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	04/16/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that all allegations involving abuse, neglect, and misappropriation were reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involved abuse, to the State Survey Agency for 1 of 4 residents (Resident #1) reviewed for abuse. The facility did not report to the State Survey Agency (HHSC) an allegation of Resident #1 being sexually abused by three unknown men in the facility on 4/1/16. This failure could place residents at risk for harm to include sexual abuse, a diminished quality of life, and psychosocial harm.The findings include:Record review of Resident #1's face sheet, dated 4/14/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: schizoaffective disorder (chronic mental health condition cauterized by hallucinations and delusions), bi-polar disorder (a serious mental illness characterized by shifts in mood), anxiety, quadriplegic (paralysis affecting all four limbs and the torso), and chronic pain. The RP was listed as: self.Record review of Resident#1's admissions MDS, dated [DATE], reflected a BIMS score of 15 indicative of no impairment in cognition. In section GG of the MDS, the ADLs for: bowel was a colostomy (a surgical opening to allow stool) and incontinent for urine. Transfer and Mobility was total assistance. ROM was upper and lower. Assistive devices: none.Record review of Resident #1's CP, undated, revealed the resident was at risk for behaviors associated with schizoaffective disorder, delusions and bi-polar disorder that could result in allegations of sexual abuse of self and others. Interventions included psych services and notifying the physician.Record review of Resident's #1 Nurse Note, dated 4/1/16 at 8:00 a.m., MHNP revealed Staff has reported numerous complaints of delusions including reports that somebody stuck a metal rod in between her vagina and her anus.Record review of Resident #1's Nurse Note dated 4/1/26 at 9:13 p.m., authored by the DON revealed Resident # 1 made an allegation of sexual abuse involving a mental rod inserted between her vagina and rectum. [The MD was not notified but the MHNP representing the MD was aware of the sexual allegation on 4/1/26] Record review of the facility's grievance log for the month of April 2026 revealed the alleged sexual abuse on 4/1/26 was not recorded as a grievance.Observation and interview on 4/15/26 at 10:00 a.m., Resident #1 was lying in bed with no visible injuries, skin tears, or bruises noted. The resident was noted to have contractures to both hands. Resident #1 stated three black men sexually abused her, and they shoved an object in her vagina and somehow it was removed. She stated [witnessed by SW] there was no need for a SANE exam because the men did not lay on top of her body and the object came out. Resident #1 stated the alleged sexual abuse occurred two weeks ago and she told the Administrator. She stated LVN A was present during the rape incident. During an interview on 4/15/26 at 10:04 a.m., the SW stated she heard the resident alleged during the surveyor's interview that three males did not rape her instead they put an object in her and the object came out. The SW stated that Resident #1 stated that a Nurse (LVN A) was present during the rape. The SW stated based on a prior interview with the resident, the resident felt safe in the facility. The SW stated she did not recall if the facility called law enforcement or HHS on 4/1/16. The SW stated preventative measures were put in place to have two (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	female staff present when giving care to the resident after the sexual allegation on 4/1/16. During an interview on 4/15/26 at 10:57 a.m., LVN A stated she was not present during a rape scene on 4/1/26 and would not have let it happen. LVN A stated once she was alerted of the alleged sexual abuse by Resident #1 on 4/1/26, she informed the Administrator and the DON. LVN A stated at the time of the alleged sexual abuse on 4/1/26, she and another LVN (LVN B) did a head-to-toe on the-resident and there were no new skin issues. LVN A stated she did not remember whether an ER visit for a SANE examination was offered to the resident or if law enforcement or HHS were notified. LVN A stated based on her training on ANE, if a resident made an outcry of sexual abuse the procedure was to notify immediately the Administrator and law enforcement. LVN A stated the resident had a right to go to the hospital for an assessment of whether the allegation was real or a delusion. During an interview on 4/15/25 at 11:48 a.m., LVN B stated she had worked with Resident #1 since her admissions. LVN B stated the first time that the resident claimed a person put a metal rod though her vagina and it came out through her rectum was about two weeks ago. LVN B stated the resident was assessed on 4/1/26 and the Administrator and DON were informed of the alleged sexual abuse. LVN B stated the resident was offered an ER visit for a SANE examination but declined. LVN B stated by policy the Administrator/DON needed to be informed immediately about any allegations of sexual abuse whether it was true or not and follow any reporting polices. LVN B stated she received training on ANE, and the highlight of the training was to report ANE to the Abuse Coordinator, the Administrator. During an interview on 4/15/26 at 2:37 p.m., the ADON, LVN stated she did not have knowledge of Resident#1's first allegation of sexual abuse on 4/1/26. The ADON stated the facility's policy was when any resident made an outcry of sexual abuse the policy was to notify the Abuse Coordinator and send applicable reports to law enforcement and HHS. During an interview on 4/15/26 at 3:52 PM, the DON stated she had worked in the facility for over one and half years. The DON stated she was familiar with Resident #1's care and refusal of care and delusions. The DON stated that when any resident made an allegation of sexual abuse the facility's policy included: notify the abuse coordinator, any family member, law enforcement, and HHS and start an in-service on ANE and initiate a Provider investigation. The DON stated the first allegation of sexual abuse by Resident #1 occurred on 4/1/26 which was conveyed to her by the MHNP. The DON stated that law enforcement was not called because the resident had a history of making false sexual allegations and the assessment revealed there was no finding of sexual abuse. The DON stated the Administrator was aware of the allegation and as the Abuse Coordinator he would determine whether the facts merited filing a report with HHS. The DON stated she did not have an explanation why on the first allegation of sexual abuse, 4/1/26, was not reported to law enforcement or HHS but reported on the second incident of alleged sexual abuse on 4/14/26. During a telephone interview on 4/15/26 at 4:25 p.m., the MHNP stated that Resident #1 made an allegation of sexual abuse on 4/1/26. The MHNP stated she was familiar with the resident, and the resident had a history of false allegations and delusions. The MHNP stated the resident was delusional on an on-going basis and would make sexual abuse allegations. The MHNP stated she only did a psychological evaluation on 4/1/26 and the resident was not sent to the ER. The MHNP stated the facility (DON) was informed of the allegation and it was up to the facility to call law enforcement and HHS. Given the resident's delusional history and history of making delusional allegations the MHNP stated she did not write an order to send the resident to the ER unless facility nursing staff found evidence of an actual sexual assault. During an interview on 4/15/26 at 4:49 p.m., the Administrator stated he did not contact law enforcement or HHS on the first allegation of sexual abuse on 4/1/26 because: the MHNP felt the allegation made by Resident #1 was not in the realm of possibility and there were no named perpetrators except three unknown men. The Administrator stated the second allegation of sexual abuse on 4/14/26 was reported to HHS and law enforcement because there was a named alleged perpetrator [CNA E]. The Administrator stated that he was familiar with the facility's policy on reporting ANE. Record review of Facility's policy titled, Abuse, Neglect and Exploitation dated 7/2/2025, read . Abuse means the willful inflection of injury.resulting (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in physical harm, pain or mental anguish.it includes .sexual abuse.The facility will have written procedures that include:.Reporting all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified time framed:. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse.