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	05/14/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observations, interviews, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for three (Resident #1, Resident #2, and Resident #3) of six residents reviewed for Reasonable Accommodation of Needs. The facility failed to ensure the call light system in Resident #1, Resident #2, and Resident #3's rooms was in a position that was accessible to the residents on 05/14/2025. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings included: 1. Record review of Resident #1's Face Sheet, dated 05/14/25, reflected he was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included repeated falls, and seizures. Record review of Resident #1's Quarterly MDS assessment, dated 02/11/25, reflected he had a BIMS score of 00 (severe cognitive impairment). For ADL care, it reflected the resident required extensive assistance. Record review of Resident #1's Comprehensive Care Plan, dated 03/17/2025, reflected the resident was a fall risk and one of the interventions was to ensure the resident's call light was within reach. In an observation on 05/14/25 at 7:55 AM, Resident #1 was observed lying in his bed and his call light button was on the floor, out of reach for the resident. In an interview and observation on 05/14/25 at 8:10 AM, CNA S stated she checked on residents frequently, and was just in Resident #1's room about 30 minutes ago. She observed the resident's call light button on the ground and stated she had fed the resident and may have forgotten to place the call light back near the resident. She stated not having the call light button within reach of the resident, could prevent the resident from requesting help if he needed it. 2. Record review of Resident #2's Face Sheet, dated 05/14/25, reflected she was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included repeated falls, and unsteadiness on feet. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's Quarterly MDS assessment, dated 02/22/25, reflected she had a BIMS score of 14 (intact cognitive response). For ADL care, it reflected the resident required substantial assistance. Record review of Resident #2's Comprehensive Care Plan, dated 04/24/25, reflected the resident had a history of falls and one of the interventions was to ensure the resident's call light was within reach. In an observation on 05/14/25 at 8:01 AM, Resident #2 was observed lying in bed and her call light button was on the floor near a 3-drawer chest, next to her bed. The call light button was out of reach for the resident. In an interview and observation on 05/14/25 at 8:15 AM, CNA M stated she checked on Resident #2 in the morning. She observed the resident's call light button on the ground and picked it up to place it near the resident. Resident #2 stated she needed the call light button near her because she used it to get help getting up after she ate. CNA M stated not having the call light button within reach of the resident, could prevent the resident from requesting help if he needed it. 3. Record review of Resident #3's Face Sheet, dated 05/14/25, reflected he was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included chronic respiratory failure (low oxygen), and unsteadiness on feet. Record review of Resident #3's Quarterly MDS assessment, dated 04/24/25, reflected he had a BIMS score of 11 (moderate cognitive impairment). For ADL care, it reflected the resident required extensive assistance. Record review of Resident #3's Comprehensive Care Plan, dated 03/27/25, reflected the resident was a risk for falls and to ensure the resident's call light was within reach. In an observation and interview on 05/14/25 at 8:04 AM, Resident #3 was observed lying in bed, and his call light pad was clipped at the top of the mattress. Resident #3 was asked if he knew where his call light was located, and he stated he did not know where the call light was and asked if it could be handed to him. The call light pad was out of reach for the resident's use. In an interview and observation on 05/14/25 at 8:20 AM, LVN T stated she was the nurse for the 100 and 200 halls. She was advised and shown a photo of Resident#1 and Resident #2's call light button being on the floor and out of reach for the residents. She stated the call light needed to be in reach of the resident so that they would be able to contact staff if they needed help. In an interview on 05/14/25 at 12:00 PM, the DON stated she was made aware of Resident #1, Resident #2, and Resident #3 not having their call lights within reach. She stated staff make their rounds at least every two hours and they have to ensure the resident's call lights were within their reach. She advised she was in-servicing staff on 05/14/25 on ensuring call lights are within reach of the residents. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's In-service training on Call Lights (11/2019), revealed Call lights: types, what is in reach & why is in reach important? In reach means the resident is able to reach the call light, without assistance from anyone else . If the resident requires a touch pad, please secure this CLOSE TO THEIR HAND. If resident has hands on chest, then lay the pad on the chest. If arm is beside the body, then lay the pad CLOSE TO THEIR HAND. The HEAD OF THE BED IS NOT AN APPROPRIATE LOCATION FOR ATTACHING A CALL LIGHT. The facility did not have a policy referencing call lights.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observations, interviews, and record reviews, the facility failed to ensure that residents' were free from physical or chemical restraints imposed for purposes of discipline or convenience and that were not required to treat the resident's medical symptoms 3 of 6 residents (Residents #1, #5, and #6) reviewed for physical restraints. The facility failed to ensure Residents #1, #5, and #6 had physician orders for the scoop mattresses on their beds. This failure could prevent the residents from having an environment that was free from physical restraints. Findings include: 1. Record review of Resident #1's Face Sheet, dated 05/14/25, reflected he was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included repeated falls, and seizures. Record review of Resident #1's Quarterly MDS assessment, dated 02/11/25, reflected he had a BIMS score of 00 (severe cognitive impairment). For ADL care, it reflected the resident required extensive assistance. Record review of Resident #1's physician orders, dated 05/14/25, reflected no physician orders for a scoop mattress. In an observation on 05/14/25 at 7:55 AM, Resident #1 was observed lying on a scoop mattress. 2. Record review of Resident #5's Face Sheet, dated 05/14/25, reflected he was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included repeated falls, and unsteadiness on feet. Record review of Resident #5's Quarterly MDS assessment, dated 04/10/25, reflected he had a BIMS score of 00 (severe cognitive impairment). For ADL care, it reflected the resident required substantial assistance. Record review of Resident #5's physician orders, dated 05/14/25, reflected no physician orders for a scoop mattress. In an observation on 05/14/25 at 7:58 AM, Resident #5 was observed lying on a scoop mattress. 3. Record review of Resident #6's Face Sheet, dated 05/14/25, reflected he was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included muscle weakness, and unsteadiness on feet. Record review of Resident #6's Quarterly MDS assessment, dated 04/25/25, reflected he had a BIMS score of 10 (moderate cognitive impairment). For ADL care, it reflected the resident required substantial assistance with some ADL care. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #6's physician orders, dated 05/14/25, reflected no physician orders for a scoop mattress. In an observation on 05/14/25 at 9:48 AM, Resident #6 was observed with a scoop mattress. In an interview and observation on 05/14/25 at 11:30 AM, the ADON observed Resident #1, Resident #5, and Resident #6's beds, and she confirmed that all of the residents mentioned had a scoop mattress. She stated she was not sure if they had physician orders for the scoop mattress but would check. After checking each resident, she stated none of them had physician orders for the scoop mattresses. She stated physician orders were needed to ensure that they were not a restraint for the residents. She stated the residents were a fall risk and needed the scoop mattress to prevent falls. In an interview on 05/14/25 at 11:20 AM, the DON stated her ADON had informed her that Resident #1, Resident #5, and Resident #6 had scoop mattresses but no physician orders on file. She stated they needed physician orders to ensure that the scoop mattress was not a restraint for the residents. She stated the residents were considered a fall risk and they were working on obtaining physician orders for the scoop mattresses. Record review of the facility's policy Restraints (05/05/23) reflected The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

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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** 45055 Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained as free of accident hazards as was possible for 1 of 6 residents (Resident #4) reviewed for accident prevention. The facility failed to ensure Resident #4 had a fall mat placed alongside her bed while she was lying in it on 05/14/25. This failure could prevent the residents from having an environment that was free and clear of accident hazards. Findings include: Record review of Resident #4's Face Sheet, dated 05/14/25, reflected she was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included history of falls, and unsteadiness on feet. Record review of Resident #4's Quarterly MDS assessment, dated 02/06/25, reflected she had a BIMS score of 00 (severe cognitive impairment). For ADL care, it reflected the resident required substantial assistance. Record review of Resident #4's Comprehensive Care Plan, dated 04/08/25, reflected the resident had a hip fracture from a fall and one intervention was for the resident to have a floor mat alongside the bed. In an observation on 05/14/25 at 9:15 AM, Resident #6 was observed lying in bed, the bed was in a low position, but the fall mat was observed under the resident's bed. In an interview and observation on 05/14/25 at 9:20 AM, LVN M was shown Resident #4 lying in bed, and her fall mat located under her bed as opposed to being alongside her bed. She stated the resident was a fall risk and it was required for her bed to be in a low position and a fall mat placed alongside her bed for fall prevention. She stated she checked on residents at least every 2 hours. She stated the CNA may have fed her and forgotten to place the fall mat back in place. She stated the fall mat not being placed alongside the resident's bed could result in her falling from her bed and injuring herself. In an interview on 05/14/25 at 11:20 AM, the DON was advised of Resident #4's fall mat not being placed alongside the resident's bed. She stated the resident was a fall risk and her bed needed to be in a low position and the fall mat alongside her bed. She stated not having the fall mat placed alongside the resident's bed could result in her falling out of bed and injuring herself. She stated staff makes their rounds at least every two hours and staff should be checking to ensure her environment was free of accident hazards. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy Fall Management (12/2023) reflected It is the policy of this facility to provide an environment that remains as free of accident hazards as possible. It is also the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs.