

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 04/24/2026
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>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</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 they established and maintained identical policies and practices regarding transfer, discharge and the provision of services under the State plan for all residents regardless of payment source as well as failing to ensure the residents were free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required for 1(Resident #2) of 1 residents reviewed.The facility failed to allow and assist Resident #2 to exercise his right to discharge from the facility to an outside provider per his request.The facility failed to ensure that Resident #2's rights to be free from interference from the facility were respected.This failure placed Resident #2 at risk of low self-esteem, increase in depression symptoms, breakthrough of repeat suicidal ideation and embarrassment due to facility's accusation of resident not being able to be successful outside of facility. The findings included:Review of Resident #2's face sheet, dated 04/22/2026, revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Suicidal Ideation (thinking about, or considering,, or planning suicide); Schizoaffective Disorder, Bipolar type (a chronic mental health condition combining schizophrenia symptoms (psychosis) with mood disorder symptoms (mania and sometimes depression)); Schizoaffective Disorder, Depressive type (a chronic mental health condition combining schizophrenia symptoms (hallucinations, delusions) with major depressive episodes); Vascular Demetia without Behavioral Disturbance (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, often following a stroke or chronic vessel damage); and Major Depressive Disorder (mood disorder that causes a persistent feeling of sadness and loss of interest).Review of Resident #2's Comprehensive MD assessment, dated 03/02/2026, revealed a BIMS score of 13, which indicated he was cognitively intact. The MDS also revealed that Resident #2 ambulated independently, felt that his daily preferences were very important to him, and needed supervision or was independent for ADL's. Review of Resident #2's Comprehensive Care Plan, dated 02/17/2026, indicated that Resident #2 was a smoker, left the facility when he wanted to, enjoyed sitting outside, and preferred his own routine.During an interview on 04/22/2026 at 3:40 pm, SW stated that she attempted to help Resident #2 find an outside group home and she was directed by the ADMIN to stop because the family did not want Resident #2 to move. SW claimed to have called the sister of Resident #2 and the sister stated that the original plan was for him to move to a group home after he was balanced out and better, in their mind about a year. SW then told ADMIN that the sister was on board with the move and SW claimed that the ADMIN called her into the office after that and told her to hold the discharge. SW claimed the ADMIN then told the SW that if she continued and did not stop discharging patients that she would be let go from the facility. SW stated that she then told Resident #2 when he came to follow-up that she could not help him. SW stated she informed the sister of her stopping the assistance to find a place. Resident #2's sister was upset and wanted to know how the ADMIN could stop the discharge and why the administrator was involved anyway. SW confirmed that Resident #2 mentioned discharge in his Quarterly Care Plan meeting.During an (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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>interview on 04/22/2026 at 4:53 pm Resident #2 stated that he wanted to discharge and that was the plan from admission. Resident #2 stated that SW told him she could not move him or they would fire her. Resident #2 shared that this upset him and made him sad. They just want to make money off of me, Resident #2 expressed. resident #2 shared that he felt that the facility was finding reasons to keep him here. During an interview on 04/22/2026 at 5:00 pm the ADMIN stated that she was not aware of Resident #2 attempting to discharge, stating He has not told me he wanted to go and she Did not know if he told anyone else. ADMIN stated that Resident #2 was not good with money, would need a Representative Payee to assist with bills and that she wanted residents set-up for success. ADMIN claimed if she knew they would have made sure that Resident #2 was ready and had everything in place for him to be successful in the community. ADMIN did recall a conversation, but not the timeframe, that Resident #2 told her he wanted to live independently in the community and go to nursing school. During an interview on 04/22/2026 at 5:21 pm on the phone with SW, Resident #2, and Resident's sister it was confirmed that the SW had told the sister everything she claimed she had. Resident #2's sister was upset that they would hold someone against their will and what happens to residents with no family involved that want to leave?. Resident #2's sister shared she took it upon herself to look for group homes in town that were within his budget and had found one but was not sure about the next steps. SW gave the sister needed information with surveyor on phone and Resident #2's discharge was set for Friday, April 24th. Record review of Resident #2's Progress Notes, dated, revealed on 11/18/2025 during a Quarterly Care Plan meeting that Resident #2 expressed his desire to move into the community to a group home. Resident asked SW to help him locate a group home around \$700/month. No other Progress Note mentioning resident's desire to move afterwards. Review of facility policy, Resident Rights, dated 2001, revealed that residents within the facility should be able to exercise their rights without interference, coercion, discrimination, or reprisal from the facility.</p>		

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<p>F 0557</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 be treated with respect and dignity and to retain and use personal possessions.</p> <p>Based on observation, interview, and record review, the facility failed to provide an environment that maintained or enhanced each resident's respect and dignity for 5 of 19 residents observed in dining room. The facility failed to provide a dignified and respectful dining experience for each resident in the dining room by allowing residents to watch their tablemates eat or be fed, and/or have their meals placed in front of them but they were not able to feed themselves due to physical or mental handicaps for extended periods of time. This failure could place residents at risk of embarrassment, low self-esteem, anxiety, or potential weight loss. The findings include: During an observation on 04/22/2026 at 12:10 pm, the surveyor observed a plate of food in front of an unknown resident in dining room. The resident appeared to need assistance to eat. The food was uncovered in front of resident until 12:22 pm when a staff member sat down next to resident to feed them. CNA D confirmed resident needed feeding assistance. During an observation on 04/22/2026 at 12:17 pm, the surveyor observed a plate of food was sat in front of an unknown resident in dining room. Unknown resident was in a specialized chair and had contractures to bilateral upper extremities. Staff member sat next to this resident at 12:25 pm to assist resident to eat. Food had sat uncovered in front of resident until then. CNA D confirmed resident needed feeding assistance. During an observation on 04/23/2026 at 12:05 pm, the surveyor observed an unknown resident sitting with two table mates that had their food in front of them while this resident did not. This resident had his tray placed in front of him and set up at 12:20 pm. A staff member returned to assist this resident, who had not touched the plate due to physical handicaps, at 12:23 pm to eat. CNA D confirmed resident needed feeding assistance. During an observation on 04/23/2026 at 12:04 pm, the surveyor observed an unknown resident at a table with table mates who had obtained their plates and were being assisted to eat while this resident had not received his tray. This resident's tray was brought at 12:20 pm, however a staff member did not sit to assist this resident to eat until 12:24 pm. CNA D confirmed resident needed feeding assistance. During an observation on 04/24/2026 at 12:09 pm, the surveyor observed a plate set up in front of an unknown resident and the staff member that brought the plate sitting down to assist this resident to eat. This resident had a tablemate that had not received his meal. The resident that was assisted finished at 12:19 pm and left the dining room while his table mate had still not received his plate. A staff member escorted a different unknown resident to that table and was presented with their tray at 12:21 pm to eat, while the original resident (tablemate) had still not received his meal. At 12:22 pm the original resident (tablemate) received his plate and it was set up. This resident could not feed himself and a staff member did not return to the table to assist the original resident (tablemate) till 12:24 pm. CNA D confirmed residents needed feeding assistance. During an interview on 04/24/3036 at 12:41 pm, the DM stated that the expectation when bringing plates to residents was that they need to be given in order of how the residents are at the table. There should not be a time gap between residents at the same table when receiving their plates. DM also stated the residents needing assistance to eat should be placed at same tables together and their food not given until someone is immediately ready to assist them to eat. During an interview on 04/24/2026 at 1:22 pm, the ADON stated that the plates in the dining room should be handed out in order and a table mate should not have to wait to receive their plate while the other residents at the table eat. ADON also stated that residents needing assistance should be given their food and then immediately fed. During an interview on 04/24/2026 at 1:44 pm, the ADMIN stated that resident needing assistance to eat should be given their food when a staff member is able to assist, not before. ADMIN also stated that the plates should be given to residents at the same table at the same time, no gaps or skipping over a resident so that they have to watch another resident eat. Record review of the facility's Dignity policy, dated 2001, stated that residents are provided with a dignified dining experience. Policy statement revealed that Each resident shall be cared for in a manner that promotes and enhances his or her (continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Record review of the facility's Resident Rights policy, dated 2001, stated that Employees shall treat all residents with kindness, respect and dignity. Resident rights include: a dignified experience. Record review of the facility's Food and Nutrition Services policy, dated 2001, stated that staff will be available and adequately staffed to assist residents with eating as needed and that staff will provide support to enhance the resident experience in dining room.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had a right to a safe, clean, comfortable and homelike environment, including but not limited to clean towels for showers for 4 of 4 (Resident #1, Resident #9, Resident #10 and Resident #12) reviewed for available linen. The facility failed to ensure Resident #9, Resident #10, and Resident #12 had clean towels available to them to shower. This failure could lead to residents feeling neglected, infection control concerns, and emotional well-being. The findings include: Record review of Resident #1's admission Record, dated 04/22/2026, revealed a [AGE] year-old-male that admitted on [DATE] with diagnoses that included Morbid Obesity (a chronic, complex disease defined by a body mass index of 40 or higher, or 35 or higher with serious obesity-related comorbidities); Psychoactive Substance Abuse; and Major Depressive Disorder (serious mental health condition characterized by persistent, severe low mood, loss of interest in activities, and fatigue lasting at least two weeks). Record review of Resident #1's Comprehensive MDS assessment completed 03/23/2026 revealed a BIMS score of 15 which indicated intact cognition. Record review of Resident #1's Care Plan completed 03/16/2026 revealed risk of elopement; wound management; ADL self-care performance deficit; medication refusal; verbal aggression; physical aggression; major depressive disorder; pressure ulcer development risk. Record review of Progress Notes dated 03/22/2026-04/22/2026 revealed no documentation of shower refusal. Record review of Resident #9's admission Record, dated 04/22/2026, revealed a [AGE] year-old-female admitted to the facility on [DATE] with diagnoses that include Seizures (temporary uncontrolled surge of electrical activity in the brain that causes involuntary movements, sensory disturbances, or altered awareness); Hemiplegia Left side (severe or complete paralysis affecting one side of the body, usually caused by brain or spinal cord injury); Morbid Obesity (a chronic, complex disease defined by a body mass index of 40 or higher, or 35 or higher with serious obesity-related comorbidities); Nontraumatic Intracerebral Hemorrhage (severe type of stroke caused by bleeding within the brain tissue, not trauma); and Congestive Heart Failure (chronic, progressive condition where the heart cannot pump blood effectively, causing fluid buildup in the lungs and body). Record review of Resident #9's Quarterly MDS assessment completed 04/12/2026 revealed a BIMS score of 09 which indicated moderate cognitive impairment. Record review of Resident #9's Care Plan completed on 03/30/2026 revealed risk of alteration in comfort related to debility; an ADL self-care deficit; risk for urinary tract infections; and a potential for pressure ulcer development and skin breakdown. No mention of refusing care or showers was mentioned in care plan. Record review of Resident #9's Progress Notes, dated 03/24/2026-04/24/2026, revealed no documented refusals of showers. Record review of Resident #10's admission record, dated 04/22/2026, revealed a [AGE] year-old-female admitted to the facility on [DATE] with diagnoses that include Quadriplegia (paralysis affecting all four limbs and the torso, usually caused by cervical spinal cord injury (C1-C8) from trauma, disease, or congenital conditions); Pressure Ulcer of Left buttocks (localized injuries to skin and underlying tissue, usually over bony prominences like hips, heels, or tailbone, caused by prolonged pressure, friction, or shear); Urinary Tract Infections (bacterial infection- most commonly E. coli- in the urinary system, causing burning pain during urination, frequent urges, and cloudy or foul-smelling urine); Irritant Contact Dermatitis due to fecal, urinary, or dual incontinence (non-allergic skin inflammation caused by direct damage from substances); Major Depressive Disorder (serious mental health condition characterized by persistent, severe low mood, loss of interest in activities, and fatigue lasting at least two weeks). Record review of Resident #10's Quarterly MDS assessment completed on 04/12/2026 revealed a BIMS score of 15 which indicated intact cognition. Record review of Resident #10's Care Plan completed on 02/20/2026 revealed incontinence; chronic pain related to wounds; colostomy; PASRR positive for MI; Impaired skin integrity related to immobility and (continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>incontinence; self-care performance deficit related to quadriplegia; major depressive disorder. Record review of Resident #10's Progress Notes, dated 03/24/2026-04/24/2026, revealed no documentation regarding refusals of showers. Record review of Resident #12's admission record, dated 04/22/2026, revealed a [AGE] year-old-female admitted to the facility on [DATE] with diagnoses which include Dementia without Behavioral Disturbance (progressive; umbrella term for a decline in cognitive function-memory, language, problem-solving- that interferes with daily life, typically caused by neurodegenerative diseases like Alzheimer's) Major Depressive Disorder (serious mental health condition characterized by persistent, severe low mood, loss of interest in activities, and fatigue lasting at least two weeks); Contracture Left Knee (permanent tightening of muscles, tendons, ligaments, or skin, causing stiffened joints and restricted motion, often caused by prolonged immobility, scarring (burns), or neurological damage); and Cellulitis (common, potentially serious bacterial skin infection affecting deep dermis and subcutaneous tissues, usually caused by Streptococcus or Staphylococcus bacteria entering through broken skin). Record review of Resident #12's Quarterly MDS assessment completed on 04/06/2026 revealed a BIMS score of 15 which indicated intact cognition. Record review of Resident #12's Care Plan completed on 02/26/2026 revealed risk for depression; communication problem related neurological symptoms; contracture left knee; right artificial hip; and incontinence. During an observation on 04/22/2026 10:30 am of the linen closets on 100/200 hall and 300/400 hall, the surveyor observed no more than 4 towels in each closet. During an observation on 04/23/2026 1:45 pm of the linen closets on 100/200 hall and 300/400 hall, the surveyor observed no more than 5 towels in each closet. During an observation on 04/24/2026 3:30 pm of the linen closets on 100/200 hall and 300/400 hall, the surveyor observed 7 towels on 100/200 hall and 6 towels on 300/400 hall. During an interview on 04/22/2026 at 11:40 am, Resident #1 stated that he does not get showered regularly and staff tells him it is because they do not have towels. Resident #1 claimed he had told management multiple times and they do not care about the residents and do not do anything to fix the issue. During an interview on 04/22/2026 at 2:16 pm, CNA B stated that sometimes staff have issues getting towels. CNA B stated that she will even use blankets if she can and that management is aware. Laundry gave some poor excuse about how the towels shrank but she can tell they ordered the wrong size. She stated that the towels they bought are slightly larger than hand towels. CNA B stated that the towels are so thin that she can see light through the towels and it takes several towels for a shower. Especially if they only have these tiny ones. During an interview on 04/23/2026 at 10:19 am, LVN A stated that there is a towel shortage and that management is aware. LVN A stated that sometimes there are only 10 towels for the day and it takes several towels to shower a resident. During an interview on 04/23/2026 at 1:55 pm, Resident #9 stated that she had not had a bed bath in a week or so because the staff keeps saying that there are not any towels. Resident stated that staff claims they will give her one later when they get towels, but no one comes back to bathe her. Resident stated she has told management of this concern, but the towels are still an issue. During an interview on 04/23/2026 at 2:04pm, Resident #10 stated that she goes days without a shower due to the staff not having any towels. Resident stated that staff tells her they will do the shower later but they never come back. When she asks for a shower the next day the staff tell her that it is not her day. During an interview on 04/23/2026 at 3:02pm, HSK SUP stated that she bought towels and they shrank in the dryer. HSK SUP also stated that she ordered another case of towels. HSK SUP also stated that no one has mentioned needing more towels purchased at stand-up in the mornings. During an interview on 04/23/2026 at 3:10pm, Resident #12 stated that she misses showers because staff does not have any towels, Resident stated she would get one shower a week when she is supposed to get three. Resident claimed to have said something to management although she cannot recall for sure but feels like management should know because staff should be telling them. During an interview on 04/23/2026 at 3:15pm, CNA A stated that overnight just washes linen when they need it. There is never any linen. During an interview on 04/24/2026 at 1:22pm, ADON stated that there is a towel issue and that yes, some (continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>showers were missed because of it. ADON stated that towels were being ordered and there should be grievances for the towels. During an interview on 04/24/2026 at 1:44pm, ADMIN stated that towels were delivered and they shrank. Company keeps sending wrong size of towels when ordered. ADMIN did admit that there was a towels shortage and that the facility was actively working on it. Review of HSK SUP email revealed an order for a case of 75 towels with the confirmation email dated 04/23/2026. Facility does not currently have specific policies for towels per HSK SUP.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 4 of 4 residents (Resident #1, Resident #9, Resident #10, Resident #12) reviewed for ADL care. The facility failed to ensure that Resident #1, Resident #9, Resident #10, and Resident #12 regularly obtained showers, per resident rights. This failure could place residents at risk for altered social experiences, minimized emotional well-being, and infection control issues. The findings include: Record review of Resident #1's admission Record, dated 04/22/2026, revealed a [AGE] year-old-male that admitted on [DATE] with diagnoses that included Morbid Obesity (a chronic, complex disease defined by a body mass index of 40 or higher, or 35 or higher with serious obesity-related comorbidities); Psychoactive Substance Abuse; and Major Depressive Disorder (serious mental health condition characterized by persistent, severe low mood, loss of interest in activities, and fatigue lasting at least two weeks). Record review of Resident #1's Comprehensive MDS assessment completed 03/23/2026 revealed a BIMS score of 15 which indicated intact cognition. The ADL's section showed Resident #1 needed assistance to bathe. Record review of Resident #1's Care Plan completed 03/16/2026 revealed risk of elopement; wound management; ADL self-care performance deficit; medication refusal; verbal aggression; physical aggression; major depressive disorder; pressure ulcer development risk. Record review of Resident #1's Progress Notes dated 03/22/2026-04/22/2026 revealed no documentation of shower refusal. Record review of Resident #1's Shower Task List for April on 04/23/2026, revealed Resident #1 to be on a Monday, Wednesday, Friday shower schedule for nights. Resident #1 did not receive a shower between April 1st through April 6th, did not receive a shower April 10th through April 12th, and did not receive a shower April 19th through the 23rd of April. Record review of Resident #9's admission Record, dated 04/22/2026, revealed a [AGE] year-old-female admitted to the facility on [DATE] with diagnoses that include Seizures (temporary uncontrolled surge of electrical activity in the brain that causes involuntary movements, sensory disturbances, or altered awareness); Hemiplegia Left side (severe or complete paralysis affecting one side of the body, usually caused by brain or spinal cord injury); Morbid Obesity (a chronic, complex disease defined by a body mass index of 40 or higher, or 35 or higher with serious obesity-related comorbidities); Nontraumatic Intracerebral Hemorrhage (severe type of stroke caused by bleeding within the brain tissue, not trauma); and Congestive Heart Failure (chronic, progressive condition where the heart cannot pump blood effectively, causing fluid buildup in the lungs and body). Record review of Resident #9's Quarterly MDS assessment completed 04/12/2026 revealed a BIMS score of 09 which indicated moderate cognitive impairment. The ADL's section showed Resident #9 needed assistance to bathe. Record review of Resident #9's Care Plan completed on 03/30/2026 revealed risk of alteration in comfort related to debility; an ADL self-care deficit; risk for urinary tract infections; and a potential for pressure ulcer development and skin breakdown. No mention of refusing care or showers was mentioned in care plan. Record review of Resident #9's Progress Notes, dated 03/24/2026-04/24/2026, revealed no documented refusals of showers. Record review of Resident #9's Shower Task List for April on 04/23/2026, revealed Resident #9 to be on a Monday, Wednesday, Friday shower schedule for days. Resident #9 did not receive a shower for the entire month of April according to the documentation. Record review of Resident #10's admission record, dated 04/22/2026, revealed a [AGE] year-old-female admitted to the facility on [DATE] with diagnoses that include Quadriplegia (paralysis affecting all four limbs and the torso, usually caused by cervical spinal cord injury (C1-C8) from trauma, disease, or congenital conditions); Pressure Ulcer of Left buttocks (localized injuries to skin and underlying tissue, usually over bony prominences like hips, heels, or tailbone, caused by prolonged pressure, friction, or shear); Urinary Tract Infections (bacterial infection- most commonly E. coli- in the urinary system, causing burning (continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>pain during urination, frequent urges, and cloudy or foul-smelling urine); Irritant Contact Dermatitis due to fecal, urinary, or dual incontinence (non-allergic skin inflammation caused by direct damage from substances); Major Depressive Disorder (serious mental health condition characterized by persistent, severe low mood, loss of interest in activities, and fatigue lasting at least two weeks).Record review of Resident #10's Quarterly MDS assessment completed on 04/12/2026 revealed a BIMS score of 15 which indicated intact cognition. The ADL's section showed Resident #10 needed assistance to bathe.Record review of Resident #10's Care Plan completed on 02/20/2026 revealed incontinence; chronic pain related to wounds; colostomy; PASRR positive for MI; Impaired skin integrity related to immobility and incontinence; self-care performance deficit related to quadriplegia; major depressive disorder.Record review of Resident #10's Progress Notes, dated 03/24/2026-04/24/2026, revealed no documentation regarding refusals of showers.Record review of Resident #10's Shower Task List for April on 04/23/2026, revealed Resident #10 to be a Monday, Wednesday, Friday shower schedule for nights. Resident #10 did not receive a shower April 1st -3rd , 6th - 11th, 18th - 20th. Record review of Resident #12's admission Record, dated 04/22/2026, revealed a [AGE] year-old-female admitted to the facility on [DATE] with diagnoses which include Dementia without Behavioral Disturbance (progressive; umbrella term for a decline in cognitive function-memory, language, problem-solving- that interferes with daily life, typically caused by neurodegenerative diseases like Alzheimer's) Major Depressive Disorder (serious mental health condition characterized by persistent, severe low mood, loss of interest in activities, and fatigue lasting at least two weeks).; Contracture Left Knee (permanent tightening of muscles, tendons, ligaments, or skin, causing stiffened joints and restricted motion, often caused by prolonged immobility, scarring (burns), or neurological damage); and Cellulitis (common, potentially serious bacterial skin infection affecting deep dermis and subcutaneous tissues, usually caused by Streptococcus or Staphylococcus bacteria entering through broken skin).Record review of Resident #12's Quarterly MDS assessment completed on 04/06/2026 revealed a BIMS score of 15 which indicated intact cognition. The ADL's section showed Resident #12 needed assistance to bathe.Record review of Resident #12's Care Plan completed on 02/26/2026 revealed risk for depression; communication problem related neurological symptoms; contracture left knee; right artificial hip; and incontinence.Record review of Resident #12's Progress Notes, dated 03/24/2026 through 04/23/2026, revealed no refusals for showers documented.Record review of Resident #12's Shower Task List for April on 04/23/2026, revealed Resident #12 to be a Monday, Wednesday, Friday shower schedule for days. Resident #12 did not receive a shower April 2nd - 10th ,April 11th - April 14th , and April 18th - April 20th .During an observation on 04/22/2026 at 10:30am of the linen closets on 100/200 hall and 300/400 hall, the surveyor observed no more than 4 towels in each closet. During an observation on 04/23/2026 at 1:45 pm of the linen closets on 100/200 hall and 300/400 hall, the surveyor observed no more than 5 towels in each closet. During an observation on 04/24/2026 at #:30 pm of the linen closets on 100/200 hall and 300/400 hall, the surveyor observed 7 towels on 100/200 hall and 6 towels on 300/400 hall.During an interview on 04/22/2026 at 11:40 am, Resident #1 stated that he does not get showered regularly and staff tells him it is because they do not have towels. Resident #1 claimed he had told management multiple times and they do not care about the residents and do not do anything to fix the issue.During an interview on 04/22/2026 at 2:16 pm, CNA B stated that sometimes staff have issues getting towels. CNA B stated that she will even use blankets if she can and that management is aware. Laundry gave some poor excuse about how the towels shrank but she can tell they ordered the wrong size. She stated that the towels they bought are slightly larger than hand towels. CNA B stated that the towels are so thin that she can see light through the towels and it takes several towels for a shower. Especially if they only have these tiny ones. CNA B stated that this affects all of the residents in the facility as she cannot think of any who shower themselves with their own towels. During an interview on 04/23/2026 at 10:19 am, LVN A stated that there is a towel shortage and that management is aware. LVN A stated that sometimes there are only 10 towels (continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Northgate Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5757 N Knoll San Antonio, TX 78240	
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>for the day and it takes several towels to shower a resident. LVN A stated that some showers were missed, but he could not recall who. During an interview on 04/23/2026 at 1:55 pm, Resident #9 stated that she had not had a bed bath in a week or so because the staff keeps saying that there are not any towels. Resident stated that staff claims they will give her one later when they get towels, but no one comes back to bathe her. Resident stated she has told management of this concern, but the towels are still an issue. During an interview on 04/23/2026 at 2:04pm, Resident #10 stated that she goes days without a shower due to the staff not having any towels. Resident stated that staff tells her they will do the shower later but they never come back. When she asks for a shower the next day the staff tell her that it is not her day. During an interview on 04/23/2026 at 3:02pm, HSK SUP stated that she bought towels and they shrank in the dryer. HSK SUP also stated that she ordered another case of towels. HSK SUP also stated that no one has mentioned needing more towels purchased at stand-up in the mornings. During an interview on 04/23/2026 at 3:10pm, Resident #12 stated that she misses showers because staff does not have any towels, Resident stated she would get one shower a week when she is supposed to get three. Resident claimed to have said something to management although she cannot recall for sure but feels like management should know because staff should be telling them. During an interview on 04/23/2026 at 3:15pm, CNA A stated that overnight just washes linen when they need it. There is never any linen. During an interview on 04/24/2026 at 1:22pm, ADON stated that there is a towel issue and that yes, some showers were missed because of it. ADON stated that towels were being ordered and there should be grievances for the towels. During an interview on 04/24/2026 at 1:44pm, ADMIN stated that towels were delivered and they shrank. Company keeps sending wrong size of towels when ordered. ADMIN did admit that there was a towels shortage and that the facility was actively working on it. The shortage has caused some problems with showers. Review of HSK SUP email revealed an order for a case of 75 towels with the confirmation email dated 04/23/2026. Policy review of facility's Resident Rights policy, dated 2001, states that resident have a right to a dignified existence. Policy review of facility's Dignity policy, dated 2001, states when assisting with care residents are groomed as they wish allowed to choose when to conduct ADL's. Policy review of facility's Bath, Shower/Tub protocol, dated 2001, states that staff member will document when showers are given and/or if resident refused the shower.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, interview and record review the facility failed to ensure each resident received and the facility provided food and drink that was palatable, attractive, and at a safe and appetizing temperature for 1 of 1 meal reviewed for palatability, attractiveness, and appetizing foods. The facility failed to provide food that was palatable and at an appetizing temperature for residents related to cold, soggy shrimp and warm coleslaw. The temperature of the items on the meal tray were not within regulated safety guidelines to ensure residents are not exposed to hazardous bacterial growth. This failure could place residents at risk of a decrease in food intake, hunger, and unwanted weight loss. The findings included: During confidential resident interviews at an undisclosed date and time, multiple residents in a hallway stated that they ate in their rooms for meals and the food was always cold. Residents lived on two different halls and wanted to remain anonymous. During an observation on 04/22/2026 at 11:27 am, CNA A was pushing a meal tray cart down the 100 hall with the doors open on both sides of the cart during meal pass. CNA A closed the doors at the end of meal tray pass on the 100 hall to transition to the 200 hall and then proceeded to leave the doors on the meal tray cart open until completion of meal tray pass on the 200 hall. During an observation on 04/22/2026 at 12:17 pm, a meal was placed in front of an unknown resident with warming lid removed. Resident presented with contracted hands bilaterally. Unknown CNA sat down next to unknown resident to feed them at 12:25 pm. During an observation and interview on 04/24/2026 at 11:01 am, the surveyor monitored meal tray preparation. DM stated that the 300/400 hall trays were the last sent out of the kitchen so the surveyor requested a food tray to be put on that cart last, and surveyor would obtain tray at end of meal pass. At 11:24 am the meal tray cart for 300/400 hall was wheeled to the halls and left with nursing staff. At 11:26 am RN A opened cart to check trays for accuracy. CNA D arrived and proceeded to pass out trays to 400 hall first at 11:31 am, with door open to meal tray cart. CNA D moved meal tray cart to 300 hall at 11:36 am. The surveyor obtained sample tray and took it to conference room at 11:44 am to test temperatures. Temperature for coleslaw was 86.0 degrees Fahrenheit, boiled shrimp at 96.4 degrees Fahrenheit, tater tots at 97.5 degrees Fahrenheit, hushpuppies at 103.6 degrees Fahrenheit, and fruit at 70.9 degrees Fahrenheit. During an interview on 04/24/2026 at 12:41 pm, DM stated that the expectation was that the residents receive meals at the appropriate temperatures to ensure they do not obtain a food borne illness and the food was palatable. DM stated that the fruit and coleslaw should have been cold, closer to 40 degrees and the rest of the food should not have been under 100 degrees Fahrenheit. DM stated that he understood that this could lead to residents not wanting to eat their meals. During an interview on 04/24/2026 at 1:44 pm, ADMIN stated that all foods should be provided to residents within the appropriate temperature ranges. ADMIN stated that the coleslaw should never be that warm and that the shrimp should have been warmer for sure. ADMIN confirmed that failure to serve food at appropriate temperatures could cause issues for residents like upset stomach, vomiting, and maybe diarrhea. Record review of the facility's the Food and Nutrition Services policy, dated 2001, stated that each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.</p>		

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<p>F 0811</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised.</p> <p>Based on observation, interview and record review, the facility failed to ensure staff had successfully completed a State-approved training course for feeding assistance before feeding resident who required staff to feed them for 3 of 7 unknown residents in the dining room over 3-day period of observations. The facility did not ensure that the Administrator and the Medical Records clerk completed a state approved training course for feeding assistance before assisting residents to eat. This failure could place residents who require assistance with eating at risk of aspiration and choking. Findings include: During an observation on 04/22/2026 at 12:10pm, the surveyor observed the MR clerk assisting an unknown resident to eat. Unknown resident appeared to have bilateral upper extremities weakness and contractures. CNA D confirmed unknown resident needed feeding assistance. During an observation on 04/22/2026 at 12:10 pm, the surveyor observed the ADMIN assisting an unknown resident to eat. Unknown resident was sitting upright in specialized chair. Unknown resident did not make any effort to lift upper extremities bilaterally. CNA D confirmed unknown resident needed feeding assistance. During an observation on 04/23/2026 at 12:15 pm, the surveyor observed the ADMIN assisting an unknown resident to eat. Unknown resident was sitting slightly hunched over and was not trying to lift bilateral upper extremities. CNA D confirmed unknown resident needed feeding assistance. During an observation on 04/24/2026 at 12:20 pm, the surveyor observed the ADMIN assisting an unknown resident to eat. Unknown resident only opened mouth for ADMIN when verbally prompted. CNA D confirmed unknown resident needed feeding assistance. During an interview on 04/24/2026 at 10:20 am, the HR representative for the facility stated that the feeding assistance training for staff was not part of the new hire packet but sometimes there are trainings done that are more of an in-service or is specialized to a department. The surveyor asked if HR had the records of these trainings. HR could not locate the paper copies but did inform surveyor that the company switched systems when they were bought out by a new company last summer. HR stated that she would reach out to her regional boss to get the information. During an interview on 04/24/2026 at 11:05 am, HR handed the paperwork for the training before the new company's acquisition to the surveyor. The surveyor quickly reviewed the paper and did not see the training. HR stated that she would have the Administrator go through in-services and bring them to conference room. HR also stated that the training for feeding assistance would be done if there was an issue but she does not think that the training auto-populates anywhere for the new company. During an interview on 04/24/2026 at 1:22 pm, the ADON stated that she believed that the feeding assistance training was included in their dementia training that the facility does. The surveyor asked for that information and the ADON stated it was in Relias. The surveyor shared that HR could not find the training related to feeding assistance. The ADON then stated that they just did that training last month and it may be in the DON's office and that she would get with the Administrator to locate it. During an interview on 04/24/2026 at 1:44 pm, the ADMIN stated that she could not locate the trainings. The in-services the ADMIN brought did not have her name or the MR clerk's name listed as having attended. The ADMIN stated that maybe the RNC may have it as she was the one that gave the training. During a phone interview on 04/24/2026 at 2:21 pm, the RNC stated that she did not have the paperwork for the training with signatures, but she could verbally verify that the ADMIN and MR were present for training. The surveyor shared that she needed physical documentation, not verbal verification that the training happened. Record review of training records from hire to current date for ADMIN and MR on 04/24/2026 at 10:20 am revealed that there was not any training documented as completed for feeding assistance. Record review on 04/26/2026 at 1:44 pm revealed that the ADMIN and MR had not signed the in-service sheet acknowledging they attended the training for feeding assistance for residents. Facility did not have a policy on training for feeding assistance per ADMIN, however, Appendix PP of the State Operating Manual states, Use of Existing Staff as Paid Feeding (continued on next page)</p>		

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistants - Facilities may use existing staff, i.e., licensed nurses, certified nursing assistants, to assist residents in feeding. However, other employees for example, administrative, clerical, housekeeping, dietary staff, or activity specialists, etc. must have successfully completed a State-approved training course for paid feeding assistants, as required in S483.160		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions for 2 of 2 halls (100 and 200 halls) for room trays and 1 of 1 dining room reviewed, in that: 1. On 04/22/2026, the facility failed to ensure CNA A sanitized her hands between resident meal trays while passing out room trays for 2 of 2 halls. 2. On 04/22/2026, the facility failed to ensure LVN C sanitized her hands between resident trays in the dining room while checking trays for accuracy and passing out trays for staff to deliver to tables for 12 of 23 residents. 3. On 4/23/2026, the facility failed to ensure CNA A sanitized her hands between resident meal trays while passing out room trays for 2 of 2 halls. 4. On 04/23/2026, facility failed to ensure LVN C sanitized her hands between resident trays in the dining room while checking trays for accuracy and passing out trays for staff to deliver to tables for 10 of 25 residents. These failures could place residents at risk of cross-contamination and the spread of infection. The findings included: During an observation on 04/22/2024 at 11:27 am, CNA A was observed passing room trays to residents dining in their rooms. The surveyor observed the doors on both sides of the meal cart were open during the meal tray pass as well as CNA A not performing hand hygiene before or after passing meal trays to 8 or 8 residents on 100 hall and 4 of 4 residents on 200 hall. During an observation on 04/22/2026 at 12:03, DM was observed passing out meal trays to 5 of 5 residents who requested optional meal items without sanitizing before or after entering resident rooms with meal tray. During an observation on 04/22/2026 at 12:10 pm, LVN C was observed checking meal trays for dining room residents for accuracy and handing trays to other staff members to pass out without sanitizing hands before or after touching trays. LVN C was observed touching the meal cart, her scrubs, her hair, the doorframe and her face all between touching the meal trays. During an observation on 04/23/2026 at 11:27 am, CNA A was observed passing room trays to residents dining in their rooms. The surveyor observed CNA A passing out meal trays without sanitizing hands before or after passing out meal trays to 7 of 7 residents on 100 hall and 5 of 5 residents on 200 hall. During an observation on 04/23/2026 at 12:02 pm, LVN C was observed checking the meal trays for the dining room residents for accuracy and handing trays to other staff members to pass out without sanitizing hands before or after touching trays. LVN C was observed touching her face, touching her scrubs, brushing her hair out of her face, touching the rack that the trays sat on and touching the door and doorframe between the kitchen and dining room between trays. During an observation on 04/23/2026 at 12:19 pm, ADMIN was observed switching residents for feeding assistance and did not sanitize or wash hands between residents. During an interview with CNA A on 04/23/2026 at 12:50 pm, CNA A stated that staff should wash and/or sanitize their hands before and after providing care to residents. CNA A stated that passing out meal trays and assisting to feed was considered care. During an interview with ADON on 04/24/2026 at 1:22 pm, ADON stated that hand hygiene should be performed between care, to include handing out meal trays. The negative outcome to residents could include acquiring an infection. During an interview with ADMIN on 04/24/2026 at 1:44 pm, ADMIN stated that the expectation is that staff perform hand hygiene between assisting residents, whether it is care or meals, it did not matter. The negative outcome to residents could be that they get sick. Record review of portion of Infection Control Policy for Handwashing/Hand Hygiene dated 2001 stated that Hand hygiene is indicated: after touching a resident's environment.</p>		