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	09/19/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268 Based on interview and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive assessment and quarterly review assessments for one (Resident #1) of four residents were reviewed for comprehensive care plans. The facility failed to ensure the interdisciplinary team revised and reviewed the plan of care for Resident #1 with interventions following elopement attempts on 07/24/24,08/22/24 and 09/12/24. This failure could affect residents by placing them at risk for not having their individual needs met. Findings included: Review of Resident #1's electronic face sheet printed 09/18/2024 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included but not limited to Dementia with mood disorder (term used to describe a group of symptoms affecting memory, thinking and social abilities), dementia with psychotic disturbance, anxiety disorder (frequently have intense, excessive and persistent worry and fear about everyday situations), and insomnia(trouble falling asleep and staying asleep). Record Review of Resident #1's Quarterly MDS dated [DATE] revealed a BIMS score of 01 which indicated Resident #1 was severely cognitively impaired. Review of Resident #1's care plan revised 01/19/2024 revealed Resident #1 was an elopement risk and wandered aimlessly. Interventions included distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, document wandering behavior and attempted diversional interventions, and monitor wander guard placement on right ankle. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675967	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Northgate Plaza		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Northgate Dr Irving, TX 75062	

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/19/2024 at 3:30 PM with the MDS Nurse stated care plans were to be updated annually, quarterly, and as needed. The MDS Nurse stated she was responsible for updating care plan based on incidents. She stated there may have been a communication error between her and the nurses which resulted in the care plan not being updated for each elopement incident for Resident #1. The MDS nurse stated she would also be made aware of incidents under the incident elopement tab, however no incident reports were made. The MDS Nurse stated the risk of the care plan not being updated would be that there would not be preventive measures in place for those events and staff would not be able to provide care according to patient needs. Review of the facility's policy Care Planning dated August 2015 revealed the policy did not discuss updating care plan to include individualized interventions.

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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 - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268 Based on record reviews, and interviews, the facility failed to ensure the resident environment remains as free of accident hazards as is possible and that residents received adequate supervision to prevent accidents for one (Resident #1) of five residents reviewed for elopement. The facility failed to provide Resident #1 with adequate supervision to prevent her from leaving the building on 07/26/2024, 08/22/2024, and 09/12/2024. This failure placed residents at risk for harm and serious injury. Findings included: Review of Resident #1's electronic face sheet printed 09/18/2024 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included but not limited to Dementia with mood disorder (term used to describe a group of symptoms affecting memory, thinking and social abilities), dementia with psychotic disturbance, anxiety disorder (frequently have intense, excessive and persistent worry and fear about everyday situations), and insomnia(trouble falling asleep and staying asleep). Record Review of Resident #1's Quarterly MDS dated [DATE] revealed a BIMS score of 01 which indicated Resident #1 was severely cognitively impaired. Review of Resident #1's care plan revised 01/19/2024 revealed Resident #1 was an elopement risk and wandered aimlessly. Interventions included distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, document wandering behavior and attempted diversional interventions, and monitor wander guard placement on right ankle. Review of the nursing notes dated 07/26/2024 and authored by LPN E revealed Resident slipped through the door and attempted to elope. [Family member] notified and was told that medications were administered around 6 PM. With the assistance of the CNAs, resident agreed and came inside the building and resting in her bed at this time. Administrator, DON and MD notified. Wonderguard in place and active. Incoming nurse [SIC] duelly notified regarding elopement risks, continue to monitor Review of the nursing notes dated 08/22/2024 authored by At around 6:50pm resident attempted to leave the facility using the main door that was left opened by a visitor leaving the facility. Resident was immediately followed by staff members and broughtt back to the facility. Resident was in good condition. (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 - Few	Review of the nursing notes dated 09/12/2024 At approx. 1140 this nurse was notified by 100 hall nurse that patient was taken outside by staff and therapy walking w/patient. At approx. 1145 ADON seen running down 200 hall stating there's a patient outside! the CNA's just called me, this nurse followed nurse to parking lot where patient was seen with 6 staff members who were attempting to calm patient down due to patient attempt to continue to walk towards street however with staff assist patient was re-directed to 300 hall entry door and de-escalation tactics implemented however patient began to become combative with staff and worsening agitation. NP at nurses' station and notified psych nurse of patient agitation and order received for Haldol 5mg IM x1 NOW. ADON administered IM injection and obtained lab orders CBC, BMP, UA, STAT collected by staff nurse, and q15 minute checks initiated. Patient had one on one care for next 1 hr post IM Haldol administration. Patient had no adverse reaction to x1 dose Haldol and showed no (SIC) aggression or abnormal behaviors throughout the shift. She received a shower by CNA on duty and observed being friendly and conversating w/staff and walking with walker assist, consumed >75% of meals and tolerating PO fluids. She denies pain, no acute s/sx of distress and staff educated on de-escalation techniques when patients began to become aggressive and the importance of notifying charge nurse on duty of any changes in behavior that may cause worsening condition such as medication refusal. [Family member] notified of change in behavior and incident involving becoming physically aggressive w/staff when re-directing back to facility, she states understanding of all interventions with ADON. An interview on 09/18/2024 at 11:00 AM with LVN A via phone revealed she was a agency nurse and worked in the facility on 09/12/2024. She stated she was not informed that anyone was taking Resident #1 outside for a walk. She stated the ADON ran down the hall and yelled that Resident #1 was out of the building. LVN stated it took several staff to get Resident #1 back in the building and she was concerned due to Resident #1 walking toward the street and attempting to exit the parking lot, and staff having a hard time redirecting her. LVN A stated she was told by another nurse that Resident #1 had bitten a staff member and was very agitated during the incident. LVN A felt that the staff did not handle the situation properly, and the facility did not know how to properly redirect Resident #1. LVN A stated Resident #1 had not been aggressive toward her, however according to the chart, the resident was at baseline. LVN A stated once Resident #1 was in the building, the ADON obtained an order to give Haldol to get the resident to calm her down which was effective. LVN A stated after reviewing the electronic file and speaking to staff she determined that Resident #1 was at baseline. Interview on 09/18/2024 at 2:09 PM with the Director of Rehabilitation revealed Resident #1 received therapy 5 times a week and was taken out for walks during her therapy session. However, on 09/12/24, Resident #1 was not outside with therapy. The Director of Rehabilitation revealed a therapist was asked to assist with trying to redirect Resident #1 back into the building; the therapist was unsuccessful. The Director of Rehabilitation stated he was not sure why Resident #1 was outside the building or how she was able to exit the building. Interview on 09/18/2024 at 2:15 PM with the ADON revealed she received a call from CNA C stating Resident #1 was taken outside for fresh air, however she was refusing to come back inside. The ADON stated Resident #1 was very confused and was trying to bite staff. She stated Resident #1's family member typically took the resident out of for walks due to being exit seeking or Resident #1 may go outside with therapy for walks. The ADON stated if staff were taking Resident #1 out for a walk then LVN A should have been notified because she was the nurse working the hall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/18/2024 at 2:58 PM via phone with CNA C revealed she was working on Resident #1's hall, however Resident #1 went to the 100 hall and was able to exit the door. CNA C stated she heard the alarm going off, alerting staff that Resident #1 was at the door. However, by the time she got to the hall Resident #1 was going out the door with CNA B going after her. CNA C stated CNA B was working the 100 hall and following Resident #1 out the door. CNA A stated she had never taken Resident #1 out for a walk due to exit seeking behaviors because she was aware that Resident #1 would not want to go back inside. Interview on 09/18/2024 at 3:15 PM with CNA B revealed he was working on 100 hall and charting when Resident #1 walked toward the door, and the wander guard alarm did activate. CNA B stated he attempted to verbally redirect Resident #1, however was unsuccessful. CNA B stated Resident #1 continued to hold the door and after 15 seconds was able to exit the building to the parking lot and he was 2 steps behind her. CNA B stated he and the med aide stayed outside with Resident #1 and attempted to redirect her, however they were unsuccessful. CNA B stated therapy attempted to redirect Resident #1, however was unsuccessful. CNA B stated Resident #1 became aggressive and grabbed a staff by the collar and bit another staff member. CNA B stated he was able to call the ADON outside to help redirect Resident #1 back inside. CNA B stated a wheelchair was bought out and Resident #1 eventually sat down and they were able to get Resident #1 back in the building. Interview on 09/19/2024 at 10:30 AM with the Clinical Resource revealed Resident #1 had attempted to elope the night of 09/18/2024 however staff were able to redirect her before she exited the building. The Clinical Resource stated Resident #1 had been at baseline however in the last 12 hours Resident #1 had become unable to be redirected and required 1:1 care. The Clinical Resource stated Resident #1 was being discharged today (09/19/2024) to a facility with a secured unit due to an increase in exiting seeking behavior and not being able to be redirected. Review of the facility policy Elopement / Unsafe Wandering revised September 2022 revealed It is the policy of this facility to provide a safe environment for all residents through appropriate assessment and interventions to prevent accidents related to unsafe wandering or elopement. Wandering is defined as random or repetitive locomotion and can be either goal directed or non-goal directed/aimless. Elopement is when a resident leaves the facility premises or a safe area without authorization (i.e. an order for discharge or leave of absence) and/or any necessary supervision to do so. Staff shall promptly report any resident who is trying to leave the premises or is suspected of being missing to the Charge Nurse or Supervisor to evaluate the need for further interventions.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268 Based on interviews, and record review, the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for two (Resident #1 and Resident #2) of four residents reviewed for pharmacy services. 1. The facility failed to document that Resident #1 was given albuterol sulfate (for asthma) on 09/08/2024, and buspirone HCL (for anxiety) on 09/06/2024 2. The facility failed to document that Resident #2 was given atorvastatin calcium (for hyperlipidemia), on 09/12/2024 duloxetine oral (for depression) on 09/12/2024, melatonin (for insomnia) on 09/12/2024, sennosides-docusate sodium (for constipation)on 09/12/2024, and carboxymethyl cellulose (for dry eyes on 09/12/2024,09/13/2024,09/16/2024. This failure could place residents at risk of medical complications and a decrease in therapeutic dosages of their medications as ordered by the physician. Findings included: Review of Resident #1's electronic face sheet printed 09/18/2024 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included but not limited to Dementia with mood disorder (term used to describe a group of symptoms affecting memory, thinking and social abilities), dementia with psychotic disturbance, anxiety disorder (frequently have intense, excessive and persistent worry and fear about everyday situations), and insomnia(trouble falling asleep and staying asleep). Record Review of Resident #1's Quarterly MDS dated [DATE] revealed a BIMS score of 01 which indicated Resident #1 was severely cognitively impaired. Review of Resident #1's care plan revised 01/19/2024 revealed Resident #1 was an elopement risk and wandered aimlessly. Interventions included distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, document wandering behavior and attempted diversional interventions, and monitor wander guard placement on right ankle. Review of Resident # 1's order summary dated active 09/18/2024 revealed the following orders: - Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT 2 puff inhale orally three times a day, start date 07/24/2024 -Buspirone HCI Oral Tablet 5 MG Give 1 tablet by mouth two times a day for Anxiety, start date 09/05/2024 Review of Resident #1's MAR for the month of September 2024 reflected: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-09/06/24, there was no documentation of buspirone HCL given at 8PM. -09/08/24, there was no documentation of Albuterol Sulfate afternoon. Review of Resident #1's nursing notes from 08/19/24-09/19/24 revealed no documentation regarding missed medication on 09/06/2024 or 09/08/2024. Interview on 09/19/2024 at 3:48 PM via phone with LVN H revealed did work the night shift on 09/06/2024 however she did not remember why it was not documented that buspirone HCL was not given to Resident #1 on 09/06. LVN H stated she no longer worked in the facility, however it would have been a medication aide who was responsible for administering the medication. LVN H stated she did not know who the medication aide would have been. Review of Resident #2's the electronic face sheet printed 09/18/2024 revealed an [AGE] year-old male admitted to the facility initially on 12/11/2022 and re admitted on [DATE] with diagnosis that included acute kidney (kidneys stop working suddenly), atrial fibrillation (irregular heart rhythm), dementia(group of symptoms affecting memory, thinking and social abilities), and dry eye syndrome. Review of Resident #2' quarterly MDS dated [DATE] revealed a BIMS score of 07 which indicated Resident #2 was moderately cognitively impaired. Review of Resident #'2 care plan revised 09/12/2024 revealed pain medication therapy, opioid use, and constipation with interventions to provide medication as prescribed. Review of Resident # 2's order summary dated active 09/18/2024 revealed the following orders: -Atorvastatin Calcium Oral Tablet 20 MG Give 1 tablet by mouth at bedtime related to HYPERLIPIDEMIA with a start date of 08/30/2024 -DuLoxetine HCl Oral Capsule Delayed Release Sprinkle 20 MG Give 1 capsule by mouth at bedtime for depression with start date of 08/30/2024 -Carboxymethy cellulose Sod PF Ophthalmic Solution 0.5 % Instill 1 drop in both eyes three times a day for dry eyes with a start date of 08/30/2024 -Melatonin Oral Capsule 10 MG Give 1 capsule by mouth at bedtime for SUPPLEMENT with an initial start date of 08/30/204 and discontinue date of 9/15/24 and re start date of 09/15/2024 -Sennosides-Docusate Sodium Oral Tablet 8.6-50 MG Give 1 tablet by mouth two times a day for Constipation with a start date of 08/30/2024 Review of Resident #2's MAR dated September 2024 reflected: 09/06/24 there was no documentation of sennoside- docusate sodium given afternoon (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-09/12/2024 there was no documentation of atorvastatin calcium given at 8:00PM. -09/12/2024 there was no documentation of Duloxetine oral given at 8PM. -09/12/2024 there was no documentation of melatonin given at 8PM. -.-09/12/24 there was no documentation of carboxymethyl cellulose given at 8PM. -09/13 /24 there was no documentation of carboxymethyl cellulose given afternoon. -.09/16 /24 there was no documentation of carboxymethyl cellulose given afternoon -09/17/24 there was no documentation of carboxymethyl cellulose given afternoon. Review of the schedule provided by the facility, LVN L worked night shift on 09/12/2024. Review of the schedule provided by the facility LVN G worked day shift on 09/13/2024. Attempted interview with LVN L on 09/19/2024 at 4:05 PM via phone was not successful. Attempted interview with LVN G on 09/20/2024 at 4:30 PM via phone was not successful. An interview on 09/25/2024 at 4:30 PM with LVN L revealed she worked on the day shift on 09/08/2024, however she was not sure why she did not document that albuterol sulfate was given. LVN L stated she gave Resident #1 all of her medication however because she was PRN and new to using the facility system she may have forgot to document the medication was given. LVN L stated the risk of not documenting that the medication was given would be that there was no evidence that the medication was given. An interview on 09/19/2024 at 10:15 AM with the Clinical Resources revealed he was new to the building and recently returned from maternity leave. He stated he was not sure why the MAR had not been completed, however he would get with all staff and look at the schedule to determine who worked those days. He stated there had been a lot of agency nurses working however he would re train to ensure proper documentation was completed during med pass. Review of the facility policy Administration of Medication dated July 2017 revealed Should a drug be withheld, refused, or given other than at the scheduled time, the staff administering must indicate the reason on the MAR. For those utilizing eMARs, the appropriate code must be entered with any follow up documentation as appropriate for the situation.