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	05/08/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan to include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for each resident for (Resident #1) of 6 residents reviewed for Comprehensive Care Plans. The facility failed to ensure Resident #1 had sufficient comprehensive care plan to reflect his negative pressure wound treatment device and monitoring care needs. This failure could place residents at risk of their needs not being met. Findings included: Review of Resident #1's re-admission MDS dated [DATE] revealed he was a [AGE] year-old male originally admitted to the facility on [DATE] from an acute care facility. Relevant diagnoses included paraplegia (decreased function of lower body,) cancer (cellular malfunction,) aplastic anemia (bone marrow dysfunction,) diabetes (glucose dysfunction,) osteomyelitis to vertebra, sacral, and sacrococcygeal (back and hip area) region (infection to the bone.) He was admitted with stage IV pressure ulcers of the sacral and coccyx (hip area) region. He was cognitively intact with a BIMS score of 14. No documentation of behaviors or rejection of care. Resident #1 required a wheelchair for mobility and substantial assistance from staff with toileting, shower/baths, and other personal hygiene care. Review of Resident #1's Provider Orders on 05/06/2026 at 2:30 PM revealed:Stage 4 Pressure Wound. Negative Pressure Wound Therapy apply three times a week continuous -125 mmhg. If NPWT is unavailable or malfunction cleanse wound with NS, pat dry and apply calcium alginate, cover with foam silicone dressing daily. ordered 03/24/2026 at 8:34 PM. Review of Resident #1's Comprehensive Care Plan, dated 02/27/2026, revealed: Focus: Stage 4 pressure injury to sacrum. initiated 04/10/2026. Goal: Management of Pressure Ulcer. Interventions/Tasks: [NPWT] to sacral pressure injury per orders. Provide wound care per treatment order. In interview with the Wound Care NP on 05/06/2026 at 1:04 PM revealed she applied Resident #1's NPWT device to his wounds and expected his comprehensive care plan to detail specific care concerns customized to the resident. She stated this could include specific care, monitoring, maintenance, and signs and symptoms to notify her in the event of a change of condition should be included in the care plan. She stated facility care plans were important to guide facility staff on Resident #1's individualized care needs. In interview with facility's nursing leadership representative, RN C, on 05/08/2026 at 10:20 AM she stated the facility's acting DON was currently on leave and the facility's ADON during 03/19/2026 was no longer employed at the facility. She stated that while Resident #1's NPWT was mentioned on his comprehensive care plan, the interventions were not sufficient and did not include care, monitoring, and care requirements customized for the resident's specific care needs. She stated that would have been the ADON's responsibility, but ultimately the DON's role to ensure completion and she was not available for interview. She further stated it's important for care plans to be centered to residents' care needs for safety and to ensure their goals can be met. In interview with the facility's Administrator on 05/08/2026 at 1:42 PM, she stated she expected Resident #1's care plan be personalized with specific care interventions for his care needs. She stated it was nursing leadership's responsibility to ensure that resident care plans (continued on next page)

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

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	05/08/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were completed to be centered to resident's individual care needs for safety reasons and to ensure their care goals can be met. Attempts to interview Resident #1 via telephone on 05/06/2026 at 1:12 PM and 05/08/2026 at 11:53 AM were unsuccessful; and he was no longer at the facility during the time of the investigation. Attempts to interview facility's DON (at the time of the incident) on 05/06/2026, 05/07/2026, and 05/08/2026 at approximately 11:30 AM were unsuccessful. Attempts to interview facility's ADON (at the time of the incident) 05/06/2026, 05/07/2026, and 05/08/2026 at approximately 11:45 AM were unsuccessful. Review of the facility's Counseling/Disciplinary Notice for ADON, dated 04/01/2026, revealed she was suspended due to lack of adequate and appropriate documentation. Review of facility's Termination Form for ADON, dated 04/14/2026, revealed she was terminated for failing to carry out general and/or specific instructions promptly or to perform job responsibilities. Review of Facility Policy Comprehensive Person-Centered Care Planning rev. 04/2026 revealed the facility shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. which includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care.

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	05/08/2026

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 - Few	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 interview and record review the facility failed to ensure and maintain medical records on each resident that are complete and accurately documented for 1 of 6 residents (Resident #1) reviewed for wound care. The facility failed to enter a verbal provider order for a Negative Pressure Wound Treatment device (NPWT) ordered during her rounds at the facility on 03/19/2026. Subsequently, no consistent documentation of care, monitoring, or treatment was documented on Resident #1's EMR between 03/19/2026 - 03/24/2026. This failure could affect residents that require a change in their treatments to ensure they receive accurate orders from providers which could lead to lack of care, infection, and not following provider orders.Findings Included: Review of Resident #1's re-admission MDS dated [DATE] revealed he was a [AGE] year-old male originally admitted to the facility on [DATE] from an acute care facility. Relevant diagnoses included paraplegia (decreased function of lower body,) cancer (cellular malfunction,) aplastic anemia (bone marrow dysfunction,) diabetes (glucose dysfunction,) osteomyelitis to vertebra, sacral, and sacrococcygeal (back and hip area) region (infection to the bone.) He was admitted with stage IV pressure ulcers of the sacral and coccyx (hip area) region. He was cognitively intact with a BIMS score of 14. No documentation of behaviors or rejection of care. Resident #1 required a wheelchair for mobility and substantial assistance from staff with toileting, shower/baths, and other personal hygiene care. Review of Resident #1's Provider Orders on 05/06/2026 at 2:30 PM revealed:Stage 4 Pressure Wound. Negative Pressure Wound Therapy apply three times a week continuous -125 mmhg. If NPWT is unavailable or malfunction cleanse wound with NS, pat dry and apply calcium alginate, cover with foam silicone dressing daily. ordered 03/24/2026 at 8:34 PM. Review of Resident #1's Comprehensive Care Plan, dated 02/27/2026, revealed: Focus: Stage 4 pressure injury to sacrum. initiated 04/10/2026Goal: Management of Pressure Ulcer Interventions/Tasks: [NPWT] to sacral pressure injury per orders. Provide wound care per treatment order. In interview with the Wound Care NP on 05/06/2026 at 1:04 PM revealed she rounded with the facility's ADON and provided her with a verbal order for a NPWT for Resident #1 on 03/19/2026. She then applied Resident #1's NPWT device to his sacrum and ischial area (hip) on 03/19/2026. She stated she expected the facility's ADON to have received the order and have entered it in Resident #1's EMR, and further implemented by the facility nursing staff. She stated during her rounds of Resident #1, the device was appropriately functioning and she had no reason to suspect the facility did not manage the device appropriately. She further stated that his decline in condition was more closely related to his co-morbidities in her professional opinion. She denied any suspicion of abuse or neglect related to Resident #1's care and NPWT device management. She stated it was important for provider orders to be entered in the EMR in a timely manner so their care can be documented accurately. In an interview with nursing staff in charge of Resident #1's care between 03/19/2026 - 03/24/2026, LPN F, she stated she recalled working with Resident #1, he had a NPWT device and it was functioning as expected during her shift working with him. She did not recall any concerns related to his care and did not recall why she did not document that in the EMR. She stated it was important to document in a resident's EMR accurately for safety reasons. In an interview with nursing staff in charge of Resident #1's care between 03/19/2026 - 03/24/2026, LPN A, she stated she recalled working with Resident #1, he had a NPWT device and it was functioning as expected during her shift working with him. She stated she did not recall any concerns related to his care and did not know why she did not document his device management in the EMR. She stated it was important to document any resident care in the EMR for safety reasons. Attempts to interview Resident #1 via telephone on 05/06/2026 at 1:12 PM and 05/08/2026 at 11:53 AM were unsuccessful; and he was no longer at the facility during the time of the investigation. In interview with the facility's nursing leadership representative, RN C, on 05/08/2026 at 10:20 AM she stated the facility's acting (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	05/08/2026

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 - Few	DON was currently on leave and the facility's ADON during the time of this incident was no longer employed at the facility. Her expectations were for the ADON to input the provider's order and be completed, and for staff to provide the proper care needed to the residents as stated in their provider orders. She further stated she was not sure why it was not completed at the time, but based on her understanding assessment, care, treatment, and monitoring of the device was completed by the nursing staff during the days in question. She stated it was important orders were put in a timely manner to ensure the best care was provided for the residents. She stated the ADON was suspended pending investigation and then later terminated based on the findings due to her lack of urgency to put in the provider order. She stated this would have been the ADON's responsibility, but ultimately the DON's role to ensure completion and she was not available for interview. She stated in response to the incident she completed a facility-wide audit on documentation with her nursing staff between 04/15/2026 - 05/04/2026 to ensure all residents' documentation was completed to facility policy. Additionally, she stated she conducted skills checkoffs for the nurses related to wound care and device management; and nursing staff in-services related to accurate documentation. In interview with the facility's Administrator on 05/08/2026 on 1:42 PM revealed her understanding was the ADON rounded with the Wound Care NP and received a verbal order for Resident #1's NPWT but did not put in the order until 03/24/2026. She stated sufficient assessment, care, treatment, and monitoring of the device was completed by the nursing staff but she was not sure why the ADON did not put in the order in a timely manner. She stated this did not meet her expectations and a full investigation of her conduct was conducted, the ADON was suspended pending investigation and was later terminated as a result of the findings including the delay in documentation. She stated it was important her nursing staff enter provider orders in a timely manner to ensure the best care can be provided for her residents. Attempts to interview facility's DON (at the time of the incident) on 05/06/2026, 05/07/2026, and 05/08/2026 at approximately 11:30 AM were unsuccessful. Attempts to interview facility's ADON (at the time of the incident) 05/06/2026, 05/07/2026, and 05/08/2026 at approximately 11:45 AM were unsuccessful. Review of facility's Ad Hoc QAPI meeting revealed on 04/14/2026, RN C led a meeting reviewing the incident with facility's Administrator, Executive Director, and Medical Director in attendance. Review of facility wide audit documentation, dated between 04/15/2026 - 05/04/2026 revealed documentation that the charge nurse on that shift reviewed each resident's MAR/TAR and was signed off by the supervisor on that shift. Review of facility In-Service Training Report Medication Administration Documentation, dated 04/14/2026 revealed facility nursing staff training conducted by Clinical Resource Nurse detailing facility policy, procedures, and expectations related to Medication/Treatment Administration Documentation. Nursing staff. are expected to order/reorder medications in a timely manner. When you receive an order from a provider, please update the order to be given from the provider it was received. Review of facility's Counseling/Disciplinary Notice for the ADON, dated 04/01/2026, revealed she was suspended due to lack of adequate and appropriate documentation. Review of facility's Termination Form for the ADON, dated 04/14/2026, revealed she was terminated for failing to carry out general and/or specific instructions promptly or to perform job responsibilities. Review of Facility Policy Physician Services rev. 05/2025 revealed 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. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include the date and time of the order. Orders for medications must include: Name and strength of the drug; Quantity or specific duration of therapy; Dosage and frequency of administration; Route of administration if other than oral; and Reason or problem for which given.