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	03/12/2026

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care plans were developed with the resident and the resident's representative for 3 (Resident #3, Resident #7 and Resident #39) of 5 residents reviewed for comprehensive care plans. The facility failed to ensure that Resident #3, Resident #7 and Resident #39 or the resident's representative were invited to and participated in the resident's care plan meeting. This failure placed residents at risk for loss of independence, psychosocial well-being and the opportunity for them to participate in the planning of their care. Findings included: Record Review of Resident # 3's face sheet dated 03/11/2026 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included COPD (a progressive but treatable lung disease that causes chronic air flow blockage) bipolar disorder (a mental health condition characterized by intense alternating mood swings), type II diabetes (a condition where the body resists insulin), depression and pulmonary hypertension (high blood pressure in the arteries of the lungs). Record review of Resident #3's quarterly MDS dated [DATE] reflected a BIMS score of 7 indicating severe cognitive impairment. Resident #3 required supervision or touching assistance with toileting and personal hygiene and partial assistance with showering and dressing. She was able to express her needs. In an interview on 03/11/2026 at 3:04 p.m., Resident #3 revealed she had never been invited to a care plan meeting and did not know what the purpose of the meeting was. Record review of Resident #3's electronic record reflected her last documented care plan was 03/31/2025. Record review of Resident #7's face sheet dated 03/11/2026 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included traumatic brain injury (damage to the brain caused by an external physical force), post traumatic seizures (abnormal electrical brain events occurring after a traumatic brain injury), anemia (blood lacks enough healthy red blood cells), and mood disorder (a mental health condition characterized by long lasting disturbances in emotions). Record review of Resident #7's Quarterly MDS dated [DATE] reflected a BIMS score of 00 indicating the resident was unable to complete the interview. Resident #7 needed maximal assistance with toileting, showering, personal hygiene and dressing and moderate assistance with eating and oral hygiene. She was not able to express her needs. In an interview on 03/12/2026 at 3:12 p.m. with Resident #7's family member revealed she couldn't remember the last time she had been invited to a meeting, but it had been several months ago. Record review of Resident #7's electronic record reflected her last documented care plan was 11/06/2025. Record review of Resident #39's face sheet dated 03/11/2026 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Sickle Cell disease, (a group of inherited red blood cells disorders that cause red blood cells to become hard and sticky) schizophrenia (a severe mental disorder characterized by a breakdown in the relationship between thought, emotion and behavior) hypertension (high blood pressure) and ileostomy status (a surgically created opening in the abdomen that connects the last part of the small intestine to the outside of the body). Record review of Resident #39's quarterly MDS dated [DATE] reflected a BIMS score of 13 indicating she was cognitively intact. Resident #39 was independent with eating, oral hygiene and personal hygiene. She needed set-up help with upper body (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	03/12/2026

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dressing, supervision with showers and moderate assistance with toileting and lower body dressing. She was able to express her needs. In an interview on 03/11/2026 at 3:09 p.m. Resident # 39 revealed that it had possibly been around a year or so that she had her last care plan meeting. Record review of Resident #39's electronic record reflected her last documented care plan was 03/18/2025. In an interview on 03/11/2026 at 2:35 p.m. with the facility Social Worker revealed she had worked at the facility since June of 2025. She stated they have care plan meetings every Wednesday with the ADON, Activity Director, Dietary and Therapy to go over any concerns that the residents and/or family have. She looked up the dates in the electronic medical record of the last care plan meeting for Resident #3 and verified it was 03/31/2025, Resident #7's was 11/06/2025 and Resident # 39's was 03/18/2025. She stated the residents whose care plan meetings are scheduled for the week were documented in her journal but not in the electronic medical record. She stated they should be documented in the resident's medical record and that she must have missed those. She stated the risk to the residents is their concerns may not get addressed. In an interview on 03/11/2026 at 2:51 p.m. with the DON revealed the Social Worker sets up the weekly care plan meetings and her expectation is the meeting should be documented in the electronic medical record and completed on a weekly basis. The risk to the resident is they could have a change of condition that the IDT needed to be aware of. In an interview on 03/12/2026 at 2:56 p.m. with the Administrator revealed her expectation is the care plans should be documented in the medical record as that is the official record. The risk to the resident is there would be no communication regarding care or concerns. Review of the facility's policy/procedure for Care and Treatment/Care planning revealed the following, The MDS Coordinator, Social Services or designee staff will notify the resident, family and/or responsible party, and other interested parties designated by the resident, of the date and time of the care plan conference prior to the meeting. The resident's plan of care is reviewed and revised on an ongoing basis, quarterly at a minimum and/or as needed with changes in condition.

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	03/12/2026

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, based on the comprehensive assessment of a resident, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #45) of three residents reviewed for quality of care. The facility failed to ensure skin integrity changes were documented for Resident #45. This failure placed residents at risk for skin integrity changes occurring with no monitoring in place. Findings included: Record review of Resident #45's quarterly MDS Assessment, dated 01/14/26, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. The resident's cognitive skills for daily decision making were severely impaired. The resident's diagnoses included traumatic brain dysfunction, quadriplegia (inability to move arms and legs), and seizure disorder. Record review of Resident #45's Comprehensive Care Plan, dated 11/19/25, reflected:Potential for impaired skin integrity as evidenced by Braden Scale for predicting pressure ulcer risk.Facility interventions included:Pressure relieving device in place as needed for at risk areas and repositioning. Resident had an air mattress. Record review of Resident #45's clinical records for March 2026 did not reflect documentation for a skin assessment or an assessment of green bruises on Resident #45. Additionally, there was no documentation that reflected the resident had any injury after a fall. An observation and interview on 03/11/26 at 12:15 PM revealed Resident #45 was lying in bed. He was awake and alert and said he was, okay when asked. LVN B was in the room. The resident's arms and hands were contracted. He had faded, extensive bruising on his left upper arm and left forearm. He had the same color bruises on the top of his right hand. The resident could not say how he got the bruises. LVN B said she did not know how he got the bruises. LVN B said Resident #45 liked to sleep against the rail of the bed. An interview on 03/11/26 at 12:43 PM, CNA D stated he was new to the facility and 03/11/26 was the first time he had been assigned to care for Resident #45. CNA D said he did not pay attention to the bruises because they looked old. He said usually he reported bruises to the nurse, but Resident #45's bruises looked old. CNA D said he did not suspect abuse and would notify the Abuse Coordinator if he did. An interview on 03/11/26 at 12:55 PM, Resident #45's family member stated the resident had a camera in his room. The family member said she did not see anything happen to the resident other than a fall from his bed on 03/03/26. The family member said the resident fell on his left side and required two staff to put him in bed and that the bruises might have developed after the fall. Interviews on 03/11/25 at 1:45 PM and 2:00 PM, the DON stated Resident #45 had IV attempts on 02/16/26 and was sent to the hospital for the IV placement. The DON said she had a shower sheet that showed where a CNA had documented the bruises on Resident #45's arm. The DON provided a nurse note dated 02/20/26 that showed the resident had a yellow bruise on his left forearm. No documentation was provided by the DON regarding the current bruises. An email received from the Administrator on 03/11/26 at 2:31 PM revealed Resident #45 left the facility frequently for appointments/hospital visits. An interview on 03/11/26 at 4:30 PM, the ADON stated if staff observed bruises or injuries on a resident, they were supposed to document the issue and notify the physician. The ADON said failure to document assessments of injuries could lead to worsening skin issues. An interview on 03/12/26 at 2:11 PM, DON stated skin assessments were supposed to be completed on admission, every seven days, and as needed. She said skin assessments were supposed to be completed by the charge nurses, and the DON did not know why Resident #45 did not have a skin assessment for March 2026. The DON said nurse management was responsible for ensuring skin assessments were completed. The DON said failure to complete skin assessments could lead to worsening skin integrity. The DON said all staff were responsible for assessing residents and identifying skin issues. She said nurse management was responsible for ensuring resident skin issues were assessed and documented. Record review of the facility policy, Skin and Wound Management, (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	03/12/2026

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	revised April 2025, reflected: . A licensed nurse will assess/evaluate each pressure injury and/or non-pressure injury that exists on the resident. This assessment/evaluation should align with the scope of practice and include but not be limited to:1) Measuring the skin injury2) Staging the skin injury (when the cause is pressure)3) Describing the nature of the injury (e.g., pressure, stasis, surgical incision)4) Describing the location of the skin alteration5) Describing the characteristics of the skin alterationg. Ongoing Skin and Wound Assessments: A licensed nurse will assess/evaluate a resident's skin at least weekly.Areas of breakdown, excoriation, or discoloration, or other unusual findings (either initially identified at the time of admission or as new findings) must be documented in the nursing notes or on the appropriate weekly assessment form. (Skin Pressure Ulcer Weekly, Skin Ulcer Non-Pressure Weekly, or Skin Evaluation - PRN/Weekly)A licensed nurse will assess/evaluate at least weekly each area of alteration/injury, whether present on admission or developed after admission, which exists on the resident. This assessment/evaluation should include but not be limited to:1) Measuring the skin injury2) Staging the skin injury (when the cause is pressure)3) Describing the nature of the injury (e.g., pressure, stasis, surgical incision)4) Describing the location of the skin alteration5) Describing the characteristics of the skin alteration6) Describing the progress with healing, and any barriers to healing which may exist7) Identifying any possible complications or signs/symptoms consistent with the possibility of infection.

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	03/12/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **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 who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for one (Resident #2) of three residents reviewed for Foley catheters. The facility failed to ensure LVN A performed catheter care for Resident #2 per facility policy. This failure placed residents with Foley catheters at increased risk of infection.Findings included: Record review of Resident #2's admission MDS Assessment, dated 12/27/25, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. The resident had a BIMS score of 15 indicating the resident's cognition was intact. The resident had diagnoses including obstructive uropathy (blockage in the urinary system that impedes the normal flow of urine) and urinary tract infection. The resident had an indwelling catheter. Record review of Resident #2's Comprehensive Care Plan, dated 01/05/26, reflected:The resident had an indwelling catheter.Facility Interventions included:Position catheter bag and tubing below the level of the bladderChange catheter bag and tubing as ordered.Has indwelling catheter, provide catheter care every shift and asneeded.Monitor and document intake and output as per facility policy.Monitor/record/report to physician for signs and symptoms for UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns.Secure catheter to facilitate flow of urine, prevent kinking of tubing, and accidental removal. An observation and interview on 03/11/26 at 3:15 PM with LVN A revealed she was preparing to perform catheter care for Resident #2. Resident #2 was awake and alert. He said he did not have any problems with his catheter. LVN A performed hand hygiene, put on gloves, and picked up the catheter just below the insertion site. The penis and insertion site had a dry, crusty, yellow drainage. LVN A and cleaned down the catheter a few inches, 5 different times. LVN A did not clean the penis or insertion site where the catheter extended from. LVN A completed care and said she was finished with catheter care. LVN A was asked by the State Surveyor if she was going to clean the penis and insertion site and LVN A said, No. LVN A said she did not clean the penis or insertion site unless she was performing incontinence care. She said there was no risk to the resident because the penis would be cleaned during incontinence care. An interview on 03/11/26 at 4:24 PM with the ADON revealed catheter care for Resident #2 required the staff to clean the penis, insertion site and extend a few inches down the tubing. The ADON said she did not know if LVN A had been checked off on catheter care and did not know when the last time an in-service was completed for catheter care. The ADON said failure to perform catheter care which included cleaning the penis and insertion site could lead to infection and UTIs. The ADON said Resident #2 did not have a UTI. Interviews on 03/12/26 at 11:00 AM with the DON revealed she did not have any check-offs for catheter care for LVN A and did not have any in-services for catheter care completed. The DON said Resident #2 was at increased risk for infection if catheter care was not completed correctly. She said nurse management was responsible for assessing staff catheter care. She said she thought that catheter care assessments were completed a couple of months after she started employment in March 2025. Record review of the facility policy, Indwelling Urinary Catheter Care, revised April 2025, reflected: .9. Moisten the washcloth and apply soap to the washcloth or using moistened disposable wipes, clean the catheter in a downward motion (front to back) beginning at the urinary meatus (insertion point) and at least 4 inches down (from resident toward the collection bag). Use a clean portion of the washcloth or fresh disposable wipe for one cleansing motion.10. Repeat the procedure without soap to rinse as needed.11. Dry the resident perineal area with a clean cloth.

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	03/12/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for the facility's only kitchen. The facility failed to ensure food items in the facility's walk-in refrigerator were labeled and dated. These failures could affect residents who received their meals from the facility's only kitchen by placing them at risk for food-borne illness, and food contamination.Findings included: Observation on 03/10/2026 at 9:40 a.m. in the walk-in refrigerator revealed a package of hamburger patties and a container of brown gravy was not labeled and a package of chicken legs was not labeled or dated. In an interview on 03/11/2026 at 11:05 a.m., [NAME] C revealed that all items should be labeled and dated and that someone probably got in a hurry and forgot. She stated the risk to the residents is the food could get mixed up with something else or it could be expired. In an interview on 03/12/2026 at 10:02 a.m. the Dietician stated it was her expectation that everything be labeled and dated. The risk to the residents is that they could be served the wrong thing or they could have an allergic reaction. In an interview of 03/12/2026 at 2:15 p.m. the Administrator stated she expected all items to be labeled and dated, and the risk to the residents would be the safety of the food. Review of the facility Infection Control Policy Food Service/Procedure dated, Revised 10/2022 revealed the following, Leftovers must be dated, labeled, covered, cooled and stored (within 1/2 hour) in a refrigerator, not at room temperature. Texas Chapter 228 Retail Food establishments adopts the US FDA food Code.3-302.11 Packaged and Unpackaged Food -Separation, Packaging, and Segregation.(A)FOOD shall be protected from cross contamination by: (4)Except as specified under Subparagraph 3-501.15(B)(2) and in (B) of this section, storing the FOOD in packages, covered containers, or wrappings; 3-302.12 Food Storage Containers, Identified with Common Name of Food.Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shallbe identified with the common name of the FOOD. 3-602.11 Food Labels.(A)FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 -Food labeling, and 9 CFR 317 Labeling, marking devices, and containers.