functional abilities, leading to a reduced quality of life), pressure ulcer of sacral region, stage III (full thickness skin loss that extends to the subcutaneous tissue layer (fatty tissue beneath skin)), and peripheral vascular disease (any disease or disorder of the circulatory system outside of the brain and heart). Record review of Resident #2's EMR reflected she had not been in the facility long enough for an MDS assessment. Record review of Resident #2's baseline care plan dated 12/08/2025 reflected it had not been completed. Record review of Resident #2's Active Orders as of: 12/17/2025 reflected she had a colostomy bag which was to be checked and changed every 72 hours and as needed with start dates of 12/09/2025. Record review on 12/17/2025 at 3:00 pm of Resident #2's baseline care plan dated 12/08/25 and comprehensive person-centered care plan dated 12/10-2025 did not reflect she had a colostomy bag which required monitoring and care. Observation on 12/17/2025 at 10:00 am of Resident #2 revealed she was lying in bed moaning, because she said she was in pain, LVN C showed the surveyor that Resident #2 had a colostomy bag. During an interview on 12/17/2025 at 10:10 am, Resident #2 stated staff were doing colostomy care as needed. During an interview on 12/18/2025 at 08:40 am, the DON stated she did open a baseline care plan for Resident #2, but did not complete it, she stated that she expected her nurses to complete the care plan, but it was not done. She stated Resident #2's colostomy bag had orders that needed to be added to the baseline care plan, or she could miss care. She stated she was accountable for nursing care in the facility. During an interview on 12/17/2025 at 3:12 am, LVN C stated she was not aware Resident #2's baseline care plan had not been completed, and she stated the resident received colostomy care by either herself or the CNA assigned. She stated she was aware Resident #2 had a colostomy even without it being on the care plan, and she was trained in colostomy care. Record review of the facility policy and procedure titled Care Plans-Baseline dated March 2022 reflected a baseline plan of care to meet the resident's immediate health and safety needs is developed within forty-eight hours of admission. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident.</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  12/18/2025
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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews and record reviews, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 resident (Resident #4) of 5 residents reviewed for smoking. The facility failed to ensure Resident #4 was provided with a smoking apron during a smoke break. This facility failure could affect residents who smoke at the facility and could result in injury and harm. The findings included: Record review of Resident #4's electronic face sheet dated 12/17/2025 reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: benign neoplasm of parotid gland (non-cancerous tumor), vascular dementia (caused by conditions such as stroke, resulting in problems with memory, thinking and behavior), and mild intellectual disabilities (general learning disability). Record review of Resident #4's quarterly MDS assessment dated [DATE] reflected he could understand and be understood. He scored 13 of 15 on his BIMS which signified his cognitive status was intact. He required minimal assistance with his ADLs. Record review of Resident #4's comprehensive person-centered care plan dated 10/20/2025 reflected Focus, is a smoker, interventions, resident requires supervision while smoking and required an apron when smoking. Record review of Resident #4's Smoking Assessment dated 11/19/2025 completed by the SW reflected Resident #4 had a history of smoking-related problems that would be hazardous to self or others, puts his hands touch his clothes. He gets cigarette burns on his clothes, so he requires an apron. Resident requires adaptive equipment, smoking apron. [sic] Observation with the DON on 12/17/2025 at 08:45 am of residents smoking revealed Resident #4 being supervised by Housekeeper B. He was sitting with a cigarette lit in his hand which rested near his right pant leg. He did not have a smoking apron on. During an interview on 12/17/2025 at 08:55 am with Resident #4, he stated he knew he needed the smoking apron and would try to wear it, but he did not like it. He stated he understood he would not be able to smoke if he did not have the apron on. During an observation and interview on 12/17/2025 at 08:50 am, Housekeeper B stated Resident #4 refused to have the smoking apron on. At that time, the DON spoke up and stated Resident #4 smokes with the smoking apron or he does not smoke and assisted the resident to put on an apron. During an interview on 12/17/2025 at 10:30 am, the SW stated she performed Resident #4's smoking assessment, and he was not safe to smoke without the smoking apron, even with supervision. She stated he sets his hand down with the cigarette and it touches his pants. During an interview on 12/18/2025 at 08:40 am with DON, she stated Resident #4 required the smoking apron for safety when he smokes. She stated she needed to in-service staff, that if residents refused the apron, they would not be able to smoke. She stated he could burn himself and that was not good. During an interview on 12/18/2025 at 11:20 with Housekeeper B revealed she knew better than to let him smoke, but he was insistent. She stated it would not happen again. She stated there was a list of what residents required for smoking for their safety and others. During an interview on 12/18/2025 at 3:04 pm, the ADM stated residents who smoke were assessed and required to have the supervision and appliances needed for safety. Record review of the facility policy and procedure titled Smoking Policy-Residents dated October 2022 reflected This facility shall establish and maintain safe resident smoking practices, prior to, and upon admission, residents shall be informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. The facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safely. Record review of the facility policy and procedure titled Safety and Supervision of Residents dated July 2017 reflected our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents.</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  12/18/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</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  12/18/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record reviews, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 resident (Resident #1) of 10 residents reviewed for pharmaceutical services. The facility failed to ensure Resident #1's Tramadol and Tylenol #3 were accounted for when he left to go out on pass on Thanksgiving (11/27/2025). This facility failure could affect residents who take narcotics for pain and could result in misappropriation of medications or drug diversion. The findings included: Record review of Resident #1's electronic face sheet dated 12/16/2025 reflected he was a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included: acute respiratory failure with hypoxia (a condition where there is insufficient oxygen delivery to the tissues leading to low oxygen in the blood), muscle weakness (lack of muscle strength), schizoaffective disorder (a mental health condition that is marked by a mix of symptoms such as hallucinations (hearing things not there) and delusions (seeing things not there) and age-related osteoporosis (loss of bone density and strength), anxiety (feeling of worry, nervousness or unease), heart failure (chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs) and major depressive disorder (persistent feeling of sadness and loss of interest). Record review of Resident #1's annual MDS assessment dated [DATE] reflected he scored a 15 of 15 on his BIMS which signified his cognitive status was intact. He required minimal to no assistance with most of his ADLs. He utilized a motorized wheelchair and was taking opioid (class of drugs that include prescription pain killers) medications. Record review of Resident #1's comprehensive care plan dated 11/13/2025 reflected Focus, has osteoporosis and pain, interventions, give medications as ordered. Record review of Resident #1's Active Orders as of: 12/16/2025 reflected, he was ordered Acetaminophen with codeine (opioid), one tablet every 8 hours as needed for pain, start date 09/21/2025 and he received tramadol (opioid) 50mg tablet, 2 tablets by mouth three times a day for pain, start date 12/09/2025. During an interview on 12/16/2025 at 10:00 am, Resident #1 stated he went out on Thanksgiving and the agency nurse who signed him out gave him a bag with medications, and he asked her if they needed to count and sign, and she said that it was all taken care of. He stated he knew that was not the procedure and was out on pass for one night and came back with the medications he had left (Tramadol and Tylenol #3's). Resident #1 said he told LVN E that the nurse did not count with him when he left. He stated LVN E and LVN F counted the medications he returned with which were 115 Tramadol and 27 Tylenol #3's. He stated he was not given the narcotic sheets with his medications when he left on pass. He stated he did not miss any of his medications but was concerned about the lack of accountability for the narcotics that the facility demonstrated. During an interview on 12/17/2025 at 2:24 pm, LVN E stated Resident #1 returned from pass on Thanksgiving and brought his medications up to her and stated they were never counted when he left. She stated LVN F, and she counted his medications and LVN F went to get the narcotic sheets and stated the narcotic sheets were missing. She stated at that time, we created more sheets and accounted for what he brought into the facility. She stated that the agency nurse should have counted the narcotics with him and only provided him with what he needed to pass. She stated they reported the incident to the DON. Interviews attempted on 12/17/2025 at 2:30 pm, calls to LVN F and Agency Nurse G with no response, phones were not accepting messages or calls. During an interview on 12/18/2025 at 08:40 am, the DON stated when she questioned Agency Nurse G about Resident #1's narcotics, she stated she gave him the narcotic sheets and the narcotics. She stated she contacted pharmacy, and they gave her what they had, but they were not able to figure out how many narcotics Resident #1 should have had left. She stated she did not know why she believed Agency Nurse G at the time, but they did not report it as a drug diversion, and it could have been. She stated the process was to have an order for out on pass and count with another nurse, have the resident sign for what they are given and never provide them with the narcotic sheets. She stated she should have reported it as a misappropriation because they did not know if Resident #1 was provided with all his narcotics and he denied having sheets given to him. During an interview on 12/18/2025 at 3:04 pm, the ADM stated that at the time Resident #1's narcotics were not accounted for she stated staff did not think it was a drug diversion but now admitted that it could have been. She stated the incident needed to be reported. The procedure was broken. During an interview on 12/18/2025 at 3:52 pm with the RNC, he stated he was mentoring the DON since she was new to the position. He stated he was aware now what happened when</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  12/18/2025
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 - Few</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  12/18/2025
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 - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews and record reviews, the facility failed to establish and maintain, an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 resident (Resident #2) of 10 residents reviewed for infection control. The facility failed to ensure Resident #2 had EBP implemented when she was admitted to the facility on [DATE] with a stage 4 wound to her coccyx which required treatment and dressing. This facility failure could affect residents with wounds and could result in cross contamination and infection of an MDRO. The findings included: Record review of Resident #2's electronic face sheet dated 12/17/2025 reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: type 2 diabetes mellitus (condition in which the body cannot use insulin correctly and sugar builds up in the blood), acute pain due to trauma (sudden or urgent pain that occurs as a result of an injury or trauma), acquired absence of left and right legs above knees (legs missing both right and left above knees), adult failure to thrive (significant decline in overall health and functional abilities, leading to a reduced quality of life), pressure ulcer of sacral region, stage III (full thickness skin loss that extends to the subcutaneous tissue layer (fatty tissue beneath skin)), and peripheral vascular disease (any disease or disorder of the circulatory system outside of the brain and heart). Record review of Resident #2's EMR reflected she had not been in the facility long enough for an MDS assessment. Record review of Resident #2's baseline care plan dated 12/08/2025 reflected it had not been completed. Record review of Resident #2's Active Orders as of: 12/17/2025 reflected Stage 4 Pressure wound to sacrum, she had a treatment ordered which included a dressing and she had a colostomy bag which was to be checked and changed every 72 hours and as needed with start dates of 12/09/2025. No EBP was ordered. Record review of Resident #2's comprehensive person-centered care plan dated 12/10/2025 reflected Focus, stage 4 pressure ulcer to sacrum r/t immobility, interventions, apply treatment and dressing as ordered, EBP was not reflected under interventions. Observation on 12/17/2025 at 10:00 am of Resident #2 and the entrance to her room revealed she had no PPE bin outside her door and no sign that reflected she required EBP. She was lying in bed moaning after being medicated for pain, LVN C showed the surveyor that Resident #2 had a dressing on her coccyx. Observations on 12/17/2025 at 10:15 am, and 12/18/2025 at 10:20 am revealed no PPE bin outside of Resident #2's room door. Staff could be observed entering her room with gloves and no gown to include the ADON who performed treatment for Resident #2's coccyx wound. During an interview on 12/17/2025 at 10:10 am, Resident #2 stated she received wound care treatment for her coccyx and the nurses wore gloves but not gowns. During an interview on 12/17/2025 at 3:12 pm with LVN C, who cared for Resident #2, stated she was not aware that Resident #2 had EBP, and that staff were trained on the topic. She stated the ADON usually took care of that issue since she did wound care. She stated without the proper PPE; cross contamination could occur. During an interview on 12/18/2025 at 11:20 am, the ADON stated she did wound care, and she did not know how she missed Resident #2 not having EBP since she did her wound care. She stated that cross contamination could occur and make the wound worse. She stated she had not used the proper PPE, such as a gown when she provided Resident #2's wound care and if a sign had been posted it would have reminded her to put a gown on. During an interview on 12/18/2025 at 3:52 pm, the RNC who was the infection control preventionist stated Resident #2 needed to be on EBP and that staff were trained on what the requirements were. He provided the surveyor with ADON's training on infection control and EBP. He stated EBP was important to try and prevent the spread of infection and prevent infections from MDRO's. Record review of the ADON's training dated 01/23/2025, 04/09/2025 titled Infection Control was completed. Record review of a staff in-service titled EBP-Infection Control dated 07/25/2025 reflected the ADON had attended. Record review of the RNC certificate of training titled Nursing Home Infection Control Preventionist Training Course dated 03/30/2024 reflected completion. Record review of the facility policy and procedure titled Enhanced Barrier Precautions dated March 2024 reflected Enhanced barrier precautions are utilized to reduce the transmission of multi-drug-resistant organisms to residents. EBP's are used as an infection prevention, employ targeted gown and glove use in addition to standard precautions during high contact resident care activities, such as wound care (any skin opening requiring a dressing).</p>		