STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455817	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Antonio North Nursing and Rehabilitation	501 Ogden San Antonio, TX 78212

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide a safe and homelike for 3 of 3 residents' rooms observed for electricity and 3 of 3 residents affected (Resident #1, Resident #2, and Resident #3).Rooms #10 (Resident #3), #11 (Resident #1), and #12 (Resident #2) had no over the bed lights and electrical issues with other electronics.This failure could place residents at risk a lack of comfort, risk for falls, and a diminished quality of life in the facility. The findings included: Record review of Resident #1's face sheet dated 1/7/2026 revealed a [AGE] year-old-male was admitted to the facility on [DATE] with the diagnoses: major depressive disorder, schizoaffective disorder, bipolar type, traumatic brain injury, and PTSD.Record review of Resident #1's Care Plan dated 12/3/2025 revealed he was care planned for PTSD, traumatic brain injury, and risk for falls.Record review of Resident #1's QMDS dated [DATE] revealed he had a BIMS score of 14, indicative of cognitively intact.Record review of Resident #2's face sheet dated 1.7.2026 revealed a 64 - year- old male was admitted to the facility o 6.20.2024 with diagnoses: left side hemiplegia (left side paralysis), diabetes type 2 (body's inability to produce insulin), major depressive disorder (mood disorder that causes persistent sadness), and PTSD (Post Traumatic Stress Disorder- stems from witnessing or experiencing a traumatic event).Record review of Resident #2's Care Plan dated 12.17.2025 revealed he was care planned for PTSD, major depressive disorder, fall precautions due to hemiplegia, and mild cognitive impairment.Record review of Resident #2's QMDS dated 12.25.2025 revealed he had a BIMS score of 13, indicating no cognitive impairment.Record review of Resident #3's face sheet dated 1/7/2026 revealed a [AGE] year-old female was admitted to the facility on [DATE] with diagnoses: hypertension, anxiety disorder, and age related physical disability.Record review of Resident #3's Care Plan dated 12/29/2025 revealed she was care planned for falls, gait balance problem, falls related to seizures.Record review of Resident #3's QMDS dated [DATE] revealed she had a BIMS score of 14, indicative of cognitively intact.Interview on 1/6/2026 at 5:10PM MS said he replaced the outlets in rooms #10, #11, #12 and the main issue was room [ROOM NUMBER]. He said it was the wiring and he did not have the equipment to fix it. The MS said he had a list of electricians to contact including the one they use as contracted, but they all had prior appointments, and it would be over a month before they could come out. He said the circuit breaker was replaced but that was not the issue. He said the over-the bed lights were connected to the same circuit. The MS said the wires in the walls were old in an old building and in the past week, the circuit breaker would not stay on, so as a precaution he turned it off. He said they had a contracted electric company. The MS said it was important for the residents to be able to have things work in their rooms because it was their home. He said it was the residents' right to have a homelike environment.Interview on 1/6/2026 at 5:20PM the Administrator said they were working on finding a company to fix the electrical problems they had in the rooms. He said the residents had the right to live in an (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	environment that was safe and homelike to maintain a livable quality of life. Observation and interview on 1/9/2026 at 4:42PM revealed room [ROOM NUMBER] was dark, only the light from the hallway gave some illumination to the room. Resident #1 was sitting in his wheelchair and his roommate was asleep with the cover over his head. Resident #1 said there had not been electricity in the room since a week before Halloween. He said the lights in the room didn't work, the television didn't work, nor the over the bed lights. He said he almost fell going to the bathroom because the room was dark. He said the bathroom light worked but he did not want to see his roommate use the bathroom or have the light on all the time. He said he was told they were working on it but nothing yet. He said he was told he could go to the common area to watch television, but he said he did not want to go there because there was too much noise. The investigator attempted to turn on the lights over the beds, but they did not work. The investigator attempted to turn on the main light in the room, but it did not work. Resident #1 attempted to turn on the television, but it did not work. Observation of room#12 and interview on 1/9/2026 at 4:50PM Resident #2 was in bed, watching television. His room was dark with the illumination from the hallway lighting the room partially. A digital clock was on the nightstand that displayed the correct time, and the air conditioner was on. Resident #2 said his television would short out while he would be watching it and wouldn't work. He said he was told they were working on it and they were going to find someone to fix the problem. Resident #2 said he felt like they did not care, especially for the money he paid monthly to live there. He said he did not want to go out to watch television, and he preferred to sit in his room because other people can be unruly, fighting one another, taking other people's things if you leave it too far from your reach. He said the breaker kept tripping and caused electrical issues for his room and others. The investigator attempted to turn on the over the bed light, but it did not work.Observation of room [ROOM NUMBER] and interview on 1/9/2026 at 4:56PM Resident #3 was sitting in her chair next to her bed, talking with other people in the room. The main light was turned on, but only provided enough light for the front of the room. The investigator attempted to turn on the over the bed lights, but they did not work. Resident #3 said sometimes the bathroom light did not work. She said it didn't bother her roommate in the first bed because she was blind, (the roommate agreed) but she fell when she tried to get back in bed after she had gone to the bathroom. She said she missed sitting on the bed and slid to the floor, but she was not injured. She said it occurred once in the bathroom when the light did not work, but again, she was not injured. Record review of facility policy titled, Safe and Homelike Environment dated 2025 stated: In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. 3. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. 6. The facility will provide and maintain adequate and comfortable lighting levels in all areas.a. The Maintenance Director will perform periodic rounds to ensure functioning lights.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure the rights of the residents to be from from abuse for 3 of 3 residents reviewed for abuse.Resident # 6 was abused by LVN B.Resident #7 was abused by LVN B.Resident #8 was abused by LVN B.These failures could place residents at risk of more abuse and diminish their quality of life.Record review of Resident #8's face sheet dated 1.6.2026 revealed an [AGE] year-old female was admitted on 3.1.2019 with diagnoses: anxiety disorder, hypertensive heart disease without failure (high blood pressure that causes structural changes to the heart), and major depressive disorder.Record review of Resident #8's Care Plan dated 12.10.2025 revealed she was care planned for major depressive disorder, anxiety, and fall precautions due to dizziness and giddiness. Record review of Resident #8's AMDS dated 12.16.2025 revealed she had a BIMS score of 13, indicative of no cognitive impairment.Record review of Resident #6's face sheet dated 1.8.2026 revealed a 66 -year-old male was admitted on 7.24.2019 with diagnoses: end stage renal disease (kidneys failed), type 2 diabetes (body cannot produce enough insulin), and anxiety disorder.Record review of Resident #6's Care Plan dated 11.26.2025 revealed he was care planned for dialysis, and right leg below knee amputee.Record review of Resident #6's QMDS dated 12.21.2025 revealed he had a BIMS score of 15, indicative of cognitively intact.Record review of Resident #6's progress notes revealed Resident #6 was out to dialysis on 1.7.2026. Record review of Resident #7's face sheet dated 1.6.2026 revealed a [AGE] year-old male was admitted on 3.29.2024 with diagnoses: diabetes type 2, COPD, schizophrenia, and anxiety disorder.Record review of Resident #7's Care Plan dated 1.7.2026 revealed he was care planed for anxiety, schizophrenia, and behaviors with aggression.Record review of Resident #7's QMDS dated 12.3.2025 revealed he had a BIMS score of 5, indicative of severe cognitive impairment. However, the resident was able to interview and recalled incident with LVN B.Interview on 1.6.2026 at 3:00PM Resident #7 said he was pissed off about that nurse and what she did. He said LVN B was very disrespectful, and she always had a bad attitude. He said he was glad she was gone and things had been a lot better without her. He said he had signed himself out and wanted to listen to his radio but she would not put the code in for the door for him to go out the door to sit on the porch.Interview on 1.6.2026 at 3:10PM Resident #8 said she remembered that nurse and she was not very nice. She said that whole thing that happened went too far with her and she was glad that she was not there any longer. She said she was upset about it because it was none of her business what she did with her money, but she was glad she was gone and it's been much better without her because she acted like a bully.Interview on 1.8.2026 at 3:05PM Resident #6 said LVN B and he were going back and forth telling each other off. He said when she hit him, he hit her back, but he didn't say anything about it- it was nothing to me. I've had worse. Resident #6 said it all happened in front of other workers, and she pushed his chair and pushed him in the chest and he hit her back. He said he was very mad about it, and he wanted to find out what car she drove so he could flatten her tires. Resident #6 said when he found out she was fired, he was very happy, but he didn't say nothing to nobody, someone must have told about her and she got fired. He said he was mad for a little while and he felt better. He said when he found out she was fired, he felt much better. Interview on 01.09.2026 at 5:00PM The Administrator said LVN B called him and told him Resident #6 called her a black bitch nigger and Resident #6 was freaking out. He said she told him that the television was loud, and she asked him to turn it down but he refused, so she unplugged the television. He said she told him it was kind of late and she would turn it down and he would turn the volume back up again and he was fine at the time while he played chess with Resident #8. The Administrator said he received a call (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from MA C who told him that the call from LVN B was not true. He said she told him that Resident #6 was playing chest with Resident #8 and she asked him to turn the television down, but he did not hear because he was hard of hearing. He said CNA C told him since he did not turn it down, the LVN unplugged the television and Resident #6 became angry. He said the CNA told him that the LVN asked Resident #8 why she gave him $200 when he stole money from you? and Resident #6 became very angry and he asked CNA D to give him the telephone number to the Administrator so he could call him. MA C told him when Resident #6 tried to go to the nurses station to get the number because it was posted on the wall, LVN B grabbed his chair to keep him from going so he tried to hit LVN B and she grabbed Resident #6's wrist and held it against his chest. LVN B then used the medication cart to block Resident #6's entry. The Administrator said MA C told him that LVN B told them they were done playing chess and she dumped the pieces into the cubby under the table. MA C said Resident #6 and Resident #8 eventually returned to play chess. The Administrator said he sent a text message to LVN B who he thought was MA C (he had put the wrong number under the wrong name) and LVN B asked him if he had the right number. He said MA C told him when she was at work, LVN B confronted her and threatened to beat her up and she had threatened other staff. The Administrator said MA E recorded the incident with LVN B and Resident #7. The Administrator said he listened to the recording and LNV B told Resident #7 he could not go outside on the front porch to listen to music on his radio after he signed himself out. The Administrator said Resident #7 told LVN to shut up and she told Resident #7 to shut up. The Administrator said LVN B told Resident #7 he needed to go back upstairs, he didn't live down there and he was not going to disrespect her; there were 2 nurses upstairs and he needed to take his ass back upstairs to disrespect 2 nurses. The Administrator said LVN B had been suspended upon investigation and then terminated. He said he referred her nursing license as well. Interview on 1.13.2026 at 2:11PM during a returned call, MA C said Resident #6 and Resident #8 were playing chess and listening to music on the television. She said LVN B was on the phone with a provider, and she told Resident #6 to turn the television down, but he did not hear her. MA C said when LVN B got off the phone, she asked him to turn the television down and he turned it down but not to her satisfaction. MA C said Resident #6 asked LVN B what was her problem and she told him, we got rules down here. MA C said Resident #6 called out to CNA D to get the Administrator's telephone number and LVN B told him that until he respected her, he could not call the Administrator. MA C said she did not see when LVN B grabbed him, but Resident #6 became more angrier and called her names. MA C said LVN B asked Resident #8 why she gave Resident #6 $200 when he acted like that and she continued to antagonize her about the money and Resident #8 asked if she (MA C) told her about the money, but she (MA C) denied. MA C said she suggested to Resident #8 that maybe Resident #6 told someone because he was happy about the Christmas gift from her. MA C said LVN B tried to block Resident #6 from going to the nurses station to get the Administrator's telephone number by using a medication cart. Interview on 1.13.2026 at 4:20PM CNA D returned the call and said she was sitting at the nursing station and LVN B was on the phone. She said the television was on 15 for the sound and LVN B told them to turn it down; Resident #6 and Resident #8. CNA D said Resident #6 said it wasn't loud and LVN B told him to go back to his room. CNA D said LVN B then got up and unplugged the television because they did not turn it off. CNA D said Resident #6 asked LVN B why she did that and LVN B told him to go to his room. CNA D said while LVN B was at the nursing station, Resident #6 tried to swing on LVN B because she stopped him from going into the nurses station to get the Administrator's telephone number, and she grabbed his arm and put it on his chest. CNA D said Resident #6 told her it hurt and he sounded like he was about to cry and asking her if she was going to let it go. CNA D said LVN B finally let him go and she went (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to put the chess pieces away. CNA D said when LVN B called the Administrator, she lied about what happened.Record review of facility policy title, Abuse, Neglect, and Exploitation dated 2025 stated: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Under Policy Explanation and Compliance Guidelines stated in part: a. Prohibit and prevent abuse.