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	04/14/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain medical records on each resident that are complete; accurately documented; readily accessible; and systemically organized in accordance with accepted professional standards for 1 of 3 residents (Resident #1) reviewed for clinical records regarding wound care.The facility failed to ensure nursing staff documented that physician ordered wound care was provided to Resident #1 for 2 pressure ulcers on 03/03/26, 03/06/26, 03/07/26, 03/08/26, 03/09/26, 03/10/26, 03/11/26, 03/31/26, 04/01/26, 04/03/26, 04/06/26, 04/07/26, and 04/11/26.This failure could place residents at risk for incomplete and inaccurately documented medical records that included their progress treatment, services, and interventions.Findings included: Record review of Resident #1's Face Sheet, dated 04/14/26, reflected that the resident was a [AGE] year-old female who admitted to the facility on [DATE].Record review of Resident #1's MDS dated [DATE] reflected that the resident had the following diagnoses: Chronic Pulmonary Edema (Gradual buildup of fluid in the lungs), COPD (Ongoing lung condition caused by damage to the lungs), need for assistance with personal care, and pressure ulcer of sacral region. The MDS reflected that Resident #1 had a BIMS of 7 , indicating severe cognitive impairment and was incontinent of bowel and bladder. The MDS further reflected that the resident was at risk of developing pressure ulcers/injuries. Record review of Resident #1's Care plan, revised 01/26/26, reflected the resident was admitted to hospice services on 01/19/26. The care plan reflected that the resident admitted with a stage 4 (wound with full-thickness skin loss, exposing underlying muscle, tendon, or bone) pressure wound to coccyx (tailbone) and a stage 4 pressure wound to the left sacrum (bone at the base of the spine), with interventions to provide wound care per physician orders. Record review of Resident #1's physician orders, dated 04/14/26, reflected the following: .Wound care stage 4 pressure ulcer to the coccyx: Cleanse, apply calcium alginate [a highly absorbent, biodegradable fiber commonly used as a specialized wound dressing that aides in healing chronic or heavily draining wounds] daily cover with a dry dressing. Once time a day for wound care. Stage 4 pressure wound of the left sacrum, cleanse with normal saline [an isotonic solution that does not interfere with normal wound repair], pat dry, apply calcium alginate daily and as needed if saturate, soiled, or dislodge one time a day for wound care.Record review of Resident #1's March and April 2026 Wound Administration Record reflected that there was no documentation showing that the resident was provided with wound care for both pressure ulcers on 03/03/26, 03/06/26, 03/07/26, 03/08/26, 03/09/26, 03/10/26, 03/11/26, 03/31/26, 04/01/26, 04/03/26, 04/06/26, 04/07/26, and 04/11/26. Record review of Resident #1's wound care report by the Wound Care Physician for March and April 2026 reflected the resident was being seen and treated weekly with no evidence the wound deteriorated.During an interview and observation on 04/14/26 at 11:10 AM, Resident #1's Hospice Nurse stated she was at the facility to perform wound care on Resident #1. She stated Resident #1's RP called her on 04/13/26 to report that Resident #1's pressure ulcers did not have any bandages on them. The Hospice Nurse stated the facility staff should be performing wound care daily according to the order. She stated she was coming to do the wound care once or twice a week but stopped due to (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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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility not doing it in between her visits. She stated she would visit the resident, and it would still be the same wound bandage from the previous week. She stated she was unable to confirm dates that it occurred. She stated when the wound care nurse was at the facility it started getting completed daily again. The Hospice Nurse stated she planned to start again due to inconsistent wound care since the wound care nurse no longer worked at the facility. Observed Resident #1's bandage to sacral area contained no date or initial with a small amount of circular drainage noted to bandage. The Hospice Nurse was observed to remove the old bandage, and 2 pressure wounds were observed. Both wounds were pink in color with intact periwound skin (tissue surrounding a wound). No signs or symptoms of infection observed. The Hospice Nurse stated the wounds have improved and were smaller with less drainage. During an interview on 04/14/26 at 12:43 PM, LVN A stated she was an agency nurse, and it was her first day working at the facility. She stated she was not doing any wound care today. LVN A stated she thought there was a wound care nurse that did that and it was not told to her during report. LVN A stated she would follow up with the supervisor. During an interview on 04/14/26 at 3:09 PM, Resident #1 revealed staff were not doing wound care for her on a regular basis. She stated the hospice nurse stopped doing the wound care because then the facility would not do it at all. Resident #1 stated she had not seen the wound care nurse recently and does not believe she worked at the facility any longer. Resident #1 stated her hospice nurse was going to start to do the wound care again because it had not been cared for daily. During an interview on 04/14/26 at 3:14 PM, Resident #1's RP revealed on 04/13/26 when he visited the facility, Resident #1 did not have any bandages on her wounds. He stated he was concerned about an infection because she was incontinent and stool could get into the wound. The RP stated a nurse did put on a dressing after he asked numerous times but was unable to recall what time or what nurse had performed the care. The RP stated he knew the wound care was not being performed daily because he watched the cameras. During an interview on 04/14/26 at 4:00 PM, LVN B revealed she worked as a wound care nurse at a sister facility but was helping to train the new wound care nurse. LVN B stated she had assisted with skin assessments but was not performing routine wound care. LVN B stated she was not aware when the previous wound care nurse left the facility. LVN B stated she thought the nurses that worked in the hallways were responsible for wound care. LVN B stated the facility was responsible for wound care, but the hospice nurse could assist. LVN B stated wound care should be charted in the wound administration record/TAR. She stated if there were blanks in the TAR and no progress notes, the wound care did not get done or was not charted. She stated failure to document could cause missed care and the wounds getting infected. During an interview on 04/14/26 at 5:03 PM, RN C stated she was covering for the DON while she was out. RN C stated the facility was responsible for wound care. She stated if there were blanks in the TAR then wound care did not get done or the staff did not sign it off. She stated the previous wound care nurse left in March of 2026. RN C stated the DON was covering for wound care but was currently on leave. RN C stated they were training a new wound care nurse, but that the floor nurses had been responsible for wound care. RN C stated they had been informing the agency nurses of the responsibility, and it was on the TAR. RN C stated the risk of not documenting the TAR could cause wound care to not get completed and the wounds worsening. During an interview on 04/14/26 at 5:23 PM, the Administrator stated if there were blanks in the TAR it was possible wound care did not get completed or was not documented. She stated the floor nurses were responsible for wound care. The Administrator stated the risk of not charting wound care was the care may not be completed. Record review of the facility's policy, Skin and Wound Monitoring and Management, revised 04/25 reflected the following: .Once an area of alteration in skin integrity has been identified, assessed, and documented, nursing shall administer treatment to each affected area as per the Physician's Order. Treatments per physician order, should be documented in the resident's clinical record at the time they are administered.