

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 10/28/2024
NAME OF PROVIDER OR SUPPLIER Northgate Plaza		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32486</p> <p>Based on observation, interview and record review the facility failed to ensure all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegations were made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, for one (Resident #1) of three residents reviewed for abuse.</p> <p>The Administrator failed to report an incident to the State Survey Agency when Resident #1 alleged PTA A had physically abused him on 10/24/24.</p> <p>This failure could place the residents in the facility at risk of not receiving timely reporting of incidents involving allegations of abuse which could result in undetected abuse and misappropriation or theft and emotional distress.</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet, dated 10/25/24, revealed he originally admitted to the facility on [DATE]. His diagnoses included: bipolar disorder (episodes of mood swings ranging from depressive lows to manic highs), diabetes mellitus (too much sugar in the blood), depression (long lasting low mood and a loss of interest in activities that used to be enjoyable) and legally blind (visual or vision impairment is the partial or total inability of visual perception).</p> <p>Review of Resident #1's quarterly MDS admitted d, 09/18/24 revealed speech was clear, able to make self-understood and understood others.</p> <p>Review of Resident #1's BIMS score dated 10/21/24 revealed a score of 14 which indicates cognitively intact.</p> <p>Review of Resident #1's care plan revealed on 02/12/24 resident had the potential to demonstrate verbally abusive behaviors related to ineffective coping skills, mental/emotional illness, poor impulse control. On 09/19/23 resident had psychotropic medications use related to bipolar disorder. On 08/05/23 resident was at risk for impaired cognitive function/dementia or impairment thought processes related neurological symptoms, short term memory loss, pain. On 07/30/23 resident had ADL self-care performance deficit related to impaired balance, stroke, visual impairment.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's progress note dated 10/24/24 and documented by ADON B, reflected the following: At approximately 10:30 AM this ADON B was at the nurse's station speaking with the NP C and could hear a loud bang on the kitchen door from the dining hall. Upon entering the dining room this ADON B witnessed Resident #1 banging on the kitchen door and yelling at the kitchen staff to open the door. PTA A spoke with the resident to see if he needed assistance, as well to deescalate the resident's behavior. Resident #1 then became very outraged with the PTA A and began to yell at him in regard to wanting a new wheelchair. Resident #1 became outraged and started swinging at PTA A from his wheelchair. PTA A reattempted to deescalate Resident #1 but he continued to swing his fist at PTA A, in which this ADON B intervened by removing the resident from the dining hall. at about 1400 Resident #1 was noted to be strolling around the nurse's station with a cane in his hand while sitting in his wheelchair. Resident #1 was noted to swing his black cane at the MA C. Resident #1 was then redirected to the TV room where he made several attempts to stand up, grab the TV, turn the volume on the TV very loud. Resident #1 noted to make several racial slurs at staff. Resident #1 began to ramble that he could run this building better than anyone and that nurses need to move their F*** carts out of his damn way. Resident #1 then began to run into several tables and staff members yelling get out of my damn way. Resident #1 continued to ambulate via wheelchair around the facility cursing as well as yelling. at 1410 Police D and ambulance were notified. safety concerns for our residents. Resident #1 was approached by Police D as well as EMS in which he begins to ramble various thoughts and hallucinations to police. The Administrator was present. Resident #1 agreed to go to Hospital E for a psychological evaluation.</p> <p>Review of Resident #1's progress note from Hospital E dated 10/24/24 and documented by RN F, reflected the following 1702 entered patient room along with VIP. Patient identified with two unique identifiers. Patient reports that the manager of the therapy team, PTA A, punched him and tried to lift him out of his wheelchair. Patient states that he then went to his room to cool off, and then when he left again, he was in the hallway trying to navigate around med carts with his cane when a CNA named MA C said, don't hit my leg. Patient states then the police were called because she reported he was trying to hit her with her cane. patient states that he would like to leave hospital against medical advice and that he would like to live in his home instead of facility.</p> <p>Review of facility incident report dated 10/25/24 at 10:30 AM prepared by Interim DON, reflected Interim DON logged into Hospital E system to follow up Resident #1 who was discharged there yesterday. It was noted that resident reported to the hospital that a staff member had abused him while here on 10/24/24. Resident #1 reported that the manager of the therapy team, PTA A, punched him and tried to lift him out of his wheelchair according to hospital documentation.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Interim DON on 10/25/24 at 11:22 AM revealed, the Interim DON stated he had logged into Hospital E's system this AM to follow up on Resident #1 admission on 10/24/25. The Interim DON stated he was not at the facility all day on 10/24/24 therefore he had first learned of Resident #1's transfer to the hospital on 10/24/24 the AM of 10/25/24, about an hour ago. The Interim DON stated once he read the allegation that Resident #1 stated he was punched and lifted out of his wheelchair by PTA A he immediately suspended PTA A, started an investigation, and reported the incident to HHS as required. The Interim DON stated he was not notified on 10/24/24 about any incident involving Resident #1 and did not know why it was not self-reported by the Administrator on 10/24/24. The Interim DON stated that Resident #1 had been send out to the hospital several times in the past few weeks for psychology evaluation related to his manic behaviors. The Interim DON stated he had instructed the facility staff to call the police at the time of any of Resident #1's manic episodes moving forward in hopes of getting him an in-house psychology admission to help stabilize his manic episodes since in the past each time they had send Resident #1 to the hospital it was after an episode had occurred. The Interim DON stated that allegations of abuse and neglect need to be investigated and reported to HHS appropriately. The Interim DON stated the risk of not investigating an alleged allegation of abuse could result in such activity continuing.</p> <p>Interview on 10/28/24 at 10:58 AM with the Clinical Market Leader revealed, she stated she conducted the interview with the Administrator on 10/25/24 regarding the incident with Resident #1 on 10/24/25. The Clinical Market Leader stated during her interview with the Administrator he stated to her that he overheard Resident #1 tell the police that PTA A hit him in the face. The Clinical Market Leader stated that the alleged allegation of abuse should have been reported immediately by the Administrator on 10/24/25 as required.</p> <p>Interview with the Administrator on 10/28/24 via telephone at 11:28 AM revealed, The Administrator was asked if Resident #1 had reported any abuse by PTA A to him on 10/24/24, the Administrator stated he did hear Resident #1 say all sorts of things during his manic episode on 10/24/24, Resident #1 was yelling about his clippers/shears, he was going to sue the Interim DON for malpractice, he was going to sue the PTA A for punching him in the face and he was going to sue the Administrator for stealing his scissors. The Administrator continued saying that Resident #1 was speaking about all different things during his manic episode on 10/24/24 afternoon while exiting the facility with the police, the Administrator stated maybe I was thrown off how Resident #1 was acting. The Administrator stated he was confused at the time as to what was going on with Resident #1 since his behavior so erratic, it was hard to understand anything that Resident #1 was saying. The Administrator stated that he does recognize now high in sight at any state of a resident's behavior I have to take all allegations serious at this point moving forward and report them appropriately . The Administrator said, the allegation should have been reported if it was not witnessed. The Administrator stated the risk of not reporting allegations could result in an incident not being thoroughly investigated and abuse/neglect occurring and/or continuing to occur. The Administrator revealed he was the abuse coordinator and would have been responsible for completing the self-report to HHS on 10/24/24.</p> <p>Interview with Resident #1 on 10/28/24 via telephone at 12:07 PM revealed, Resident #1 stated he was in the hospital under a 72-hour watch for a psychological evaluation. Resident #1 stated that Hospital E told him they can hold him up to a month. Resident #1 stated he wanted to press charges against MA C and PTA A for falsifying a police report on him and for malpractice. Resident #1 spoke on random topics unrelated to the alleged allegation. Resident #1 never confirmed he was punched in the face or lifted out of his wheelchair by PTA A.</p> <p>(continued on next page)</p>		

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