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	05/29/2026

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 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 observations, interviews, and record reviews, the facility failed to ensure the resident had the right to be informed of and participate in his or her treatment including the right to be fully informed in language that he or she understood of his or her health status, including his or her medical condition for 1 of 1 resident (resident #3) reviewed for resident rights. The facility failed to have an effective method of communication with Resident #3 who was deaf and mute This failure could place residents at risk of poor communication and a demoralized sense of self-esteem and psychosocial wellbeing. The findings include: Record review of Resident #3's face sheet, dated 05/29/2026, revealed an admission date of 01/27/2025, and a readmission date of 03/27/2026, with diagnoses that included: Paraplegia (impairment in motor or sensory function of the lower extremities.), Type 2 diabetes mellitus ((high level of sugar in the blood), Focal traumatic brain injury (brain trauma in which damage is confined to a specific area of the brain, rather than affecting multiple regions), Chronic ulcer of right lower leg (nonhealing or slowly healing open sore that fails to progress through the normal wound healing sequence), Dysphagia (Difficulty swallowing), Schizoaffective disorder (mental disorder characterized by abnormal thought processes and an unstable mood), Major depressive disorder (mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure), Deaf non speaking, Hypertension (High blood pressure). Record review of Resident #3's Quarterly MDS assessment, dated 05/14/2026, revealed the resident had a BIMS score of 15, which indicated no cognitive impairment, needed limited to extensive assistance with his activities of daily living and was indicated to frequently be incontinent of bladder and bowel. Resident #3 was coded as having highly impaired hearing and no speech. Record review of Resident #3's care plan, dated 01/26/2025, reflected a problem of has impaired Communication due tobeing deaf and mute. Resident refuses to use a communication board, wishes only to have someone who can use signlanguage. Uses interpreter services with (removed name) via video. At times, resident will refuse video interpreter services provided by (removed names) Interpreters. Will communicate via IPAD. He will type and point to communicate his needs.There are staff members in the facility that basic needs for him to facility staff. VRI available for as needed communications. and an intervention of Communicate through identified communication method- sign language, writing or interrupter/communication device/pad, interrupter services. During an interview on 05/27/2025 at 11:13 a.m. the Ombudsman stated she learned from Resident #3 and the Administrator that the facility believed Resident #3 could read, write, spell, and read lips, when Resident #3 had poor reading, writing, spelling skills and could not read lips. The Ombudsman stated the facility had failed to assist Resident #3 with VRS and VRI services. During an interview on 05/28/2026 at 9:59 a.m., Anonymous stated when she visited the facility, she saw the staff giving Resident #3 medications and he did not know what they were giving him. Anonymous stated the staff did not seem to understand he was deaf and could not hear even if they talked loudly to him. She stated did not think they had a way to communicate with him since he understood very little English. During a wound care observation on 05/28/2026 at 12:27 a.m., ADON A scanned a QR code with her phone and an ASL translation service loaded with an ASL interpreter appearing on the screen. She told the interpreter what she wanted to (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	say to the resident and the interpreter used sign language to talk to the resident, signed back. Communication during the provided care, from the nurse, was observed to be translated on the screen for the resident. During an interview on 05/28/2026 at 12:34 p.m. with Resident #3, he stated the majority of the staff did not use the ASL service and he stated they did not know how to use it. He stated he wanted them to use the ASL interpreter so he could understand them. During an interview on 05/28/2026 at 12:28 p.m., LVN B stated she provided care for Resident #3. She stated she usually wrote things on paper for him. She said she had not used the ASL application, yet because the only thing she did was to give him medications. She stated he knew what medications he took because he refused some of them. She stated she was not aware he could not understand English well. She stated they received an in-service about the [NAME] application, but it was not told to them to use it all the time with the resident or that he could not read English. During an interview on 05/29/2026 at 5:19 a.m. RN C stated Resident #3 could read lips, so she talked to him facing him and slow. She stated she was not aware of the ASL application and did not know about a QR code to scan to use the application and used an ASL translator to talk to the resident. She stated did not remember an in-service about it and did not know the resident only knew very little English. During an interview on 05/29/2026 at 5:42 a.m., LVN D stated Resident #3 used his tablet to write down what he wanted from them. She stated she did not remember an in-service about the ASL app and did not know about it. She stated she did not know Resident #3 didn't fully understand English and had been talking and writing to him. During an interview on 05/29/2026 at 5:56 a.m., CNA E stated he, sometimes, used Resident #3's pad to write back and forth to him and Resident #3 read lips. He stated he was not aware Resident #3 knew very little English. CNA E stated he was not aware they could use an application to access an ASL translator. During an interview on 05/29/2026 at 7:02 a.m., the DON stated she in- serviced the staff about the ASL application so she did not understand why they were not using it to communicate with him. She stated the policy of the facility was to use the best language for the residents to understand when communicating with them. Record review of Facility's policy, titled Effective Communication, dated 05/16/2025, revealed It is the policy of this facility to accommodate needs when communicating with residents who are deaf, hard of hearing, any other language than English to promote dignity, understanding, and safety. Further review revealed Effective communication describes a process of dialogue between individuals. The skills include speaking to others in a way they can understand and active listening and observation of verbal and non-verbal cues. Understanding what the resident is trying to communicate is essential to giving a response. Additionally, effective communication ensures that information provided to the resident is provided in a form and manner that the resident can access and understand, including in a language that the resident can understand.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain an Infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 1 of 1 resident (Resident #3) reviewed for infection control, in that: The facility failed to ensure ADON A wore a gown while providing wound care for Resident #3 who was on enhanced barrier precaution. These failures could place residents at-risk for infection due to improper care practices. The findings included: Record review of Resident #3's face sheet, dated 05/29/2026, revealed an admission date of 01/27/2025, and a readmission date of 03/27/2026, with diagnoses that included: Paraplegia (impairment in motor or sensory function of the lower extremities.), Type 2 diabetes mellitus ((high level of sugar in the blood), Focal traumatic brain injury (brain trauma in which damage is confined to a specific area of the brain, rather than affecting multiple regions), Chronic ulcer of right lower leg (nonhealing or slowly healing open sore that fails to progress through the normal wound healing sequence), Dysphagia (Difficulty swallowing), Schizoaffective disorder (mental disorder characterized by abnormal thought processes and an unstable mood), Major depressive disorder (mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure), Deaf non speaking, Hypertension (High blood pressure). Record review of Resident #3's Quarterly MDS assessment, dated 05/14/2026, revealed the resident had a BIMS score of 15, which indicated no cognitive impairment, needed limited to extensive assistance with his activities of daily living and was indicated to frequently be incontinent of bladder and bowel. Resident #3 was coded as having one venous ulcer. Record review of Resident #3's care plan, dated 12/19/2025, reflected a problem of Enhanced barrier precautions r/t chronic wound. Resident refuses to have sign and organizer on door- he will remove them and an intervention of [NAME] (put on) gown and gloves during high-contact personal care activities. Observation on 05/28/2026 at 11:27 a.m., revealed while providing wound care for Resident #3, ADON A did not put a gown on to enter the room and provide care. Resident #3 was on enhanced barrier precaution due to his wound. Interview on 05/28/2026 at 11:46 a.m., ADON A stated she forgot Resident #3 was on enhanced barrier precaution. She stated she had received training on enhanced barrier precautions. Interview on 05/28/2026 at 3:55 p.m., the DON stated staff needed to wear a gown and gloves for resident on enhanced barrier precaution, for the prevention of infection to the residents but also the staff. The DON stated infection control training was provided and skills were checked annually. Review of facility's policy, titled Enhanced Barrier Precautions , dated 04/11/2025, revealed Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. Further review revealed High-contact resident care activities include:a. Dressingb. Bathingc. Transferringd. Providing hygienee. Changing linensf. Changing briefs or assisting with toiletingg. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes,hemodialysis catheters, PICC lines, midline cathetersh. Wound care: any skin opening requiring a dressing