

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  11/25/2025
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)
F 0550  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.  (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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to treat each resident with respect, dignity, and care in a manner and environment that promotes maintenance or enhancement of his or her quality of life for one (Resident #2) of eight residents reviewed for resident rights. The facility failed to treat Resident #2 with dignity and promote enhancement of his quality of life when the resident was not provided a privacy bag for his catheter bag (collects urine from the urinary bladder) on 09/30/2025. This failure could place residents at risk of not having their right to a dignified existence maintained and a decline in their quality of life. Findings included: Record review of Resident #2's Face Sheet, dated 09/30/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with urinary retention (inability to empty the bladder completely). Record review of Resident #2's Comprehensive MDS (assessment used to determine functional capabilities and health needs) Assessment, dated 09/30/2025, reflected that the resident had severe impairment in cognition with a BIMS (screening tool used to assess cognitive status) score of 00 ( a BIMS score of 00 indicated a acute level of cognitive requiring significant assistance and support in daily life). The Comprehensive MDS Assessment indicated the resident had an indwelling catheter (device that drains urine from the urinary bladder). Record review of Resident #2's Comprehensive Care Plan, dated 09/30/2025, reflected the resident had an indwelling catheter and one of the interventions was to provide catheter care. Record review of Resident #2's Physician Order, dated 09/27/2025, reflected POSITION PRIVACY BAG &amp; TUBING BELOW THE LEVEL OF THE BLADDER. An observation on 09/30/2025 at 8:12 AM revealed Resident #2 was in his bed with eyes closed. It was observed that the resident had a catheter bag hanging on the side frame of the bed. The catheter bag did not have a privacy bag. In an interview on 09/30/2025 at 8:45 AM, CNA C stated she noticed Resident #2's catheter bag did not have a privacy bag. She said she was about to tell the nurse but she forgot. She said the catheter bag should have a privacy bag even though the resident was inside his room for privacy and dignity. She said the roommate might have visitors and could see the catheter bag and its content. She said she would look for a privacy bag for Resident #2's catheter. In an interview on 09/30/2025 at 9:06 AM, Resident #2 did not reply when asked how long he had the catheter. In an interview on 09/30/2025 at 10:03 AM, the DON stated catheter bags should be inside a privacy bag whether the resident was inside the room or outside. She said the privacy bag was to maintain the resident's dignity and to prevent any kind of embarrassment. She said the expectation was for all the staff to ensure that the residents were provided dignity. She said an in-service about dignity was already on-going as soon as CNA C told her about Resident #2 catheter bag without a privacy bag. In an interview on 09/30/2025 at 11:00 AM, LVN B stated she was the one who removed Resident #2's privacy bag because it was ripped. She said she did look for one but since she was a PRN, she was not familiar with where she could get the privacy bag. She said she should have taken off the privacy bag when she already had the new privacy bag on hand. She said the privacy bag was to maintain the resident's integrity and dignity. In an interview on 09/30/2025 at 12:23 PM, the ADON stated a catheter bag must have a privacy bag to avoid incidents that could lead to embarrassment. She said some visitors might enter the resident's room and would see the catheter bag and its content. She said the purpose of the privacy bag was to provide dignity for residents with urinary catheters. She said the expectation was for the staff to make sure the catheter bags had privacy bags when the residents were inside their rooms or outside their rooms. She said an in-service was already going around and she would coordinate with the DON to closely monitor the adherence of the staff in providing dignity. In an interview on 09/30/2025 at 12:47 PM, the Administrator stated a catheter bag should be inside a privacy bag to prevent any dignity issue. She said all the staff were responsible in providing dignity to all residents. She said staff must do their due diligence in ensuring the residents have a dignified existence while in the facility. The Administrator said she would coordinate with the DON to re-educate the staff with regards to dignity and to monitor that the catheter bags were not exposed. She said the facility did not have a policy specific in putting a catheter bag in a privacy bag but in essence, there should be a privacy bag to ensure dignified existence.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>(continued on next page)</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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 #2, Resident #3, and Resident #4) of twelve residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light in Resident #2, Resident #3, and Resident #4's rooms were in a position that was accessible to the resident on 09/30/2025. 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: Resident #2 Record review of Resident #2's Face Sheet, dated 09/30/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with a history of falling, unsteadiness of feet, and muscle weakness. Record review of Resident #2's Comprehensive MDS Assessment, dated 09/30/2025, reflected that the resident had severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident was dependent on staff for personal hygiene, dressing, transfer, and bed mobility. Record review of Resident #2's Comprehensive Care Plan, dated 09/30/2025, reflected the resident was at risk for falls and one of the interventions was to ensure the call light was within reach. An observation on 09/30/2025 at 8:12 AM revealed Resident #2 was in his bed with eyes closed. It was observed that the resident's call light was on top of the resident's side table and was not within reach. Resident #3 Review of Resident #3's Face Sheet, dated 09/30/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness and lack of coordination. Review of Resident #3's Quarterly MDS Assessment, dated 08/31/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 05. The Quarterly MDS Assessment indicated that the resident required maximal assistance for toileting hygiene, dressing, bed mobility, and transfer. Review of Resident #3's Comprehensive Care Plan, dated 08/28/2025, reflected the resident was at risk for falls one of the interventions was to be sure the resident's call light was within reach. Observation and interview on 09/30/2025 at 8:14 AM revealed Resident #3 was in her bed, eating breakfast. It was observed that the resident's call light was inside the drawer of the resident's side table. When asked about her call light, the resident looked on her side and she said she could not see her call light. Resident #4 Review of Resident #4's Face Sheet, dated 09/30/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness and lack of coordination. Review of Resident #4's Quarterly MDS Assessment, dated 09/01/2025, reflected the resident had a moderate impairment (resident may need additional support and monitoring) in cognition with a BIMS score of 07. The Quarterly MDS Assessment indicated that the resident was independent with ADLs. Review of Resident #4's Comprehensive Care Plan, dated 08/28/2025, reflected the resident was at risk for falls one of the interventions was to be sure the resident's call light was within reach. Observation and interview on 09/30/2025 at 8:22 AM revealed Resident #4 was in his bed, awake. It was observed that his call light was on the floor. He said he seldom used his call light because he would just go out or would just yell if he needed something. He looked for his call light at the side of his bed but said he could not find it. He said he could not even see where the cord of the call light was. He said what if he was not feeling well, could not go out of the room, and did not have his call light. He said he guessed the only thing to do was to wait for somebody to check on him. During an observation and interview on 09/30/2025 at 8:45, CNA C stated she did not notice that Resident #2's call light was not with the resident when she brought the tray for Resident #2's roommate. She said she did not know who left the call light on the side table. She said the call light should be with the resident because that was what they used to call the staff in case they needed something. She went to Resident #2's room and checked the resident's call light. She then went inside Resident #3's room and saw Resident #3's call light was inside the drawer of the resident's side table. She took the call light from the drawer and placed it where Resident #3 could reach it when needed. She said she would also check on Resident #4's room and make sure the call light was within Resident #4's reach. She said if the call lights were not within the reach of the residents, the residents might fall or might get mad when they could not get hold of the staff. In an interview on 09/30/2025 at 10:03 AM, the DON stated call lights were safety measures wherein the residents could call the staff if they needed something or needed to do something that needed assistance. She said residents might try to go to the bathroom by themselves because she had no way to call the staff that might result in a fall and injuries. The DON said all the staff were responsible for the</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infection and to restore continence to the extent possible for one of (Resident #2) two residents reviewed for catheter care. The facility failed to ensure that RN D placed orders for Resident #2's catheter when the resident was admitted back to the facility on [DATE]. This failure could place residents with catheter at risk of no continuity of catheter care. Findings included: Record review of Resident #2's Face Sheet, dated 09/30/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with urinary retention. Record review of Resident #2's Comprehensive MDS Assessment, dated 09/30/2025, reflected that the resident had severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident had an indwelling catheter. Record review of Resident #2's Comprehensive Care Plan, dated 09/30/2025, reflected the resident had an indwelling catheter and one of the interventions was to provide catheter care. Record review of Resident #2's Physician Order on 09/30/2025 reflected the resident did not have any orders for the catheter when he was re-admitted to the facility on [DATE] with a catheter. Record review of resident #2's Progress Note, dated 09/09/2025, reflected Patient presented with urine retention . Notified NP; order received to transfer patient to ED for further evaluation . Patient left the facility in stable condition. Record review of Resident #2's Progress Note, dated 09/10/2025, reflected Patient returned from . ED at 0005 on 09/10/25 . Patient was treated for urinary retention. 16 fr (French: unit of measurement for catheter sizes) Foley catheter (device used to help drain urine from bladder) in place and draining clear yellow urine to gravity. An observation on 09/30/2025 at 8:12 AM revealed Resident #2 was in his bed with eyes closed. It was observed that the resident had a catheter bag hanging on the side frame of the bed. In an observation and interview on 09/30/2025 at 10:03 AM, the DON stated when Resident #2 was re-admitted from the hospital, the nurse admitting the resident should have placed the orders from the hospital. She said if the resident was sent out to the hospital, the orders were discontinued but as soon as the resident was re-admitted the order should be transcribed again. She said, for Resident #2, he was re-admitted with a catheter, so the orders pertaining to the catheter should have been transcribed. She said the admitting nurse should put the orders for the catheter such as, provide catheter care, when to change, when to flush, what to assess. She checked Resident #2's physician orders and saw the resident did not have any order about his catheter when he was re-admitted to the facility on [DATE]. She said the nurses knew what to do with the catheter but there should be an order to ensure continuity of care. She said she would start an in-service about physician orders. In a telephone interview on 09/30/2025 at 11:25 AM, RN D stated he admitted Resident #2 on early morning of 09/10/2025. He said the resident did not have a catheter before hospitalization and came back with one. He said he was not sure why he was not able to put the orders. He said he should have put the orders for the catheter so the next shift would know that the resident was back with a catheter. He said he knows what to do with the catheter, but orders should be in place. In an interview on 09/30/2025 at 12:23 PM, the ADON stated everything done for the resident should have an order. She said if a resident came back from the hospital with a catheter, then there should be orders pertaining to the catheter, such as what catheter size would be needed if the catheter needed to be changed, when to empty the catheter bag, or what to assess like the color of the urine. She said physician orders were important because the orders served as communication tool with the resident's treatment needs. She said an in-service was already going around. In an interview on 09/30/2025 at 12:47 PM, the Administrator stated she was not a clinician and would let the ADON and the DON to make sure the said issue would be addressed. Record review of the facility's policy entitled Physician Orders Policy/ Procedure - Nursing Clinical revised 05/2007 reflected POLICY: It is the policy of this facility that drugs and treatments shall be administered/carried out upon the order of a person duly licensed and authorized to prescribe such drugs and treatments . PROCEDURES . 1. No drugs or biologicals shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illnesses . recorded immediately in the resident's chart by the person receiving the order and must include the date and time of the order.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Resident #5) of five residents reviewed for respiratory care. The facility failed to ensure Resident #5's breathing mask was stored properly when not in use on 08/12/2025. This failure could place residents at risk for respiratory infection and not having their respiratory needs met. Findings include: Record review of Resident #5's face sheet, dated 09/30/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #5's Quarterly MDS Assessment, dated 09/15/2025, reflected the resident had severe impairment in cognition with a BIMS score of 04. The Quarterly MDS Assessment indicated the resident had chronic obstructive pulmonary disease and was on oxygen therapy. Record review of Resident #5's Comprehensive Care Plan, dated 08/25/2025, reflected the resident had chronic obstructive pulmonary disease and one of the interventions was to give aerosol (fine spray or mist used to deliver medications) or bronchodilators (medication that caused widening of the air passages) as ordered. Record review of Resident #5's Physician's Order, dated 09/11/2025, reflected Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 1 inhalation inhale orally every 4 hours for SOB related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH (ACUTE) EXACERBATION. During an observation and interview on 09/30/2025 at 8:27 AM revealed Resident #5 was walking around inside her room. It was observed that her breathing mask was on top of the resident's overbed table. She said she had a breathing treatment earlier that day. In an interview on 09/30/2025 at 8:32 AM, LVN A stated she was the one who removed the breathing mask from the plastic bag and put it on top of the overbed table. She said the plastic bag that was used to keep the breathing mask was the plastic bag used for the waste can and she planned to replace the bag. She said she got busy and forgot about it. She said she should have made sure that she had the new plastic bag on hand before removing the breathing mask. She said she would clean the breathing mask and would get a new plastic bag for it. She said the breathing mask should be inside the bag to prevent cross contamination and respiratory infection. In an interview on 09/30/2025 at 10:03 AM, the DON stated the staff administering the breathing treatment was responsible in making sure the breathing mask was bagged when not in use to prevent respiratory infection. She said Resident #5 was known for taking off her breathing mask but if the staff was the one who put it on top of the overbed table, then it was different story. She said she would start an in-service about bagging the breathing mask. In an interview on 09/30/2025 at 12:23 PM, the ADON stated the breathing mask should be stored properly to prevent cross contamination and respiratory infections. She said whoever administered the breathing treatment was responsible for cleaning it and storing it in a plastic bag. She said the DON already started an -in-service about bagging the breathing mask. She said she would coordinate with the DON to closely monitor if the staff were bagging the breathing mask and the nasal cannula as well. In an interview on 09/30/2025 at 12:47 PM, the Administrator stated the expectation was for the staff to bag the breathing mask when not in use to prevent respiratory issues. She said she would let the DON deal with the issue. She said but she did know that the breathing mask should be kept clean. Record review of the facility's policy entitled Oxygen Administration Policy/Procedure - Nursing Clinical revised 05/2017 reflected POLICY: It is the policy of this facility to maintain all oxygen therapy equipment in a clean and sanitary manner . PROCEDURES . 5. When mask or cannula is temporarily not being used, it will be covered loosely to prevent contamination from airborne microorganisms.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for one (Resident #1) of ten residents reviewed for medication storage. The facility failed to ensure Resident #1's skin protectant (medicated cream used to prevent skin irritation) was not left inside the resident's room on 09/30/2025. This failure could place residents at risk of misuse of medications that could lead to overdosing and adverse reactions. Findings include: Record review of Resident #1's Face Sheet, dated 09/30/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with soft tissue disorder (variety of conditions that affect muscles and tendons leading to pain and swelling). Record review of Resident #1's Comprehensive MDS Assessment, dated 08/24/2025, reflected the resident had severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident was incontinent for bowel and bladder. Record review of Resident #1's Comprehensive Care Plan, dated 06/28/2025, reflected the resident had incontinence and one of the interventions was to apply barrier cream after each incontinent episode. Record review of Resident #1' Physician Order, dated 01/28/2025, reflected May apply house barrier cream after each incontinent care episode. During an observation and attempted interview on 09/30/2025 at 8:18 AM revealed a tube of skin protectant was on top of the Resident #1's side table. When asked about the skin protectant, the resident did not reply. It was observed that the skin protectant had zinc oxide as an active ingredient and a warning to use externally only and to avoid contact with the eyes. During an observation and interview on 09/30/2025 at 8:45 AM, CNA C stated the tube should not be inside the room because the resident might mistakenly consume it. She said it should be somewhere secured so the resident did not have any access to it. She said the skin protectant was applied in the skin and might have adverse effects if consumed by the resident. She took the tube of skin protectant from the resident's side table. She would put the resident's name on it, put it in a plastic bag, and give it to the nurse. In an interview on 09/30/2025 at 9:01 AM, the ADON stated the skin protectant should not be inside the room or placed where the residents could access it. She said it should be inside the cart. She said confused residents might could mistake it as toothpaste and place it in their mouth. She said the expectation was for the staff to make sure no zinc oxide was placed where the residents could access them. She said she would coordinate with the DON to do an in-service about medication storage. In an interview on 09/30/2025 at 10:03 AM, the DON stated medications should not be stored inside the resident's room and the skin protectant was a form of a medication because the skin protectant was used to prevent skin issues. She said the skin protectant could be harmful when ingested. She said some residents might be allergic to it and was able to get hold of the zinc oxide because the tubes were in plain view. She said the expectations were for the staff to always scan the residents' rooms to make sure they were not leaving the tubes of skin protectants inside the room and putting them where the resident could not access them after using them. She said the ADON already started the in-service about medication storage, but she would go around to personally make sure that there were no skin protectants inside the residents' rooms. In an interview on 09/30/2025 at 12:47 PM, the Administrator stated if the skin protectant was a form of medication and be harmful when ingested, then it should not be inside the rooms of the resident. She said she would coordinate with the DON to make sure the staff were re-educated about not leaving the skin protectant inside the rooms. Record review of the facility's policy entitled, Medication Access and Storage/Drug Destruction Policy/Procedure - Nursing Clinical revised 07/2023 reflected POLICY: It is the policy of this facility to store all drugs and biological in locked compartments . The medication supply is accessible only to licensed nursing personnel.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>		

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  11/25/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to establish and 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 diseases and infections for one (Resident #2) of eight residents reviewed for infection control. The facility failed to ensure CNA C wore a gown while providing incontinent care to Resident #2, who had a catheter (flexible tube inserted into the bladder to remove the urine) and had an order for enhanced barrier protection, on 09/30/2025. This failure could place residents at risk of cross-contamination and development of infections. Findings included: Record review of Resident #2's Face Sheet, dated 09/30/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with urinary retention. Record review of Resident #2's Comprehensive MDS Assessment, dated 09/30/2025, reflected that the resident had severe impairment in cognition with a BIMS of 00. The Comprehensive MDS Assessment indicated the resident had an indwelling catheter. Record review of Resident #2's Comprehensive Care Plan, dated 09/30/2025, reflected the resident had an indwelling catheter and one of the interventions was to use enhanced barrier precautions (infection control practices that required the use of gown and gloves to reduce for high contact resident care activities). Record review of Resident #2's Physician Order, dated 09/30/2025, reflected Enhanced Barrier Precautions: PPE required for high resident contact care activities. Indication: Indwelling Catheter every shift. An observation on 09/30/2025 at 10:41 AM revealed CNA was inside Resident #2's room and fixing the resident's blanket. When asked by the DON what she was doing, she said she just provided incontinent care to the resident, and she was done. It was observed that CNA C did not have a gown, there was no gown in the trash can inside the room, and no gown in the trash can inside the bathroom. It was observed that there was sign outside the resident's door indicating EBP was required. In an interview on 09/30/2025 at 10:50 AM, the DON stated CNA C should have worn a gown because the Resident #2 had a catheter. She said the main purpose of EBP was to prevent cross contamination and spread of infection. She said when a resident was on EBP, staff should wear a gown and a pair of gloves when handling the resident. She said the expectation was for the staff to be mindful with what they were doing to protect the residents from all kinds of infections. She said she would do an in-service pertaining to infection control focusing on wearing a gown when required. She said she would closely monitor the staff with their compliance to the policy of infection control. In an interview on 09/30/2025 at 11:45 AM, CNA C stated she did Resident #2's incontinent care and she forgot to wear a gown. She said she should have worn a gown to prevent spread of infection, if there was any. She said there was sign outside the resident's door and she still forgot to wear a gown. She said she should have worn a gown and a pair of gloves while providing incontinent care because the resident was on EBP and the signage outside the room clearly stated to use EBP when providing care to a resident with a catheter. She said she would be mindful the next time she would provide care to residents who required EBP. In an interview on 09/30/2025 at 12:23 PM, the ADON stated staff must wear a gown when EBP was required. She said deviation from the said procedures could result in cross contamination and development of infection. She said the expectation was for the staff to be mindful and compliant with the policy of infection control. She said the DON already started an in-service about infection control specific to EBP. In an interview on 09/30/2025 at 12:47 PM, the Administrator stated the expectation was for the staff to follow to the policy for infection control to prevent the spread of infection. She said EBP was one way to keep the residents safe and away from any infections that could be prevented. She said she would coordinate with the DON to re-educate the staff about EBP and monitor closely their adherence to the policy of infection control. Record review of the facility's policy entitled Infection Control IPCP Standard and Transmission-Based Precautions revised 03/2024 reflected Policy: It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions . Enhanced Barrier Protection (EBP): used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident . a. PPE: The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with . Indwelling medical devices . urinary catheters</p>		