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	07/24/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents had the right to be informed in advance of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options for 1 of 6 residents (Resident #39) reviewed for informed consent.The facility failed to ensure a psychotropic medication consent was included in the medical record for Resident #39's Olanzepine (an atypical antipsychotic medication).This failure could place residents at risk of receiving care/treatment without consent and knowledge of adverse side effects.The findings included: Review of Resident #39’s face sheet with an original date of 12/23/24 and a readmission date of 4/2/25, documented a [AGE] year-old female with diagnoses including Type 2 Diabetes Mellitus, Paranoid Schizophrenia (a mental health disorder that affects how a person thinks, feels, and behaves with symptoms that include delusions and auditory hallucinations), and Celiac Disease (a disorder that causes a reaction in your body to the protein, gluten which damages your small intestine and stops it from working properly). Review of Resident #39’s most recent quarterly MDS assessment dated [DATE] documented a BIMS of 6 indicating severe cognitive impairment; a diagnosis of schizophrenia; and the use of an antipsychotic medication. Review of Resident #39’s care plan dated 6/24/25 documented antipsychotic medication usage with interventions including “AIMS every as ordered; Monitor resident’s behavior and response to medication; Pharmacy consultant review.” Review of Resident #39’s electronic medical record documented an order for the antipsychotic medication Olanzepine 10mg daily with a start date of 1/20/25. Review of Resident #39’s progress note initiated on 7/22/25 at 3:00 PM documented “Call placed to [local/contracted psychiatry agency] in regard to 3713 consents for Olanzepine 10mg.” and “Currently awaiting consent form to be sent. Plan of care to continue.” Review of Resident #39's electronic medical record revealed there was no informed consent found for the use of the antipsychotic Olanzepine 10mg QD. During an interview with the MDS Coordinator on 7/22/25 at 2:42 PM, the MDS Coordinator stated if a resident has a consent form for a psychotropic medication it would be found under the psychotropic consents tab in a resident’s documents section of the EMR. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 7/24/25 at 9:23 AM, the DON stated there is no specific staff member in charge of obtaining consents for psychotropic medications. The DON stated when a consent is needed for psychotropic medications, the facility will speak to the responsible party and provide them information on the medication including side effects and any other information. The DON stated if consent is granted, they get a verbal consent or written signature on the consent form. The DON stated it was important to get psychotropic medication consents signed quickly, so residents can be aware of what they are taking and how it can affect them. During an interview with the Administrator on 7/24/25 at 9:54 AM, the Administrator stated the nursing staff is primarily responsible for obtaining psychotropic medication consents, and the social worker will sometimes help with those consents. When asked what her expectation is of the timeline for getting psychotropic medication consents, the Administrator stated as soon as possible, within the first few days of admissions. The Administrator stated for any changes to medications, her expectation is for staff to get the consents quickly, within a few days of the change. When discussing the importance of getting psychotropic medication consents signed as soon as possible, the Administrator stated without a signed consent, the facility is unable to give a medication and a breakdown in care could occur for the resident. The Administrator further stated the consent aides the resident in understanding what a medication is for, why they are taking it, and how it can affect them. Review of the facility’s policy titled Statement of Resident Rights, undated, noted “You have a right to: (23) receive information about prescribed psychoactive medication from the person who prescribes the medication or that person's designee, to have any psychoactive medications prescribed and administered in a responsible manner, as mandated by the Texas Health and Safety Code, §242.505, and to refuse to consent to the prescription of psychoactive medications.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure 1 of 8 residents (Resident #2) received services in the facility reviewed for reasonable accommodation of resident needs related to call lights. The facility failed to ensure the call light was within reach for Resident #2. This deficient practice could affect any resident and place them at risk of not being able to ask for help as needed.The findings were: Record review of Resident #2's face sheet revealed she was admitted to the facility on [DATE] with diagnoses which included: catatonic disorder (person experiences significant disruptions in movement and behavior), Neoplasm of uncertain behavior of parathyroid gland (growth in the parathyroid gland), Sick sinus syndrome (heart's natural pacemaker doesn't work properly). Record review of Resident #2's MDS assessment, dated 05/07/2025, revealed the resident's BIMS score was 99, which indicated severe cognitive impairment. The MDS assessment further revealed Resident #2 required substantial/maximal assistance (helper does more than half the effort) for ADL assistance. Record review of Resident #2's care plan revealed Resident #2 is at risk for falls d/t impaired cognition, impaired mobility, no safety awareness and Keep call light within reachObservation on 07/22/2025 at 1:25 pm. revealed Resident #2 lying in bed with her call light lying on the floor under the head of the bed, out of view and reach of the resident. During an interview on 07/22/2025 at 1:28 pm LVN A she observed the call light was not visible to the resident and the resident was unable to reach it. She stated the potential for harm could be a lack of care due to the resident unable to call for help. During an interview on 07/22/2025 at 1:46 pm the DON stated that the call light should be within resident reach to be able to call for assistance. Record review of facility's Call Light- Use of policy, dated December 2017, showed, When providing care to residents, be sure to position the call light conveniently for the resident to use.

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(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 - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 4 of 7 residents (Resident #23, Resident #9, Resident #37 and Resident #17) reviewed for accidents and hazards: 1. The facility failed to ensure Resident #23 did not have a disposable razor at the bedside.2. The facility failed to ensure Resident #9 did not have a pair of large nail clippers in her room.3. The facility failed to ensure Resident #37 did not have a pair of large nail clippers and a disposable razor in her room.4. The facility failed to ensure Resident #17 did not have a pair of scissors at the bedside.These failures could place residents at risk of harm or injury and contribute to avoidable accidents and a decline in health.The findings included:1. Record review of Resident #23's face sheet dated 7/22/25 revealed a [AGE] year old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included schizoaffective disorder (a mental health condition characterized by mood symptoms such as depression or mania), history of suicidal ideations, and dementia (general term for a decline in mental ability that is severe enough to interfere with daily life). Record review of Resident #23's most recent quarterly MDS dated [DATE] revealed the resident was cognitively intact for daily decision-making skills and required setup or clean-up assistance with personal hygiene.Record review of Resident #23's comprehensive care plan with edited date 5/27/25 revealed the resident had an ADL self-care performance deficit related to dementia with approached that included to provide independent/supervision by 1 staff with bathing.During an observation and interview on 7/21/25 at 11:15 a.m. revealed Resident #23 lying in bed and a disposable razor was at the bedside inside of a disposable emesis basin (a shallow, kidney-shaped container use in medical settings to collect vomit, oral secretions, or other bodily fluids). Resident #23 stated he shaved himself but could not recall the last time he had shaved himself. Observations on 7/22/25 at 7:38 a.m. and again at 1:33 p.m. revealed a disposable razor blade inside of a disposable emesis basin at Resident #23's bedside.2. Record review of Resident #9's face sheet dated 7/21/25 revealed a [AGE] year old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included type 2 diabetes (a chronic medical condition where the body either does not produce enough insulin or doesn't use insulin effectively), long term use of anticoagulants, contracture of right shoulder, elbow, wrist, and hand, and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis or weakness on one side of the body that occurs after a stroke). Record review of Resident #9's most recent quarterly MDS assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills and was dependent on staff for personal hygiene.Record review of Resident #9's comprehensive care plan with edited date 6/29/25 revealed the resident had an ADL self-care performance deficit related to cerebral infarction and approaches that included the resident required total assist with ADL's. Observation on 7/21/25 at 11:39 a.m. revealed Resident #9 in bed and a large pair of nail clippers were observed on top of a chest of drawers. Resident #9 could not verbalize if she had used the nail clippers but indicated she needed help to get in and out of bed. Observation on 7/22/25 at 9:29 a.m. revealed Resident #9 in bed and a large pair of nail clippers were observed on the top of a chest of drawers. 3. Record review of Resident #37's face sheet dated 7/22/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included lack of coordination, cognitive communication deficit, abnormalities of gait and mobility, type 2 diabetes (a chronic medical condition where the body either does not produce enough insulin or doesn't use insulin effectively), and muscle weakness.Record review of Resident #37's most recent comprehensive MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills and required substantial/maximal assistance with personal hygiene, and set-up or clean-up assistance with personal grooming.Record review of Resident #37's comprehensive care plan with edited date 6/29/25 revealed the resident had limited physical mobility and required ADL assistance from staff with approaches that included extensive to total assistance by 1 to 2 staff with bathing.Observation and interview on 7/22/25 at 1:23 p.m., Resident #37 stated she used the disposable razor blade seen in a cup on the bedside table to shave her whiskers on her chin. Resident #37 was asked if she trimmed her own nails, and the resident took a pair of large nail clippers stored in the same cup as the disposable razor blade and stated she also trimmed her own nails. Resident #37 stated staff were aware she had the disposable razor blade and the nail clippers in her possession. Resident #37 stated LVN B had given her the large nail clippers when she asked for them During an interview on 7/22/25 at 1:55 p.m., LVN A stated Resident #23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident who is fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding for 1 of 3 resident (Resident #9) reviewed for enteral feeding:The facility failed to ensure Resident #9's feeding formula and water containers were labeled with the appropriate identifiers and did not discard the feeding containers after the feeding was completed.This deficient practice could place residents who received enteral nutrition at risk of infection, and bloating discomfort.The findings included:Record review of Resident #9's face sheet dated 7/21/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included nausea, aphasia (medical condition that affects a persons' ability to communicate) following cerebral infarct (a type of stroke that prevents blood flow to a part of the brain), dysphagia(condition that involves difficulty with language), gastro-esophageal reflux (chronic condition where stomach acid or bile flows back into the esophagus causing irritation), and gastrostomy status (a medical procedure in which a surgical opening is made into the stomach through the abdominal wall which allows for the placement of a feeding tube).Record review of Resident #9's most recent quarterly MDS assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills and utilized a feeding tube.Record review of Resident #9's comprehensive care plan with edited date 6/29/25 revealed the resident had a feeding tube and approaches that included to provide feedings and water flushes as ordered. Record review of Resident #9's Physician Order Report for July 2025 revealed the following:- Enteral: Free water flushes at 60 ml/hr x 12 hours, special instructions: RUN water at 60 ml per hour from 6:00 p.m. to 6:00 a.m. every night with order date 7/21/25 and no end date.- Nocturnal feedings of Novasource Renal at 45 ml with 60 ml free water flushes x 12 hours feeding tube via dual flow pump (down 6:00 a.m., on 6:00 p.m.) with order date 6/3/25 and end date 7/7/25.Observation on 7/22/25 at 9:29 a.m. revealed Resident #9 in bed and the Novasource formula and water containers were hanging from the feeding pole with the feeding tube connected to the feeding pump and the connecting end of the tube was under the resident's blanket. Resident #9's Novasource formula and water containers were unlabeled, and the feeding pump was turned off.Observation on 7/22/25 at 1:36 p.m. revealed Resident #9's Novasource formula and water containers were hanging from the feeding pole and the feeding pump turned off. During an observation and interview on 7/22/25 at 1:47 p.m., LVN A stated, Resident #9 received nocturnal feedings but was not sure of the time frame. LVN A observed the Novasource formula and water containers hanging from the feeding pole and stated, both the formula and water containers were unlabeled. LVN A stated both the formula and water containers were supposed to be labeled because it was used to identify right person, right rate, right time and right dosage. LVN A stated, without those identifiers, it would not be known how long the formula had been left there. LVN A stated she believed the formula and water had been used/infused even though there was still formula and water seen in the containers. LVN A stated, even though the formula was not finished, they could still use it again, but that would depend on how much of the formula had been infused.During an interview on 7/22/25 at 4:43 p.m. the DON stated Resident #9's feeding formula and water containers should have been labeled with the resident's name, the time, and date the formula was infused. The DON stated, the formula was only good for 24 hours and once it was used, it should be thrown away. The DON stated the resident could be affected if the formula did not have a label that indicated when the formula was given and how much and if the formula was old, it could upset the resident's stomach and make them sick.Record review of the facility document titled Enteral Formula Via: Feeding Tube, Bolus, Gravity, Pump (Closed/Open) Administration, with effective date 12/2017 revealed in part, .It is the policy of this home that the resident, who utilizes enteral nutrition, will be free, to the extent possible, from complications related to enteral nutrition.Pump - administration of formula utilizing a bottle/bag with the tubing placed through the pump device and the rate set on the pump to administer the formula. This method provides a more accurate administration as well as the pump provides the volume administered in a specified time period.The syringe and bag (if used) should be changed every 24 hours. The ready-to-hang bottles should be changed according to the manufacturer recommendations or when total amount has infused if less than the manufacturer recommendation.The syringe, bag, and/or bottle should be labeled with the resident name, room number, date changed, and the nurses' signature/initials. The bag or bottle should also specify the physician order the formula, rate, route, and means of administration

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 6 of 8 residents (Resident #15, #18, #31, #19, #17 and #9) reviewed for infection control.1. The facility failed to ensure LVN A sanitized the blood pressure cuff when obtaining Resident #15, Resident #18, and Resident #31's blood pressure. 2. The facility failed to ensure LVN A wore gloves when applying a lidocaine patch to Resident #18's lower back. 3. The facility failed to ensure LVN C sanitized the blood pressure cuff when obtaining Resident #19, and Resident #17's blood pressure. 4. The facility failed to ensure LVN C wore a gown while administering a bolus of water to Resident #9's feeding tube who was on EBP (enhanced barrier precautions) on 7/23/25.These deficient practices could affect residents who require assistance and treatments and could place residents at risk for cross contamination and infection or illness.The findings included:1. Observation on 7/22/25 at 7:44 a.m. during the medication pass revealed LVN A obtained Resident #15's blood pressure and did not sanitize the blood pressure cuff after use. LVN A then obtained Resident #18's blood pressure and Resident #31's blood pressure with the same blood pressure cuff without sanitizing the cuff between resident use. During an interview on 7/22/25 at 8:27 a.m., LVN A stated the blood pressure cuff used on the residents was her own personal equipment. LVN A stated she had forgotten to sanitize the blood pressure cuff between the residents and said she should have sanitized the blood pressure cuff because it was considered cross contamination. LVN A stated she had never been instructed by the facility to sanitize the blood pressure cuff between residents. LVN A stated cross contamination meant, whatever somebody got they could give it to somebody else. 2. Record review of Resident #18's face sheet dated 7/24/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included chronic pain syndrome, muscle spasm, and difficulty in walking.Record review of Resident #18's Physician Order Report dated 6/24/25-7/24/25 revealed the following:- lidocaine adhesive patch, medicated 4%, 1 patch topical twice a day for pain with order date 6/17/25 and no end date.Observation on 7/22/25 at 8:13 a.m. during the medication pass revealed LVN A applied Resident #18's lidocaine patch to the lower back without using gloves. During an interview on 7/22/25 at 8:27 a.m., LVN A stated she did not wear gloves when applying the lidocaine patch to Resident #18's lower back because the gloves stick to the patch. LVN A stated she did not believe she needed to wear gloves when applying the patch because she had washed her hands prior to handling the patch. 3. Observation on 7/23/25 at 8:06 a.m. during the medication pass revealed LVN C obtained Resident #19's blood pressure and did not sanitize the blood pressure cuff after use. LVN C then obtained Resident #17's blood pressure with the same blood pressure cuff used on Resident #19. During an interview on 7/23/25 at 8:47 a.m., LVN C stated the blood pressure cuff used on the residents was his own personal equipment. LVN C stated he had forgotten to sanitize the blood pressure cuff between resident use and not sanitizing the blood pressure cuff was considered cross contamination. 4. Record review of Resident #9's face sheet dated 7/21/25 revealed a [AGE] year old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included nausea, aphasia (neurological condition that affects the ability to communicate) following cerebral infarction (a type of stroke causing brain tissue to die due to lack of oxygen and nutrients), dysphagia (partial loss or difficulty with language abilities), gastro-esophageal reflux disease (a chronic digestive disorder where stomach acid or bile flows back into the esophagus), and gastrostomy status (surgical procedure in which a hole [stoma] is created through the abdominal wall directly into the stomach which allows placement for a feeding tube). Record review of Resident #9's Physician Order Report dated 6/22/25-7/22/25 revealed the following:- Enteral: free water flushes at 60 ml per hour every 12 hours. Special Instructions: RUN water at 60 ml per hour from 6:00 p.m. to 6:00 a.m. every night with order date 7/21/25 and no end date.- Enteral: Flush G-tube (feeding tube) with 10-15 cc water before and after medication administration every shift with order date 10/27/24 and no end date.- Enteral: Verify G-tube placement by aspirating stomach contents before feedings/flushes/meds. If residual is more than 60 cc, replace contents, stop feeding and notify MD, every shift with order date 10/27/24 and no end date.- Staff may utilize EBP (enhanced barrier precautions) for high contact resident care, with order date 5/20/25 and no end date.Record review of Resident #9's comprehensive care plan with edited date 6/29/25 revealed the resident required enhanced barrier precautions during contact care related to enteral feeding tube with