STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455804	A. Building B. Wing	03/07/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review the facility failed to ensure the resident environment remained as free of accident hazards as possible, and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 7 (hall 100 exit door) exit doors reviewed for accident hazards and supervision. The facility failed the ensure the exit door alarm on hall 100 was not turned off where 14 of 47 residents resided. This failure could place residents who are exit seeking at risk for elopement and possible injuries. The findings included: Record review of Resident List Report, dated 03/07/2026, revealed the facility had 14 residents located on 100 hall and a total of 47 residents. During an observation on 03/07/2026 from 11:55 a.m. to 12:49 p.m. hall 100 was observed to have two staff members working in the hallway and four (4) resident room doors open with two (2) residents in beds and two (2) residents in their wheelchairs. The residents observed were not self-ambulating (walking on their own) or moving their wheelchairs on their own. During an observation and interview on 03/07/2026 from 02:09 p.m. to 02:22 p.m. with the Maintenance Director, seven (7) exit doors were identified and checks for functioning door alarms and secured access. At 02:10 p.m., the exit door located at the end of hall 100 was observed to not sound the alarm when the release bar was pushed and the door opened. The Maintenance Director was observed to insert a key into mounted, red exit door alarm, located to the left of the upper door frame, and he stated It works. I don't know why it was off. After turning the alarm box on, the door alarm was observed to alarm when the release bar was triggered, and the door was opened. The Maintenance Director stated one of the CNAs might have let a resident out to smoke. He stated the CNAs had a copy of the key and would occasionally let the residents out of the building through the door for smoking breaks. At 02:22 p.m., the Maintenance Director stated he checked the doors every Monday so the door on hall 100 would have been caught during his Monday door checks. He stated today, 03/07/2026 was the first time he had found an unsecured door and was surprised by the finding. He stated the staff would sometimes use that door to take a patient out because it was closer to the ramps or let the residents out for smoking. He stated the residents on 100 hall were unable to walk and were dependent on staff for wheelchair mobility. During an interview on 03/07/2026 at 07:34 p.m., the DON stated her expectation was for staff to turn the door alarms back on if they used the key to disable the alarm. She stated the risk of an alarm being disabled was residents could get out the door, and staff would not know. During an interview on 03/07/2026 at 07:57 p.m., the ADMIN stated she expected fire exit doors, when the handle was pushed, for the alarm to go off. She stated the risk of an alarm being disabled was if someone were to get out, staff might not know because the alarm did not sound. She stated residents could be at risk for potential elopement. She stated unless someone had taken something out of the building and forgot to re-arm the alarm, she did not know why the alarm was disabled. She stated staff would not have a reason to disable an alarm unless they were taking something out to back of the facility. Record review of policy Wandering and Elopements, dated as revised March 2019, revealed: Policy StatementOur facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post on a daily basis and at the beginning of each shift information that included the facility name, current date, total number and actual hours worked by registered nurses, licensed practical or licensed vocational nurses, certified nurse aides directly responsible for resident care per shift and the resident census for 1 of 1 days (03/07/2026) reviewed for posting of required information. The facility failed to post the required current nurse staffing and census information on 03/07/2026 at the beginning or within two (2) hours of the beginning of shift 6:00 a.m. to 6:00 p.m. This failure could place all residents, their families, and facility visitors at risk of not having access to information regarding staffing data and the facility census. The findings included: During an observation on 03/07/2026 at 12:00 p.m., a document labeled [facility name] Daily Staffing for Friday, March 6th, dated 03/06/2026, was posted on a wall of the front lobby. The document included the following information: current census and the scheduled number and hours worked of CNAs, LVNs, RNs, Hospitality Aides (Unlicensed Aides), and the total number of hours worked per shift 6:00 a.m. to 6:00 p.m. and shift 6:00 p.m. to 6:00 a.m. During an observation on 03/07/2026 at 12:49 p.m., a document labeled [facility name] Daily Staffing for Saturday, March 7th, dated 03/07/2026, was posted on a wall of the front lobby. During an interview on 03/07/2026 at 07:34 p.m., the DON stated the weekend supervisor was responsible for posting the daily census and nurse staffing document on the weekends. She stated the weekend supervisor did not work today, 03/07/2026, and the ADMIN posted the document, but it was posted late. The DON stated she was not sure who the weekend supervisor's backup was for this task. She stated she did not know the impact of posting the document late because it had never happened before. During an interview on 03/07/2026 at 07:57 p.m., the ADMIN revealed her expectation was for the daily census and nurse staffing document to be posted upfront by the weekend supervisor. She stated the facility did not have a weekend supervisor today, 03/07/2026 so the task would usually be the manager on duty. She stated she could not say why the document was not posted. She stated the document was a notification to the general public to let them know how many staff the facility had per shift. She stated the information was also available in the staffing book, located in the front lobby. She stated her expectation was that the documents be posted. Record review of the policy, Posting Direct Care Daily Staffing Numbers, dated as revised August 2022, reflected: Policy StatementOur facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents.Policy Interpretation and Implementation1. Within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs and NAs) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.3. Within two (2) hours of the beginning of each shift, the charge nurse or designee computes the number of direct care staff and completes the Nurse Staffing Information form. The charge nurse completes the form and posts the staffing information in the location(s) designated by the administrator.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **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 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 of 1 residents (Resident #1) and 1 of 1 staff (LPN A) reviewed for infection control. The facility failed to ensure LPN A wore appropriate PPE for EBP during wound care for Resident #1 on 03/07/2026. This failure could place residents at risk of exposure to infectious diseases due to improper infection control practices. The findings included: Record review of Resident #1's Face Sheet, dated 03/07/2026, reflected Resident #1 was initially admitted on [DATE] and readmitted on [DATE]. The face sheet indicated Resident #1 was [AGE] years old. Record review of Resident #1's Diagnosis Report, dated 03/07/2026, reflected Resident #1 diagnoses included cerebral infarction (a condition when blood supply to a part of the brain was interrupted resulting in the death of brain tissue), colostomy status (a surgically created opening in the body to allow stool to leave the body), and malignant melanoma (a type of skin cancer) of right upper limb (arm). Record review of Resident #1's Quarterly MDS assessment, dated 02/19/2026, reflected Resident #1 had a BIMS score of 15, indicating she was cognitively intact. The MDS indicated she had an indwelling catheter (a medical device that allows for continuous drainage of urine) and ostomy (a surgically created opening in the body to allow stool or urine to leave the body without going through the intestine or urinary tract). The MDS Skin Conditions section indicated she had open lesion(s) other than ulcers, rashes, or cuts. Record review of Resident #1's Order Summary Report, dated active orders as of 03/07/2026 reflected the orders:- Cleanse Upper Right Arm wound with wound cleanse. Pat dry with 4x4 gauze, apply calcium alginate, cover with border island dressing Daily/PRN [sic] every day shift. The order status was noted as Active with the order date of 09/16/2025 and start date of 10/01/2025.- EBP: Staff must use gown and gloves during high-contact resident care activities that could possibly to [sic] result in transfer of MDROs to hands and clothing of staff. Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those who are not confirmed to have an MDRO (e.g., residents with wounds or indwelling medical devices). every [sic] shift for EBP Precautions. The order status was noted as Active with the order date and start date of 11/20/2025. - Staff may utilize EBP (enhanced barrier precautions) for high contact resident care r/t colostomy, chronic wound. The order status was noted as Active with the order date of 10/09/2025. During an observation and interview on 03/07/2026 at 03:20 p.m., LPN A was observed providing right upper arm wound care to Resident #1. LPN A was observed to not put on a personal protective gown during care. An EBP (enhanced barrier precaution) sign was observed next to Resident #1's door prior to entering room. LPN A stated the floor nurses normally did the residents' daily wound care, but she would round (visit each of the residents to assess their condition, status, and concerns) with the wound care physician weekly. Attempted follow up interview with LPN A on 03/07/2026 at 07:01 p.m. LPN A had left the facility for the day and did not answer her phone. During an interview on 03/07/2026 at 07:34 p.m., the DON stated her expectation was for staff to wear gloves and gowns when entering and performing care on a resident with enhanced barrier precautions. She stated the failure to wear a gown was that it put the resident at risk for getting an infection. During an interview on 03/07/2026 at 07:57 p.m., the ADMIN stated the precautionary signs on the resident doors notified staff what they needed to wear for precautions, and it might include gowns, gloves, footwear, and possibly eye protection. She stated she expected staff to wear gowns and gloves. She stated the risk of not wearing the appropriate personal protective equipment was they could put themselves and the resident at risk for infection. She stated that the gown was another layer of protection when providing care to a resident. Record review of the policy, Enhanced Barrier Precautions, dated as revised March 2024 and February 2025, reflected: Policy Statement?Enhanced (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Barrier Precautions' (EBP) refer [sic] to an infection control intervention designed to reduce transmission of multi-drug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.Policy Interpretation and Implementation1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the transmission of multi-drug-resistant organisms (MDROs) to residents.2. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as apposed to before entering the room).3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: . h. wound care (any skin opening requiring a dressing).5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.