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	03/31/2026

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** 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 four (Resident #1, #2, #3, and #4) of ten residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #1, #2, #3, and #4's room was in a position accessible to the resident on 03/31/2026.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: Record review of Resident #1's Face Sheet, dated 03/31/26, reflected a [AGE] year-old male, admitted [DATE]. Resident #1 had diagnosis of a fractured skull. Record review of Resident #1's Baseline MDS Assessment, dated 03/30/26, reflected the resident had a BIMS of 99 (unable to complete the interview). The Assessment reflected the resident was a fall risk. Record review of Resident #1's Comprehensive Care Plan, dated 03/27/26, reflected the resident was a fall risk and required assistance with ADL care.During an observation on 03/31/26 at 9:00 a.m., Resident #1 was lying in bed and his call light was located at the head of the bed out of the resident's reach. Record review of Resident #2's Face Sheet, dated 03/31/26, reflected a [AGE] year-old male, admitted [DATE]. Resident #2 had diagnosis of a need for assistance of personal care. Record review of Resident #2's Quarterly MDS Assessment, dated 02/09/26, reflected the resident had a BIMS of 99 (unable to complete the interview). The resident had active diagnoses of a stroke and difficulty swallowing. Record review of Resident #2's Comprehensive Care Plan, dated 02/03/26, reflected the resident was a fall risk and an intervention was to ensure his call light was within his reach.During an observation on 03/31/26 at 9:05 a.m., Resident #2 was lying in bed and his call light was located on the floor out of the resident's reach.Record review of Resident #3's Face Sheet, dated 03/31/26, reflected a [AGE] year-old female admitted to the facility on [DATE]. Resident #3 had diagnoses of a lack of coordination and unsteadiness on feet. Record review of Resident #3's Quarterly MDS Assessment, dated 02/25/26, reflected the resident had a BIMS of 1 (severe cognitive impairment). The resident had active diagnoses repeated falls and unsteadiness on feet. Record review of Resident #3's Comprehensive Care Plan, dated 03/05/26, reflected the resident was a fall risk and an intervention was to ensure his call light was within her reach.During an observation on 03/31/26 at 9:08 a.m., Resident #3 was lying in bed and her call light was located on her roommate's bed.Record review of Resident #4's Face Sheet, dated 03/31/26, reflected a [AGE] year-old male admitted to the facility on [DATE]. Resident #4 had a diagnosis of paralysis on the right side of body. Record review of Resident #4's Quarterly MDS Assessment, dated 02/27/26, reflected the resident had a BIMS of 14 (intact cognitive response). The resident had active diagnosis of paralysis on the right side of body. Record review of Resident #4's Comprehensive Care Plan, dated 12/22/26, reflected the resident was a fall risk and an intervention was to ensure his call light was within her reach.During an observation on 03/31/26 at 9:10 a.m., Resident #4 was observed lying in bed and his call light was located on his nightstand, out of his reach.During an interview on 03/31/26 at 09:15 a.m., CNA J was informed by the Investigator of Resident #1, #2, #3, and #4's call light being within their reach. She stated the call bell should be within reach of the Resident even if they are unable to use the call bell. She stated it is (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	the responsibility of everyone to make sure the call bell is within reach of all residents. She stated the risk of not having the call bell withing reach could be the resident having accidents and falls. During an interview on 03/31/26 at 09:20 a.m., LVN P was informed by the Investigator of Resident #1, #2, #3, and #4's call light being within their reach. She stated the call bell should always be within reach of the resident, she stated everyone is responsible to check during their rounds to make sure that the call bells are within reach. She stated the risk of not having the call bell within reach could be avoidable injuries and residents needs not being met timely.During an interview on 03/31/26 at 09:25 a.m., the DON was informed by the Investigator of Resident #1, #2, #3, and #4's call light not within their reach. She stated the call bell should always be within reach of the residents and that all staff were responsible for making sure they were reachable. She stated the risk of not having the call bell within reach could be delayed care or possible fall.Record review of the facility's policy titled, Call Light/Bell, dated 05/2020, revealed, It is the policy of this facility to provide the resident a means of communication with nursing staff. 5. Leave the resident comfortable. Place the call device within resident's reach before leaving room. If the call light/bell is defective, immediately report this information to the unit supervisor.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for seven of twelve Resident rooms (room [ROOM NUMBER], #2, #3, #4, #5, #6, and #7), and two of four halls (300 and 400) observed for cleanliness. The facility failed to ensure Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, and #7 on the 300 and 400 halls were thoroughly cleaned and sanitized.The facility failed to ensure the handrails on the 300 and 400 halls were thoroughly cleaned and sanitized.These failures could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life.Findings included:During an observation on 03/31/26 at 12:05 p.m., a portion of the handrail on the 300 hall reflected a piece of tissue with a red and brownish substance on it wedged between the rails. During an observation on 03/31/26 at 12:05 p.m., room [ROOM NUMBER] reflected the bathroom floor had brownish and grayish stains in the corners of the floor, around the toilet, and under the sink. During an observation on 03/31/26 at 12:05 p.m., room [ROOM NUMBER] reflected the bathroom floor had grayish stains in the corners of the floor, and around the toilet. Further observation reflected the air conditioning unit vents had black grime between the vents. During an observation on 03/31/26 at 12:09 p.m., room [ROOM NUMBER] reflected the bathroom floor had brownish stains in the corners of the floor, and around the toilet. A section of the wall near the entrance of the room and near a trash can had brownish stains. The air conditioning unit filters had thick dust. A container for disposing needles in the room had used dirty gloves on top of it. During an observation on 03/31/26 at 12:11 p.m., room [ROOM NUMBER] reflected the bathroom floor had brownish stains in the corners of the floor, and around the toilet. The air conditioning unit vents had black dirt between the vents. A container for disposing needles in the room used dirty gloves on top of it. During an observation on 03/31/26 at 12:11 p.m., room [ROOM NUMBER] reflected the room floor had built up dirt near a closet door and edges of the floor. The floor near a bed had brownish stains near a fall mat and closet door. The air conditioning unit vents had black dirt between the vents. During an observation on 03/31/26 at 12:17 p.m., a portion of the handrail on the 400 hall reflected a pieces of candy wrappers, gum, clear plastic materials, and large pieces of paper wedged between the rails.During an observation on 03/31/26 at 12:20 p.m., room [ROOM NUMBER] reflected the room floor had built up dirt in the corners of the door frame and edges of the floor. The bathroom floor had dark stains along the edges of the floor, in the corners, and around the toilet. A container for disposing needles in the room had used disposable gloves and pieces of trash sitting on top of it. During an observation on 03/31/26 at 12:22 p.m., room [ROOM NUMBER] reflected the bathroom floor had dark stains along the edges of the floor, in the corners, and stains around the toilet. The shower floor had grayish stains all over the floor. The room floor had dark stains near the walls. During an interview on 03/31/26 at 12:42 p.m., the Administrator was informed of the concern observed in Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, and #7, and the handrails on the 300 and 400 halls. She stated they had housekeeping performed 7 days a week and cleaning in the morning and evening. She stated the expected housekeeping to thoroughly clean the resident rooms and the facility areas because this was their home.During an interview on 03/31/26 at 2:06 p.m., Housekeeper H stated he was at the facility for four months. He stated he cleaned the 300 and 400 halls. He stated he was responsible for cleaning the entire rooms and the bathrooms. He stated he was responsible for sweeping and mopping the floors and wiping down the handrails in the hall. He stated they wipe the rails down at least once a week. He was informed by the Surveyor of the concerns observed in Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, and #7, and the handrails on the 300 and 400 halls. He stated the concerns observed were a health hazard to the residents.During an interview on 03/31/26 at 2:06 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p.m., the Housekeeping Supervisor was informed by the Surveyor of the concerns observed in Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, and #7, and the handrails on the 300 and 400 halls. He stated housekeeping and floor technician cleaned the hallways and floors. He stated housekeeping and floor techs were responsible for cleaning the handrails. He stated Housekeeping was responsible for cleaning the entire room, including the floor, bathroom, and air condition unit. He stated he would in-service the staff on proper cleaning. He stated not thoroughly cleaning the rooms and handrails could cause an infection.Record review of the facility's policy titled, Resident Rights, dated 11/2021, revealed, The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

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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** Based on observation, interview, and record review, the facility failed to ensure that residents' environment remained free of accident hazards as was possible for 1 of 23 residents (Resident #9) reviewed for hazards. The facility failed to ensure Resident #9 did not have a can disinfectant spray and a bottle of hand cleaner spray in his room on 03/31/26. This failure could prevent the residents from having an environment that was free from hazards.Findings included: During a Record review of Resident #9's Face Sheet, dated 03/31/26, revealed an [AGE] year-old male, admitted [DATE]. Resident #9 had a diagnosis of Dementia (a progressive loss of memory, reasoning and communication skills). During a Record review of Resident #9's MDS Assessment, dated 03/10/26, revealed the resident's BIMS was 7, which indicated severe cognitive impairment. The MDS Assessment reflected the resident had an active diagnosis of Dementia. During an observation on 03/31/26 at 10:45 a.m., Resident #9 was sitting in his wheelchair, a can of disinfectant spray and hand sanitizer spray was observed on the chest of drawers in his room on 03/31/26. During an interview on 03/31/26 at 11:25 a.m., Med Tech F, she stated aerosol should not be in the residents' room, she stated confused residents could get a hold of it and spray it or even ingest it. She stated some might choke due to the smell or have an allergic reaction. During an interview on 03/31/26 at 12:35 p.m., LVN A stated that disinfectant sprays should not be kept in the resident room, everyone was responsible for checking and making sure hazardous items were removed from resident rooms as they make rounds. She stated having hazardous sprays in the room can pose a risk for cognitively impaired residents who could get a hold of it and spray it and inhaling it could make them sick or cause an allergic reaction. During an interview on 03/31/26 at 2:50 p.m., the DON that stated disinfectant sprays should not be in residents' room, anything that says keep out of reach of children should not be in resident room. She stated the risk of having aerosol sprays in residents' rooms could result in poisoning if a resident with respiratory issues gets a hold of it. She stated that all staff are responsible for making sure such sprays are not in room. She stated they provide education to residents if they bring such items into the facility.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 3 of 5 residents (Resident #5, #6 and #7) of five residents reviewed for respiratory care. The facility failed to ensure Resident #5's Nasal cannula connected to the oxygen concentrator and Nebulizer mask connected to the nebulizer machine were properly stored on 03/31/2026. The facility failed to ensure Resident #6's nasal cannula connected to the oxygen concentrator was properly stored and oxygen humidifier bottle left on nightstand was 1/4 full, cracked and dated 03/15/26 on 03/31/2026. The facility failed to ensure Resident #7's nasal cannula connected to the oxygen concentrator and Nebulizer mask connected to the nebulizer machine were properly stored on 03/31/2026. These failures could place the residents at risk of respiratory infection and not having their respiratory needs met.Findings included: During a Record review on 03/31/26 of Resident #5's Face Sheet, dated 03/31/26, revealed a [AGE] year-old male admitted on [DATE]. The resident was diagnosed with COPD (a progressive, long-term lung disease that makes it hard to breathe). During a Record review on 03/31/26 of Resident #5's Physician Order, dated 07/16/25 revealed orders for, change tubing, clean filter, change O2 water bottle and nebulizer kit (set of tools used with a nebulizer machine to turn liquid medicine into a fine mist (aerosol) that is inhaled directly into the lungs)weekly every night shift every Saturday. During an observation on 03/31/2026 at 9:01 a.m., Resident #5 was in his bed, awake. It was observed there was a nasal cannula connected to the oxygen concentrator and nebulizer mask connected to the nebulizer machine were not bagged or labeled with a date. During a Record review on 03/31/26 of Resident #6's Face Sheet, dated 03/31/26, revealed a [AGE] year-old female admitted [DATE]. The resident was diagnosed with asthma (lungs become swollen and narrowed making it hard to breathe). During a Record review on 03/31/26 of Resident #6's Physician Order, dated 07/16/25, revealed orders for, change tubing, clean filter and change O2 water bottle weekly every night shift every Saturday. During an observation on 03/31/2026 at 9:05 a.m., Resident #6 was in his bed, awake, nasal cannula connected to the oxygen concentrator was not bagged or labeled and oxygen humidifier bottle (a small plastic bottle attached to an oxygen concentrator or tank that adds moisture to the dry, therapeutic oxygen before it is inhaled)left on nightstand was 1/4 full, cracked and dated 03/15/26. During a Record review on 03/31/26 of Resident #7's Face Sheet, dated 03/31/26, revealed a [AGE] year-old female admitted [DATE]. The resident was diagnosed with COPD (a progressive, long-term lung disease that makes it hard to breathe). During a Record review on 03/31/26 of Resident #7's Physician Order, dated 02/17/25 revealed orders for, change tubing, clean filter, change O2 water bottle and Nebulizer Kit weekly every night shift every Saturday. During a Record Review on 03/31/26 of physicians order dated 06/22/25 revealed orders for, after nebulizer treatment, obtain and record pulse, O2 Sat, Tx minutes post med lung sounds (Lung sounds before medications are given). During an observation on 03/31/2026 at 9:01 a.m., Resident #7 was in his bed, awake. It was observed that there was a nasal cannula connected to the oxygen concentrator and nebulizer mask connected to the nebulizer machine were not bagged or labeled with a date. During an interview on 03/31/26 at 9:15 a.m., CNA J stated the oxygen tubing/and nebulizer mask should be always bagged when not in use, she stated she notifies the nurse if she notices any nebulizer mask or Oxygen tubing that is not bagged and dated. She stated the risk of not having the oxygen tube and nebulizer mask bagged could result in infection to the resident. During an interview on 03/31/26 at 9:40 a.m., LVN P stated the oxygen tube/nebulizer mask should always be bagged and dated, she stated they changed the bags once weekly and as needed if soiled. She stated the nurse was responsible for making sure they were bagged and dated, but the CNA reported to the nurse if she noticed they were not. She stated it was important to have them bagged to prevent bacterial (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infection. She stated the humidifier bottles were changed every 2-3 days or when empty During an interview on 03/31/26 at 9:53 a.m., DON stated the oxygen tube/nebulizer mask should always be bagged when not in use and the bags are changed and dated weekly or as needed if soiled, humidifier bottles are changed weekly or as needed. She stated the risk of not having the bags changed and dated could be an infection control issue, sepsis (when the immuned systems stops fighting infection and begins damaging it's own organs) hospitalization and life-threatening conditions. During a Record review on 03/31/26 of the facility's Infection Prevention and Control Program policy and procedure, dated 06.2021 and revised 05.2025 revealed: The infection prevention and control program is a facility-wide effort involving all disciplines and individualsand is an integral part of the quality assurance and performance improvement program. Goalsˆ Decrease the risk of infection to residents and personnel.ˆ Recognize infection control practices while providing care.ˆ Identify and correct problems relating to infection control.ˆ Ensure compliance with state and federal regulations related to infection controlˆ Promote individual resident's rights and well-being while trying to prevent and control the spread ofinfection.ˆ Monitor personnel health and safety.

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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** Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 10 of 10 residents (Residents #8, #9, #10, #11, #12, #13, #14, #15, #16, and #17) reviewed for pharmacy services. 1. The Facility failed to administered Residents #8, #9, #10, #11, #12, #13, #14, #15, #16, and #17's medications greater than one hour after the scheduled administration time. 2. The Facility failed to check Resident #10's blood pressure before dispensing medication for administered. 3.The Facility failed to keep Med pass nutritional supplement refrigerated or on ice before serving as directed by manufacture and facility protocol. 4.The facility failed to date 12 out of 14 insulin vials on 100, 200 and 400 Halls. This deficient practice residents on the 100 and 200 Hall at risk for receiving less than therapeutic benefits from medications.Findings included: During a Record Review of Resident #8's face sheet on [DATE] reflected a [AGE] year old male admitted on [DATE] with diagnoses of Type 2 Diabetes (high blood sugar). During a Record review on [DATE] of Resident #8's physicians order, dated [DATE], reflected an order for Metformin HCL tablet 500 mg, give 1 tablet by mouth two times a day for blood sugar control. During a Record review of Resident #9's face sheet on [DATE], dated [DATE], reflected an [AGE] year-old male admitted on [DATE] with diagnoses of Dementia (A progressive loss of memory, reasoning and communication skills), Type 2 Diabetes Mellitus, end stage renal disease (final permanent stage of kidney failure), Hypertension (high blood pressure) During a Record review on [DATE] of Resident #9's active physicians' orders as of[DATE], reflected active order as of [DATE] for Carvedilol tablet 3.125 mg, give 1 tablet by mouth 2 times a day, Eliquis oral tablet 2.5 mg, give one tablet two times a day, Sevelamer HCL oral tablet 800 mg, give 2 tablets by mouth with meals. During a Record review on [DATE] of Resident #10's face sheet, dated [DATE] reflected a [AGE] year-old female admitted on [DATE] with diagnoses of Type 2 Diabetes, Seizures (uncontrolled surge of electric activity in the brain that disrupts normal brain function), Hypertension, Hypothyroidism (low thyroid hormone). During a Record review of Resident #10's active physicians' orders as of [DATE] reflected active orders as for Amlodipine besylate tablet 10 mg, give 1 tablet daily for hypertension, Levetiracetam oral tablet 750 mg 2 times daily for seizures, levothyroxine sodium tablet 100 MCG daily for low thyroid. During a record Review of Resident #11's face sheet dated [DATE] reflected a [AGE] year-old male admitted on [DATE] with diagnoses of Heart Failure (when heart is too stiff to pump blood), Hypertension. During a record Review of Resident #11's active physicians' orders as of [DATE], reflected active order for Eliquis oral tablet 2.5 mg 2 times daily, Furosemide 40 MG tablet 1 time daily, Hydralazine tablet 10 MG give 3 times daily, metoprolol 25 MG tablet 2 times daily. During a record Review of Resident #12's face sheet, dated [DATE], reflected a [AGE] year-old female admitted on [DATE] with diagnoses of Schizophrenia (severe brain disorder that causes people to interpret reality abnormally), Bipolar (condition where depressive episodes alternate with periods of abnormally high energy or mania), Hypothyroidism. During a Record review of Resident #12's active physicians orders as of [DATE] reflected active order for Levothyroxine 25 MCG 1 tablet in the morning for hypothyroidism, Olanzapine tablet 5 MG 2 times daily for Bipolar and schizoaffective disorder. During a record Review of Resident #13's face sheet dated [DATE] reflected an [AGE] year-old female admitted on [DATE] with diagnoses of hypertension. During a Review of Resident #13's active physicians' orders as of [DATE], reflected active order for Carvedilol tablet 25 MG, give 1 tablet by mouth 2 times a day, hydralazine tablet 25 MG 3 times daily, Gabapentin oral capsules 300 MG 3 times daily. During a record Review of Resident #14's face sheet dated [DATE] reflected a [AGE] year-old male admitted on [DATE] with diagnoses of: hypertension, Dementia. During a record Review of Resident #14's active physicians' orders as of [DATE], reflected (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	active order for Benazepril HCL oral tablet 40 MG, 1 tablet by mouth daily for hypertension. During a record Review of Resident #15's face sheet dated [DATE] reflected a [AGE] year-old female admitted on [DATE] with diagnosis of hypertension and dementia. During a record Review of Resident #15's active physicians' orders as of [DATE] reflected active order for Memantine 10 MG tablet 2 times daily, Nifedipine ER osmotic release tablet 60 MG in the morning, Quetiapine Fumarate 25 MG tablet 2 times daily. During a record Review of Resident #16's face sheet dated [DATE] reflected a [AGE] year-old female admitted on [DATE] with diagnoses of Dementia, Pain in unspecified shoulder. During a record Review of Resident #16's active physicians' orders as of [DATE] reflected active order for Baclofen 10 MG and 5 MG tablets 2 times daily for muscle relaxant, Gabapentin tablet 400 MG every 8 hours for Neuropathy, Galantamine Hydrobromide tablet 8 MG 2 times daily for Dementia, Lidoderm patch 5%, apply to left shoulder topically in the morning, may wear for 12 hours and remove per schedule, Metoprolol Tartrate 25 MG 2 times daily. During a record Review of Resident #17's face sheet dated [DATE] reflected a [AGE] year-old female admitted on [DATE] with diagnoses of Congestive Heart Failure, Hypertension. Review of Resident #17's active physicians orders as of [DATE] reflected active order for Carvedilol 12.5 MG tablet 2 times daily, Hydralazine 100 MG tablet 3 times daily, Isosorbide Dinitrate 20 MG tablet 3 times daily, Furosemide 80 MG tablet daily for Congestive heart Failure. During an Observation on [DATE] at 10:15 am to 11:14 a.m. revealed Med Tech F was not done passing morning medications on Hallway 100 and 200, which were scheduled for 8:00 a.m. and 9:00 a.m. During an interview on [DATE] at 11:25 a.m., Med Tech F stated the med pass (Liquid nutritional supplement) should be refrigerated as the direction on the container states to prevent bacterial growth. She stated the risk of not serving the Med pass as directed could cause bacterial infection which could cause diarrhea to residents who received it. She stated the meds should be given as scheduled or one hour before or after schedule. She stated giving the meds in time preserves the window of effectiveness to remain active in the residents' body. She stated the risk of not giving the medications on time could make the medication not work as it was supposed to; she stated with antibiotics it could cause antibiotic resistance if not given when it was scheduled. She stated that any medication that directs blood pressure should be checked first before dispensing medication into cup. She stated the risk of dispensing the medication before checking blood pressure before dispensing medication could result in an overdose and would be difficult to take out the medication If there are several medications that look alike. She stated if the blood pressure is low and medications are given; it could drop the residents' blood pressure and lead to hospitalization. In an interview on [DATE] at 12:35 p.m., LVN A stated the Med pass supplement should be on ice as the direction stated, if not refrigerated or put on ice it could go bad since it is a milk-based product. She stated that if it goes bad giving it to any resident could make them sick and even cause diarrhea or other gastrointestinal issues. She stated that meds should be given for the times it was ordered for or not more than one hour before or after the ordered time. She stated it is important to give meds at ordered times to maintain the effectiveness of the medication. The risk of not giving the medication on time could result in doses being given too close together and may cause toxicity, overdose, especially for pain pills or medications like digoxin. She stated that for all medication with blood pressure check parameters, the blood pressure should be checked first before medication wasdispensed into cup. She stated it could be difficult to remove the medication if there are medications that look alike and can result in an overdose or not giving the right medication if they forget to remove the pill if the blood pressure is low. She stated that all insulin vials should be dated with the date of first use and discarded after 28-30 days. She stated that the risk of not dating when it is first opened for use can result in not knowing when to discard the vial. She stated that expired insulin could lose its effectiveness and cause the residents receiving it to not have proper control of their blood sugars and can lead to high blood sugars and even hospitalization. In an interview on [DATE] at 2:20 pm with LVN B, he stated the facility policy is that insulin vials should be dated when they are opened and discarded after 30 days. He stated all the nurses in each hall are responsible for (continued on next page)

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	03/31/2026

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	making sure the insulin vials are dated. He stated that if the vials are not dated and are used if they are open for over 30 days, it could become ineffective or even cause a reaction if expired. In an interview on [DATE] at 2:50 PM with DON, she stated the med pass on ice should be on Ice during med pass or refrigerated before it is administered. Not having it on Ice or refrigerated could cause it to go bad and could make the resident who receive it sick with issues like nausea vomiting. She stated each nurse or CMA was responsible for making sure they put the Med pass on ice as part of their setup for medication administration. She stated the medication administration window was hour before or after, of the ordered time on physicians' orders. She stated that the ADON monitors to make sure meds are given on time.She stated the risk of not giving medications at scheduled times could cause interaction with order meds, and other possible adverse effects. She stated Insulin should be dated, some have a discard date of 14 days or 28 days after opening. She stated that nurses are responsible to date the vial when they open them. She stated that if they are not dated, the expiration date will be unknown. She stated that expired insulin loses its potency. She stated the risk of giving expired insulin could result in adverse effects like Hyperglycemia (too much sugar in the blood) or Hypoglycemia (very little sugar in the blood). During a record review of the facilities medication administration policy and procedures Policy Number 7C on [DATE] it revealed: POLICY: It is the policy of this Facility, medication shall be administered as prescribed by the resident's physician, nurse practitioner, or physician's assistant. PROCEDURE:1. Only licensed medical and nursing personnel or other lawfully authorized staff members may prepare, administer, and record medication administration.2. Medications must be given in accordance with the resident's service plan.3. Medications must be administered in accordance with the written orders of the attending physician.4. All current drugs and dosage schedules must be recorded on the resident's medication administration record (MAR).5. Topical medications used in treatments should be recorded on the resident's medication administration record (MAR).6. Identification of the resident must be made prior to administering medication to the resident.7. Unless otherwise specified by the resident's attending physician, routine medications will be administered per the facility time ranges. This is to promote the continuance of a home- like environment for our residents.8. The nurse or medication technician administering the medication must record such information on the resident's MAR before administering the next resident's medication.9. When PRN medications are administered, the nurse or medication technician must record the date and time administered, and later the results achieved from the PRN medication as appropriate.10. 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.11. Prior to administering the resident's medication, the nurse or medication technician should compare the drug and dosage schedule on the resident's MAR with the drug label. NOTE: If there is any reason to question the dosage or the schedule, the nurse or med tech should check the physician's orders.12. An adequate supply of disposable containers (e.g., cups, straws, etc.) should be available at all times.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to 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 1 of 10 residents (Resident #9) reviewed medication administration, and for residents residing on two of four halls (Hall 100 and 200) reviewed for infection control The facility failed to ensure personal items were not stored on the medication carts located on the 100 and 200 halls on 03/31/2026.The facility failed to have staff sanitize hands after going from dirty to clean task before donning clean gloves and entered the resident room to administer medication. These failures could place residents at risk for infection. Findings included: During an interview and observation on 03/31/26 at 8:55 a.m., Medication Technician F was observed with a personal water bottle on top of the medication cart on 200 hall. She stated it was her personal water bottle, and she had brought it out to drink some water and she did not have time to put it up. She stated she could not have the water bottle on top of the medication cart because it was an infection control concern. During an observation on 03/31/26 at 9:04 a.m., the medication cart on the 100- hall had a personal water bottle sitting on top of the medication cart. During an interview on 03/31/26 at 09:10 a.m., LVN A stated she was passing out medication on 100 hall and the personal water bottle on the medication cart was hers. She stated she was thirsty and needed a drink of water. LVN A was observed sitting at the nurses' station during the interview and not at the medication cart. She stated they were not allowed to have personal items on the medication cart because it was an infection control concern. During an interview on 03/31/26 at 09:30 a.m., the Administrator and Corporate Nurse J were informed by the Surveyor of Medication Technician F and LVN A having personal items (water bottles) on top of the medication carts on the 100 and 200 halls. Corporate Nurse J stated staff were not to have any personal items on top of the medication carts because of infection control.During an interview on 03/31/26 at 10:10 a.m., the DON was informed by the Surveyor of Medication Technician F and LVN A having personal items (water bottles) on top of the medication carts on the 100 and 200 halls. The DON stated the nursing staff were not to have any personal items on top of the medication carts because of contamination.During a Record review of Resident #9's Face Sheet, dated 03/31/26, revealed an [AGE] year-old male, admitted [DATE]. Resident #9 had a diagnosis of dementia (a progressive loss of memory, reasoning and communication skills). During a Record review of Resident #9's MDS Assessment, dated 03/10/26, revealed the resident's BIMS was 7, which indicated severe cognitive impairment. The MDS Assessment reflected the resident had an active diagnosis of Dementia.During a Record review of Resident #9's care plan on 03/31/26, dated 12/03/25, revealed the resident was at risk of infection related to dialysis access with intervention of Enhanced Barrier Precaution during the provision of close contact care.During a Record review of Resident #9's physician orders on 03/31/26, dated 12/03/25, revealed, enhanced barrier precaution: PPE required for high resident contact care activities. Indication: Dialysis Access every shift for monitoring.During an observation on 03/31/26 at 10:30 am, Med Tech F picked her keys up from the floor after sanitizing her hands, she failed to sanitize her hand again before donning (putting on) clean gloves and entered Resident #9's room to administer medication.During an interview on 03/31/26 at 11:25 a.m., Med Tech F stated it was required she sanitized her hands whenever she touched a dirty surface or before each resident care and when she changed gloves. She stated the risk of not sanitizing her hands could cause bacteria to spread from resident to resident. She stated this could make them sick, cause a decline in health or even unnecessary hospitalization.During an interview on 03/31/26 at 12:35 p.m., LVN A stated hands should be sanitized between each resident and after performing a dirty task and between glove changes. She stated that sanitizing hands was a part of infection control. She stated the risk of not sanitizing hands could cause a spread of infection to residents, unnecessary antibiotic use or even (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hospitalization.During an interview on 03/31/26 at 2:50 p.m., DON stated sanitizing hands before putting on gloves and after taking them off or going from dirty to clean task was required per infection control policy to prevent spread on infection to the residents being served. She stated the risk of not performing hand hygiene could spread germs and make the residents sick.During a Document review on 03/31/26 of the facility's Infection Prevention and Control Program policy and procedure dated 06.2021 Revision/Review Date(s): 6.2021; 1.2022; 10.2022; 05.2025 revealed: The infection prevention and control program is a facility-wide effort involving all disciplines and individualsand is an integral part of the quality assurance and performance improvement program.Goals Decrease the risk of infection to residents and personnel. Recognize infection control practices while providing care. Identify and correct problems relating to infection control. Ensure compliance with state and federal regulations related to infection control Promote individual resident's rights and well-being while trying to prevent and control the spread ofinfection. Monitor personnel health and safety3. The facility personnel will conduct themselves and provide care in a way that minimizes the spreadof infection.a. Facility personnel with a communicable disease or infected skin lesion will not directly contactresidents or their food, if direct contact could transmit the disease; andb. Facility personnel will wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.c. Validation of the personnel infection prevention and control practices are monitored by theinfection preventionist through skills competency evaluation such as observation of handhygiene.