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	06/03/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary treatment and services, based on the comprehensive assessment and consistent with professional standards of practice, to prevent development of pressure injuries for 2 of 8 residents reviewed for pressure injuries. (Residents #2 and #4) The Facility failed to ensure that Resident #2 buttocks and sacral were covered with dressing as ordered on 06/02/26. The facility failed to ensure that an order for wound care was in place for Resident #2 who had a non-pressure ulcer to the left buttocks and sacrum (triangular area at base of spine). The facility failed to ensure that Resident #4's sacral wound was covered with dressing as ordered on 06/03/26. These failure can place the residents at risk for worsening or pressure and non-pressure injuries and could result in a decline in health. Findings included: 1.Record review of Resident #2's face sheet dated 06/02/26 revealed a [AGE] year-old male admitted to the facility initially on 03/27/26 with the following diagnoses: protein calorie malnutrition (a serious condition caused by not eating or absorbing enough calories and protein, leading to severe weight loss, muscle wasting, and weakness), and muscle wasting and atrophy (the wasting or loss of muscle tissue, which causes the muscles to shrink and weaken), Record review of Resident #2's MDS dated [DATE] revealed that the resident that stage 4 pressure ulcer which was present on admission and was coded for risk of developing pressure ulcers/injuries. Record review of Resident #2's care plan dated 03/27/26 revealed the resident has potential for pressure ulcer development related to immobility incontinence of bowel and blader and listed MASD to left buttocks with the following interventions: Daily body checks, monitor nutritional status, weekly head to toe skin at risk assessment, notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration noted during bath or daily care. * Record review of Resident #2's TAR dated for May 2026 revealed an order dated 04/23/26 for: non-pressure left buttock: cleanse area with normal saline or wound cleanser. apply hydrogel and a dry dressing. every day shift, that was discontinued on 05/20/26. No new orders were recorded for continued wound care for the present wound Record review of Resident #2's TAR for June 2026 did not reveal any orders for the wound care to the non-pressure ulcer of the left buttock. Record Review of Resident #2's progress note dated 05/07/26 revealed #009: Skin issue has been evaluated. Location: Buttocks - generalized. Laterality / Orientation: Left. Issue type: Other skin issue. Other skin issue description: Non Pressure Wound Partial Thickness Progress: Improving: overall wound characteristics improved. Wound was present on admission. Length (cm): 4 Width (cm): 4.7 Depth (cm): 0.2 Undermining: No. Tunneling: No. Skin Issue: #010: Skin issue has not been evaluated. Location: Buttocks - generalized. Laterality / Orientation: Circumferential. Issue type: Pressure ulcer / injury (localized damage to the skin and/or underlying soft tissue usually over a bony prominence). Wound was present on admission. It is unknown how long the wound has been present Record review or Resident #2's progress noted dated 05/20/26 revealed Issue: #003: Skin issue is resolved. Location: Buttocks - generalized. Laterality / Orientation: Circumferential. Issue type: Pressure ulcer / injury. Progress: Resolved: Wound healed and / or closed. Wound was present on admission. It is unknown how long the wound has been present. Length (cm): 0 Width (cm): 0 Depth (cm): 0 Undermining: No. Tunneling: No. Epithelial: 100%. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Peri wound: Epithelialization. Frequency of treatment. Wound care Observation on 06/02/26 at 12:53 P.M, revealed Resident #2 had no wound dressing in place for the wound on his left buttocks and sacrum (Skin issue #009). No sign and symptom of infection noted. Interview on 06/02/26 at 1:15 P.M RN J stated that the dressing must have come off during care by the CNA. She stated that the expectation was that if the CNA observes a wound without dressing or that wound dressing needs to be changed while performing incontinent care, they need to notify the nurse right away. She stated due to the Resident #2 and #4 being incontinent the wound must be covered at all times to prevent the wound from getting infected. She stated that it was expected that all wound care must be ordered by the Resident physician, she stated that having an order and following it is important for the wound to heal. She stated that if there was no order, the wound care could be inconsistent and missed, wound could get worse and systemic infection possibly. She stated that she and the nursing staff are responsible for making sure there was an order for all wound care provided. She stated she updated the order with the wound care provider to make sure the wound care was consistent. Interview on 06/02/26 at 1:20 P.M. CNA S stated that if the wound dressing was soiled or not in place, she would inform the nurse to come put a new dressing on. She stated that not having the wound dressing in place could cause fecal matter to get in the wound and cause an infection and make the wound not heal. Record review of Resident #4's MDS dated [DATE] revealed that the resident that stage 4 pressure ulcer was present on admission and was coded for risk of developing pressure ulcers/injuries. MDS revealed the a BIMS of 7 (indicates severe cognitive impairment) and Resident is always incontinent of bowel. Record review of Resident #4's care plan dated 04/09/26 revealed the resident Has stage 4 pressure ulcer to sacrum andpotential for pressure ulcer development r/t impaired mobility, impaired sensation, with the following interventions: Administer treatments as ordered and monitor for effectiveness. Record Review of Resident #4's physicians' orders dated 05/21/26 revealed: pressure injury stage 4: cleanse withwound cleanser, pat dry, apply collagen to wound bed, followed by alginate, and cover with dry dsg. change daily and prn soilage/dislodgement every day shift. Record review of Resident #4's face sheet dated 06/02/26 revealed a [AGE] year-old female admitted to the facility initially on 04/09/26 with the following diagnoses: Pressure ulcer of sacral region stage 4 (full thickness skin and tissue loss), muscle wasting, and weakness), muscle wasting and atrophy (the wasting or loss of muscle tissue, which causes the muscles to shrink and weaken) Wound care observation on 06/03/26 at 1:23 P.M. revealed Resident #4 had no wound dressing to the stage 4 pressure ulcer on her sacral area. Interview on 06/03/26 at 2:56 P.M. NP M stated wound care orders need to be followed, she stated that when new residents are admitted the facility sends new consultation for her to evaluate the resident and they should also be reporting any worsening of wounds to her for further evaluation. She stated she is satisfied with wound care by wound nurse. She stated the standard is there should always be an order for any wound care provided to any resident in the facility. She stated sometimes with Residents going in and out of the hospital, we need to keep up with any new orders. She stated the orders for Resident #2's wound care orders were in her notes and expected to be put in the resident's treatment orders, she stated she is not sure why it was not in place. She stated that the wound care orders for Resident #2 were accidentally discontinued on 05/20/26 and have now been reinstated on 06/02/26.She stated that not having a wound order could result in wound care not being done, which could result in the wound getting infected and not healing. She stated that the CNA's will be educated to notify the wound nurse if wound dressings need to be changed during care. Interview on 06/02/26 at 3:50 P.M with DON. She stated that the wound dressing should always be in place, she stated the CNA's are responsible to report to the nurse if a dressing was dislodged. The nurses are ultimately responsible for making sure the wound dressing was in place. She stated the wound care nurse was responsible to transcribe the wound care orders into the resident's medical record. She stated that if there was no order the dressing change would not be done. She stated that if there was no order and the dressing was not done it will lead to a deterioration in the wound condition. Review of the facility's Policy and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedure for quality for Skin and Wound monitoring and management dated 03.2015 Revision/Review Date(s) 12.2019; 1.2022; 12.2023; 4.2025. revealed: It is the policy of this facility that:.2. A resident having pressure injury(s) receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing.i. 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.j. Treatments per physician order, should be documented in the resident's clinical record at the time they are administered.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident receiving enteral feeding received appropriate care and services to prevent complication of enteral feeding for 2 out of 8 residents (Resident #2 and #3) reviewed for enteral feeding. The facility failed to ensure that Resident #3 was provided with her G-Tube (a medical device inserted through the abdominal wall directly into the stomach. It provides a direct route to deliver nutrition (fluids) feeding on 06/02/26 as ordered by her physician. The facility failed to ensure that Resident #2 had continuous feeding via G-Tube from 12:00 A.M to 10:00 P.M. as ordered on 06/02/26 as ordered by his physician. This failure could place 14 residents who had feeding tubes at risk for dehydration, weight loss, and/or metabolic abnormalities. Findings included: 1.Record review of Resident #3's face sheet dated 06/02/26 revealed a [AGE] year-old female admitted to the facility initially on 02/27/26 muscle wasting and atrophy, severe protein-calorie malnutrition, pressure ulcer of sacral region, stage 4. Record review of Resident #3's care plan dated 02/28/26 revealed the resident has a required tube feeding related to Dysphagia, Resident is non-compliant with NPO diet. Family brings in outside food. Intervention noted on care plan was: 1) Is dependent with tube feeding and water flushes. See MD orders for current feeding orders. 2) Encourage responsible parties to follow NPO diet status. Record review of Resident #3's physician order dated 05/21/26 revealed an order for: Jevity 1.5 cal at 60ml/hr between 6 :00 A.M.-6:00 P.M. flush 20ml/hr of h2o. up at 6PM DOWN AND 6AM. one time a day. Record review of Resident #3's progress note dated 05/29/26 revealed that Resident #3s alert and oriented x3, communicated verbally with clear speech and is able to understand and be understood when speaking. 2. Record review of Resident #2's face sheet dated 06/02/26 revealed a [AGE] year-old male admitted to the facility initially on 03/27/26 with the following diagnoses: protein calorie malnutrition (a serious condition caused by not eating or absorbing enough calories and protein, leading to severe weight loss, muscle wasting, and weakness), muscle wasting and atrophy (the wasting or loss of muscle tissue, which causes the muscles to shrink and weaken) Record review of Resident #2's MDS dated [DATE] revealed all his nutrition via a feeding tube. Record review of Resident #2's care plan dated 03/27/26 revealed the resident has potential nutritional problem r/t NPOstatus, dependence on tube feedings with intervention: Diet as ordered by the physician. Record review of Resident #2's physician order dated 04/23/26 revealed an order for: Enteral Feed Order every shift related toUnspecified Severe Protein-Calorie Malnutrition (E43) Formula: Jevity 1.5 At 40 Ml/Hr X 22 Hrs to Provide Cc/Cal./Day with H2o Free Water Flushes Of 200 Mls Q 4 Hrs. Feeding Pump to Run From 0000 TO 2200 (12:00 A.M. to 10:00 P.M.). During observation on 06/02/23 at 12:53 P.M. It was observed that Resident #2's feeding bag was empty while the feeding pump was still running at 40 ML/HR. During an interview and observation on 06/02/26 at 1:36 P.M it was noted that Resident #2's feeding bag was still empty. LVN M was notified. LVN M, stated that the CNA should let her know when the feeding was running low. She stated the Feeding should be continuous; she stated that it was his only means of nutrition. She stated if he does not get enough nutrition, he could lose weight. Could lead to skin breakdown and other health issues. She proceeded to change the feeding bag and turn on the pump. During an observation and interview on 06/02/26 at 12:11 P.M. with Resident #3. It was observed that her feeding bag dated 06/01/26 time 8:00 P.M was full and not connected to her Feeding tube. When asked if she receives feeding by G-Tube she stated yes and stated that it was supposed to be run last night but the nurse likely forgot. During an interview on 06/02/26 at 12:37 P.M. with RN M. She stated that the nurses are responsible for the feeding, that night shift gives the GT feeding to Resident #4. Facility policy was for the feeding to be given as ordered by the physician. If the feeding was not done as ordered, Resident will not get the amount of feeding to maintain her wellbeing. She stated as a nurse on the floor she should have noticed that the feeding was not done (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	last night and find out why it was not done and report to the DON. During an interview on 06/02/26 at 1;20 P.M. with CNA S. She stated that when she notices a Feeding bag empty or any issues with the feeding pump, she calls the nurse and does not touch it at all. She stated that it is important for residents to have their food since it's the only way for them to have their nutrition. She stated that if the feeding is not given as ordered, the resident could get malnourished and dehydrated and wounds would not heal. During an interview on 06/02/26 at 3:50 P.M. the DON stated the expectation was that the Tube feeding should be done as ordered and if an issue comes up why the feeding could not be done it should be documented. She stated that residents with continuous feeding should be monitored every 8-hour shift, check orders for the Tube feeding and carry out any task due during the shift. She stated that the nurses are responsible for the care provided and I am ultimately responsible for making sure of care given.She stated that Resident #3 refused the feeding during the shift, but it was not documented. She stated the risk of not following the orders for Tube feedings could be a risk for malnutrition.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 1 of 8 residents (Resident #1) reviewed for respiratory care. The facility failed to ensure Resident #1's Humidifier bottle was not empty when Oxygen concentrator was in use by Resident #1. The facility failed to ensure Resident #1's nasal cannula storage bag was changed weekly as ordered. These failures could place the residents at risk of respiratory infection and not having their respiratory needs met.Findings included: Record review of Resident #1's Face Sheet, dated 06/02/26, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Diagnosis included Shortness of Breath and Asthma (Lungs become swollen and Narrowed making it hard to breath) Record review of Resident #1's Quarterly MDS assessment, dated 04/01/26, revealed the resident was coded for oxygen therapy. MDS assessment indicated a BIMS of 7 (indicates severe cognitive impairment) Record review of Resident #1's active care plan dated 02/19/24 revealed the resident: Has Oxygen Therapy r/t shortness of breathsecondary to asthma with interventions to: provide oxygen per physician's orders. Record review of Resident #1's active physician's orders date 10/10/2025 revealed active orders for: O2 at 2-6l/min continuous &prn via Nasal Cannula to maintain O2 sats, may titrate to maintain Greater/equal to 90% every shift for SOB related to other asthma; shortness of breath. And change tubing, clean filter and change o2 water bottle weekly every night shifts every Saturday. During an observation and interview on 06/02/26 at 9:44 A.M., the humidified bottle connected to the oxygen concentrator was empty while it was in use by Resident #1 and the nasal canula storage bag was dated 04/25/26. The resident stated she was not aware if the bag should be changed or not. During an interview on 06/02/26 at 10:03 A.M. with LVN M. She stated she does not know the facility policy for oxygen management, but in general the bag and nasal canula should be changed every 7 days, since it's a part of infection control. Water bottle should be changed when empty or every 7 days. She stated that if the bag and nasal canula are not changed every 7 days it could cause infection to the residents and if the humidifier bottle is empty, it could cause dryness to the nostrils which can lead to discomfort. LVN M stated she will go ahead to change the bag and nasal canula and let the DON know. During an interview on 06/02/26 at 10:29 A.M. the DON stated that the Expectation was to have the bag and nasal canula (lightweight, flexible plastic tubing that hooks over the ears and features two small tips that sit inside the nostrils to deliver supplemental oxygen) changed every Saturday as ordered. She stated the evening nurse and ultimately, I will be responsible for doing that. She stated the humidifier bottle should be changed weekly or when it runs out of water. She stated changing the bag and nasal canula prevents risk of infection to the resident, the humidifier bottle should be changed when empty to prevent risk of irritation to the nostrils and changing weekly also prevents infection to the resident. Record review of the facility undated Oxygen equipment policy and procedures revealed: It is the policy of this facility to maintain all oxygen therapy equipment in a clean and sanitary manner and to use disposable pre-filled humidifiers, tubing, masks and cannulas for residents receiving oxygen. This equipment is to be discarded after use. The facility will maintain clean tanks, connectors and concentrators.PROCEDURES:1. Oxygen Tanks, Connectors and ConcentratorsOxygen tanks, connectors and concentrators must be cleaned after useOxygen masks, nasal cannulas, and tubing will be used for one resident only. When used continuously or intermittently, tubing will be routinely changed to prevent the build-up of respiratory secretions, mucous, and bacterial growth.When mask or cannula is temporarily not being used, it will be covered loosely to prevent contamination from airborne microorganisms. It will not be covered tightly.