STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675967	A. Building B. Wing	01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northgate Plaza	2101 Northgate Dr Irving, TX 75062

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44405 Based on interviews and record review, the facility failed to immediately inform the resident's representative(s) of a significant change in the resident's physical, mental, or psychosocial status for one (Resident #1) of three resident reviewed for resident rights. The facility failed to ensure the WCN notified the resident's representative on 01/03/24 that Resident #1 had a change of condition in clinical status (exposed hardware [screw] in the left lower extremity wound). This deficient practice placed residents at high risk or the likelihood of, serious injury, harm, impairment, or death by not having their needs met, or receiving treatment in a timely manner in accordance with professional standards of practice. Findings included: Record review of Resident #1's Face Sheet revealed the resident was a [AGE] year-old female, who admitted to the facility on [DATE] with the following diagnoses: Unspecified Fracture of Left Tibia Shaft (The big bone between the knee and ankle. The shaft [shinbone] is the middle of that bone); T2DM (a chronic condition that affects the way the body processes glucose [blood sugar]); Parkinson's Disease without Dyskinesia (involuntary, erratic, writhing movements of the face, arms, legs, or trunk); COPD; non-Alzheimer's Dementia (a decline in mental ability severe enough to interfere with daily life - Alzheimer's is a specific disease); and a burn of unspecified body region, unspecified degree. Resident #1's [family member] was listed as an emergency contact. Record review of Resident #1's Admission MDS assessment, dated 11/22/23, revealed Resident #1 had a BIMS Summary Score of 12 which suggested moderately impaired cognition. Resident #1's functional abilities required one-person physical assist with ADLs and transfers. Resident #1 was always continent of bowel and bladder. Record review of Resident #1's wound care notes revealed a surgical note, dated 01/03/24. The WMD wrote, The patient has wounds at the right lower extremity lateral, left heel, and left infrapatellar (kneecap). The left infrapatellar wound is recently acquired by erosion of metal screw through the skin. Recommend orthopedic consult to remove exposed hardware in the left infrapatellar wound. Record review of Resident #1's progress notes reflected: (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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NAME OF PROVIDER OR SUPPLIER Northgate Plaza		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Northgate Dr Irving, TX 75062	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/03/24 at 12:47 PM, the WCN entered, [Resident #1] see by WMD . surgical wound to infrapatellar with screw [WMD] recommended [Resident #1] to see surgeon, upcoming appointment on Friday. Will follow up. [Responsible Party] aware. On 01/05/24 at 12:43 PM during a Skin Committee IDT meeting, the DON entered: Right lateral leg burn stayed the same . Left heel diabetic wound stayed the same . continue with plan of care. Left inferior patellar surgical wound: Oozing. Intervention: Dry dressing; Will also contact: Surgeon. [Resident #1] has an orthopedic appointment on 01/05/24. Will continue to monitor oozing at this moment. Resident/RP, nurse, and provider aware. On 01/05/24 at 1:50 PM, LVN A entered, [Resident #1] left for ortho appointment. On 01/08/24 at 1:49 PM (LATE ENTRY), LVN A entered, (Effective Date: 01/02/24 at 1:35 PM), While resident [Resident #1] at the nurses' station nurse noticed wounds to left lower extremity, denies pain or discomfort, no bleeding noted. NP here notified assessed resident stated continue [antibiotic] and will be seen by ortho this Friday 01/05/24. [family member] notified. Record review of Resident #1's comprehensive care plan Focus problem(s) reflected actual impairment to right lower extremity anterior r/t Burn, trauma to right knee, area to left heel and right leg (Initiated: 01/08/24; Revision on: 01/14/24); actual impairment to skin integrity r/t surgical wound (Initiated: 01/08/24; Revision on: 01/14/24); ADL Self Care Performance Deficit r/t impaired mobility s/p (after) surgical repair of tibia fracture LLE, post procedural pain (Initiated: 11/16/23); At risk for falls r/t history of falling, impaired balance, acute post procedural pain (Initiated: 11/16/23; Revision on: 12/28/23); Actual Fall(s) on 11/18/23, 11/26/23, 12/06/23, and 12/26/23; and acute pain r/t surgical repair of left tibia fracture (Initiated: 11/16/23). Resident #1's care plan goals reflected the impaired skin issues would be healed and have intact skin and would not sustain serious injury from falls by/through review date (Target Date: 03/08/24). Resident #1's care plan interventions/tasks revealed bedside care and assistance, medication administration, pain control, fall prevention, position changes, teaching moments, monitoring, and reporting to doctor as needed, to improve the resident's comfort and health. Record review of Resident #1's wound care notes revealed a surgical note, dated 01/08/24. The WMD wrote, . The right knee wound is a newly acquired traumatic injury. The following wounds are healing slowly and require continued topical wound dressing therapy as noted . Orthopedic screw was removed from the infrapatellar wound. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 01/14/24 at 12:56 PM, the RP indicated Resident #1 admitted to SNF following a surgical procedure. The RP stated Resident #1 participated with rehab, activities, etc. and had no concerns. The RP stated that staff were good at notifying [the RP] of any incidents, changes in medications/treatments, or anything that related to Resident #1's care. The RP stated she visited Resident #1 the Monday and Tuesday before the scheduled follow up appointment with the ortho surgeon on Friday, 01/05/24, to check on the healing and recovery of the left tibia fracture surgical site. The RP arrived at the Ortho surgeon's office and waited for Resident #1, transported by the facility, to arrive. The RP said she was taken aback when the surgeon's nurse pulled Resident #1's pants leg up, the knee was swollen, and a gold-colored screw was exposed at the left tibia fracture surgical site. The RP said the surgeon was also concerned when saw the screw. The RP said the used a [NAME] head screwdriver, made one twist, and the screw came out. The RP said that the ortho surgeon scheduled an appointment on 01/09/24 to perform surgery and remove the hardware in Resident #1's left tibia. The RP said she spoke with the NFA on 01/05/24 when Resident #1 returned to the SNF and asked when the screw was noticed and how come she wasn't notified. The RP said the NFA reviewed [Resident #1's] chart and indicated record review reflected staff notified the Ortho MD on 01/05/24 at midnight. During an interview on 01/19/24 at 10:00 AM, the DON said that she remembered on 01/03/24 the WCN saw that there was a screw at the left leg wound, there were two dots of overlapping skin, nothing protruding out, it was oozing and the WMD said to cover the site with a dry dressing. The DON said that a Skin IDT meeting was held on 01/05/24 that Resident #1 skin issues were discussed and had a follow up appointment scheduled on 01/05/24. The DON identified Resident #1's [family member] as a responsible party and that should be notified when Resident #1 had a change in condition. During an interview on 01/19/24 at 10:56 AM, the WCN said that Resident #1 received daily wound care to the left heel and to a burn on the right leg present on admission to the facility. The WCN said that the WMD was notified about the left leg surgical site where the screw was observed. The WMD said to cover with dry dressing and refer to orthopedic surgeon. The WCN said she did not recall oozing. The WCN said that she should have notified the RP [Resident #1's family member] when the screw was noted. During a phone interview on 01/19/24 at 2:54 PM, LVN A said that the note he entered on 01/08/24 indicated that the NP looked at the wound on Resident #1's left leg and to ensure follow up with surgeon. LVN A said that he did not see any wounds and the RP was aware of the wound sites. LVN A identified Resident #1's [family member] as the RP. LVN A said he guessed that he should have written the progress note differently. Record Review of an undated policy titled Change of Condition, reflected: POLICY: To identify and evaluate a change in condition and notify the Physician/Extender and Responsible Party when indicated. A significant change in Resident's status is any sign or symptom that is: - Acute or sudden onset - A marked change (i.e., more severe) in relation to usual signs and symptoms - New or worsening symptoms (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PROCEDURE: When a change in condition occurs, the Licensed Nurse will: 3. Document date, time Physician/Extender, Responsible Party was notified of findings from the evaluation and any new orders obtained. 6. If the Physician/Extender chooses to send the Resident to the hospital for further evaluation and treatment, the charge nurse will initiate the transfer process. Evaluation findings will be documented on the communication tool used to transition the Resident to the next level of care. 7. The Resident's plan of care will be updated accordingly. Record review of the State Operations Manual Appendix PP, Rev. 02-03-23, reflected, Even when a resident is mentally competent, his or her designated resident representative or family, as appropriate, should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident.