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	05/22/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to treat residents with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 8 (Resident #1). The facility failed to ensure Resident #1 received respect and dignity when CNA F was observed using the word exorcist via electronic monitoring. This failure could place residents at risk of psychosocial harm, feeling disrespected or uncomfortable, decreased self-esteem, impaired quality of life. Findings included: Record review of Resident #1's Face Sheet, dated 5/18/26, revealed the resident was admitted to the facility on [DATE] and re-admitted [DATE] with diagnoses which included: Irritable Bowel Syndrome (a gastrointestinal disorder characterized by abdominal pain, cramping, bloating, diarrhea and/or constipation) , Malignant Neoplasm (Uncontrollable cell growth that destroy body tissue) of left ovary, abnormalities of gait and mobility, Alzheimer's Disease (disease affecting memory and other important mental functions) , Dementia (group of thinking and social symptoms that interferes with daily functioning), and Cognitive Communication Deficit (difficulty with thinking and language). Record review of Resident #1's quarterly MDS dated [DATE] revealed the resident's cognitive skills for daily decision making was severely impaired. An interview with Resident #1 was attempted on 5/18/26 at 2:25 pm, Resident #1 was unable to reply to the questions. During an interview on 5/19/26 at 8:36 a.m., FM H said Resident #1 was unable to speak and believed that she would have been offended by the term exorcist because having a bowel movement was a natural body function and the resident was unable to control it. FM H further stated Resident #1 was on medication for constipation. FM H said Resident #1 was able to hear the staff and just because she was unable to talk did not mean she did not feel bad. Record review on 5/19/26 of resident electronic monitoring video, dated 5/10/26 at 4:09 p.m., revealed CNA F and RN C in Resident #1's room. RN C asked, what is that?, CNA F responded exorcist, RN C said, I don't know what they feeding her today and both CNA F and RN C walked out of Resident #1's room. During an interview on 5/19/26 at 9:07 a.m., CNA F confirmed it was her in the video saying exorcist. CNA F said, It wasn't even that word, but when I turned her, it gushed out. CNA F said she asked RN C if he had given Resident #1 a laxative because she was going all week. CNA F further stated that she thought Resident #1 had received an enema (fluid injection into the rectum/colon to relieve constipation) on the morning of the incident, 5/10/26. CNA F said that she told the nurse to stop giving Resident #1 medications and that next time she was going to press the call light so that he could come see. CNA F further stated that she had to change Resident #1's bed too much, about five times on that day, 5/10/26. CNA F said she believed that word exorcist would have made Resident #1 feel upset or angry because she and RN C were talking about her. CNA F further stated that all staff were responsible for treating the residents with dignity and respect. CNA F said she had received training on Resident Rights which included treating residents with dignity and respect. During an interview on 5/19/26 at 10:39 a.m., RN C said he did not remember a staff member calling Resident #1 an exorcist for having a bowel movement. RN C further stated he did not remember anyone speaking that word. During a joint interview on 5/19/26 at 10:48 am with the DON, (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455804	A. Building B. Wing	05/22/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RNC, ADON, and Administrator. The Administrator identified CNA F as the CNA in the video using the word exorcist while providing care to Resident #1. The Administrator said that it was not acceptable to use the exorcist when referring to the resident because it was a dignity issue. The Administrator said it was the responsibility of all staff at the facility to ensure residents were treated with respect and dignity. During an interview on 5/20/26 at 10:26 a.m., RN C confirmed it was him in the video on 5/10/26 but did not remember the incident. RN C said he remembered on that day, 5/10/26, Resident #1 was having a lot of bowel movements. RN C further stated he remembered that day but could not remember CNA F saying exorcist. RN C said he did not deny it because he was there. RN C said he did not report the incident to anyone because he did not know that he had to report that. RN C said that sort of behavior was not tolerated. RN C further stated that day was Mother's Day and CNA F had been having a hard day, so he did not give the comment exorcist a lot of importance. RN C said he knew CNA F had been having a hard day so he let it slide. RN C further stated he did not see any harm, so he did not give much importance to the comment. RN C said that thinking about it, it was offensive. RN C said it was the responsibility of everyone that worked with the residents to ensure residents were not verbally abused. RN C further stated at the moment the incident happened it was his responsibility because he was the nurse. Record review of facility's Resident Rights, revised February 2021, revealed: Policy Statement Employees shall treat all residents with kindness, respect, and dignity .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity; c. be free from abuse.

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	05/22/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on interview and record review, the facility failed to ensure that each resident had the right to secure and confidential personal and clinical records for 1 of 10 residents (Resident #9) reviewed for Privacy and Confidentiality. The facility failed to ensure resident clinical information was not discussed in other resident rooms and/or during electronic monitoring for Resident #9. This failure could result in residents' personal information being exposed to unauthorized individuals.Findings included: Record review on 5/19/26 of resident electronic monitoring video, dated 5/10/26 at 6:06 pm, revealed CNA F was giving report to CNA C about Resident #1 and Resident #9 in Resident #1's room, while the resident was in the room and the resident's electronic monitoring was active. During an interview on 5/19/26 at 9:07 a.m., CNA F said she was not aware if she had discussed resident information in resident rooms, adding if that were the case numbers were used instead of resident names. CNA F further stated she was currently unfamiliar with the residents' names and used case numbers. CNA F was hired by the facility on 4/16/26. CNA F verified she was the staff in the video discussing other resident information in Resident #1's room. CNA F said Yes, I was speaking about other residents by name in her room. CNA F said she was aware that Resident #1's room was electronically monitored but was not aware that the audio was monitored as well. CNA F said it was not okay to speak about other residents' information in front of other residents because it was confidential. CNA F further stated that divulging confidential information could make the residents stressed. CNA F said it was everyone's responsibility to ensure that resident information was kept confidential. During a joint interview on 5/19/26 at 10:48 a.m., with the DON, RNC, ADON, and Administrator. The Administrator identified CNA F as the CNA in the video discussing other residents' information in Resident #1's room with CNA C. The Administrator said discussing other residents' information in Resident #1's room was unacceptable and violated HIPAA. The Administrator further stated that it was all of the facility staff's responsibility to ensure that resident information was kept confidential. Record review of a Resident Rights policy, revised February 2021, revealed: .The unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues . Record review of the U.S. Department of Health and Human Services website at https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html accessed on 5/20/26, revealed: .The Privacy Rule protects all individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. Individually identifiable health information is information, including demographic data, that relates to: the individual's past, present or future physical or mental health or condition, the provision of health care to the individual.

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	05/22/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that the resident environment remained as free of accident hazards as was possible for 1 of 5 residents (Resident #1) reviewed for mechanical lift transfers. The facility failed to ensure transfers performed using a mechanical lift were completed by two staff members as per facility policy. This deficient practice could place residents at risk of falls and or accidents causing injuries.Findings included: Record review of Resident #1's Face Sheet, dated 5/18/26, revealed the resident was admitted to the facility on [DATE] and re-admitted [DATE] with diagnoses which included: Irritable Bowel Syndrome (a gastrointestinal disorder characterized by abdominal pain, cramping, bloating, diarrhea and/or constipation) , Malignant Neoplasm (Uncontrollable cell growth that destroy body tissue) of left ovary, abnormalities of gait and mobility, Alzheimer's Disease (disease affecting memory and other important mental functions) , Dementia (group of thinking and social symptoms that interferes with daily functioning), and Cognitive Communication Deficit (difficulty with thinking and language). Record review of Resident #1's Care Plan, dated 11/15/25, revealed the resident required total assistance with transfers and read Mechanical Hoyer with a sling. Record review of Resident #1's quarterly MDS dated [DATE] revealed the resident's cognitive skills for daily decision making was severely impaired. Further review of the MDS revealed the resident was dependent (Helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers for the resident to complete the activity) for chair/bed-to-chair transfer. During an interview on 5/19/26 at 9:07 a.m., CNA F said the staff tried to use two people when transferring Resident #1 using the mechanical lift but sometimes it was hard to find someone else because staff were with other residents. CNA F said she had transferred residents using the mechanical lift without the assistance of a second staff member. CNA F further stated that she knew she was not supposed to. CNA F said she did transfer Resident #1 this month using a mechanical lift without another staff member because she was in a hurry. CNA F said that it was recommended that the mechanical lift be operated by two people because the lift could flip or the straps could bust. CNA F further stated that the resident could be badly injured or the resident could fall to the floor with the lift falling on her. Record review on 5/20/26 of resident electronic monitoring video, dated 5/18/26 at 8:42 am, revealed CNA F entered Resident #1's room with a mechanical lift. CNA F attached the sling to the arm of the mechanical lift and began to lift Resident #1 out of the wheelchair. CNA F lifted Resident #1 until she was completely out of the wheelchair and suspended without support. CNA F wheeled the lift to Resident #1's bed and lowered the resident onto the bed. Further review of the video revealed CNA F was not assisted by a second staff member with the transfer. During an interview on 5/20/26 at 9:29 a.m., CNA E said she transferred Resident #1 by herself using a mechanical lift. CNA E said it was important to have two staff members when operating a mechanical lift because anything could happen, a strap can break, the resident could be injured, or the resident could hit the floor. CNA E further stated that two people were needed when using a mechanical lift because the second person guided the left and for safety reasons. During a joint interview on 5/22/26 at 9:46 am, the DON identified the staff member in the electronic monitoring video. The Administrator said staff had been trained and she was not sure why staff did not use 2 people when transferring Resident #1 using the mechanical lift. Record review of facility policy Lifting Machine, Using a Mechanical, revised July 2017 revealed: .The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lift device. It is not a substitute for manufacturer's training or instructions .General Guidelines 1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift.16. Gently support the resident as he or she is moved.

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	05/22/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure, in accordance withˆstate andˆfederal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 2 ofˆ4 medication carts (MCˆ#1 and MC#2) reviewed for medication storage.ˆˆ ˆˆ The facilityˆfailed toˆensure that MC #1 and MC #2 in public areas were locked on 5/19/26.ˆˆˆ ˆˆ This failure could place residents at risk of medication misuse and drug diversion.ˆˆ Findings included:ˆˆ ˆˆ During observation onˆ5/19/26ˆatˆ4:50 a.m., MC #1 wasˆobservedˆto beˆunlocked and unattendedˆon the Rosewood hall, medication bottles and medication blister packs were noted in the drawers of the medication cart. During an interview with LVN B on 5/19/26 at 4:52 a.m., she said the medication cart was not supposed to be unlocked because residents could access the medications. During observation onˆ5/19/26ˆatˆ7:20 a.m., MC #2 wasˆobservedˆto beˆunlocked and unattendedˆon the Brentwood Hall, medication bottles and medication blister packs were noted in the drawers of the medication cart. During an interview with LVN A on 5/19/26 at 7:21 a.m., she said she forgot to lock the cart because a call light had gone off and she responded to it. LVN A further stated the medication cart was not supposed to be left unlocked when unattended because anybody can get in and could take some of the medications. LVN A said if a resident ingested something from the cart it could hurt them. LVN A further stated the nurse was responsible for ensuring that the medication cart was locked when unattended. Record review of the facility's policy titled, Medication Labeling and Storage revised February 2023, revealed: .The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. 4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.ˆ