

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676135	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER Presbyterian Village North Special Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 8600 Skyline Dr Dallas, TX 75243	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35747</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision and assistive devices to prevent accidents for one of six residents (Resident #1) reviewed for accidents and supervision.</p> <p>CNA A failed to transfer Resident #1 in accordance with her care plan and facility protocol when she independently transferred Resident #1 via mechanical lift (a mechanical device used to safely transfer individuals with limited mobility, typically those who are unable to bear weight or have difficulty moving independently, from one place to another, such as a bed, chair, or wheelchair). As a result, Resident #1 fell from the mechanical lift and sustained a head laceration that required staples.</p> <p>The noncompliance was identified as past noncompliance (PNC). The Immediate Jeopardy (IJ) began on 02/21/25 and ended on 03/04/25. The facility had corrected the noncompliance before the investigation began.</p> <p>This failure could place residents at risk for serious accidents/injuries and/or death.</p> <p>Findings included:</p> <p>Review of Resident #1's Face Sheet, dated 03/12/25, reflected she was an [AGE] year-old female, who admitted to the facility on [DATE], with diagnoses including dementia in other diseases classified elsewhere (dementia is a general term for a decline in mental ability severe enough to interfere with daily life, encompassing memory loss, thinking, and behavioral changes), age-related physical disability (impairments in physical function that become more common with advancing age, often due to conditions like arthritis, hearing loss, or decreased mobility), and muscle weakness (a condition where muscles are unable to contract or move as easily as they used to, potentially due to various underlying causes).</p> <p>Review of Resident #1's MDS Assessment, dated 02/06/25, reflected she had moderate cognitive impairment. Resident #1 was identified as needing staff assistance for transfers.</p> <p>Review of Resident #1's Care Plan, dated 05/02/24, reflected she required the use of a mechanical lift for transfers, with two staff members to assist in the transfer.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the facility's Incident Report, dated 02/21/25, reflected LVN B was called to Resident #1's room. When she arrived, she noted Resident #1 was lying on the floor and bleeding from her head. LVN B immediately called 911 for assistance. It was noted that CNA A reported Resident #1 slid out of the mechanical lift sling as she was being transferred. Resident #1's family, physician, and HHSC were notified of the incident. The mechanical lift was inspected with no noted issues to the mechanical lift or the sling.</p> <p>Review of the facility's Provider Investigation Report, dated 02/21/25, reflected on 02/21/25 at around 11:00AM, CNA A attempted to independently transfer Resident #1 from her wheelchair and into her bed via mechanical lift. While Resident #1 was in a lifted position, she slid out of the mechanical sling. Resident #1 fell to the ground and sustained a head laceration. LVN B was called to the room, and upon seeing Resident #1's condition, immediately called 911 for assistance. Resident #1 was sent to the hospital for further evaluation and treatment, and she returned to the facility that same day with staples to her head. CNA A was suspended pending the outcome of the investigation. She admitted ly knew that two staff members were required when transferring residents via mechanical lift. Facility staff were in-serviced on mechanical lift transfer protocols; staff completed mechanical lift competency checks. CNA A was also in-serviced on mechanical lift transfer protocols and completed a competency check prior to returning to work. In addition, she received a final written warning for unsatisfactory conduct.</p> <p>Observation of Resident #1 on 03/12/25 at 11:40AM revealed she was clean, well-groomed, and appropriately dressed. She was free from any odors. There were no concerning marks or bruises noted on her person. The area of her head in which she previously sustained a laceration as a result of falling during a mechanical lift transfer had healed. Resident #1 displayed no obvious signs or symptoms of distress.</p> <p>During an interview with Resident #1 on 03/12/25 at 11:40AM, she stated she previously sustained an injury to her head when she was being transferred out of bed by facility staff. She was unable to recall any additional details to the incident. She denied any current presence of pain. She stated she believed two staff members were always present when they transferred her via mechanical lift.</p> <p>During an interview with CNA A on 03/12/25 at 12:44PM, she stated on the day of the incident (02/21/25), Resident #1's family member asked for Resident #1 to be transferred from her bed and into her wheelchair. CNA A stated she felt as though she was being rushed by Resident #1's family member, so she decided to transfer Resident #1 by herself via mechanical lift. CNA A stated she did not ask any other staff members to assist her, because she thought the other staff members were busy providing care for other residents. CNA A stated during the transfer, while Resident #1 was seated in the mechanical sling and was in a lifted position, she fell out of the sling and hit her head. CNA A stated Resident #1 sustained a laceration to her head. She immediately called for help, and LVN B promptly came to provide assistance and assess Resident #1. CNA A stated she had been in-serviced on mechanical lift transfers prior to the incident occurring, and she knew she needed two staff members to complete the mechanical lift transfer safely. CNA A stated she received a final written warning as a result of the incident. She also received additional in-servicing with competency checks on mechanical lift transfers, and she continued to participate in random competency checks conducted by upper management. CNA A stated the risk of transferring a resident without the recommended/required number of staff was that residents could be injured.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview with LVN B on 03/12/25 at 11:57AM, she stated on the day of the incident (02/21/25), CNA A yelled for assistance from Resident #1's room. LVN B stated when she arrived to Resident #1's room, she noted Resident #1 to be on the floor, bleeding from her head. LVN B immediately called 911 for further assistance. EMS arrived and transferred Resident #1 to the hospital for further evaluation and treatment. LVN B stated CNA A conducted an improper transfer for Resident #1, in which CNA A transferred Resident #1 independently via a mechanical lift transfer. LVN B stated mechanical lift transfers required at least two staff members to help ensure resident safety. She stated CNA A never asked for assistance with the transfer, prior to transferring Resident #1.</p> <p>During an interview with the Administrator on 03/12/25 at 12:21PM, she stated on 02/21/25, she was notified that Resident #1 fell while being transferred via mechanical lift by CNA A, who attempted to transfer Resident #1 without the assistance of any other staff. Resident #1 sustained a head laceration, so she was sent to the hospital for further evaluation and treatment. CNA A admitted to transferring Resident #1 independently and said she felt as though she was being rushed by Resident #1's family member. CNA A was suspended pending the outcome of the investigation. CNA A was able to return to work upon being in-serviced on mechanical lift protocol. All other direct care staff were in-serviced on mechanical lift protocol, as well. The Administrator stated there had been no additional incidents since that time. She stated the facility was monitoring for compliance by completing random mechanical lift competency checks with staff members. The Administrator stated the risk of transferring a resident without the recommended/required number of staff was that residents and/or staff could be injured.</p> <p>The surveyor attempted to contact Resident #1's family member on 03/12/25 at 4:44PM. The telephone call was not returned prior to exit.</p> <p>Review of the manual for the mechanical lift used in the incident involving Resident #1 was requested; however, the Director of Nursing stated the facility did not have access to the manual.</p> <p>Review of the facility's Lifting Machine, Using a Mechanical policy, dated 07/2017, reflected, .The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device . and .At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift .</p> <p>This noncompliance was identified as past noncompliance (PNC). The noncompliance began on 02/21/25 and ended on 03/04/25. The facility had corrected the noncompliance before the investigation began. The facility took the following actions to correct the non-compliance:</p> <p>Review of in-service records, dated 02/21/25, reflected direct care staff were in-serviced on mechanical transfer protocols.</p> <p>Review of Manual Lift Competency Assessments, dated from 02/21/25 to 02/28/25, reflected facility staff were screened for competency in using mechanical lifts. Facility staff were documented to have demonstrated competency in this area via return demonstration.</p> <p>Review of a Final Warning document, dated 03/04/25, reflected CNA A received a final written warning for unsatisfactory conduct, related to transferring Resident #1 via mechanical lift without having another staff member present to assist.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Verification of these actions by the HHSC surveyor included:</p> <p>Observations of three separate mechanical lift transfers for Resident #1 (conducted by CNA E and CNA F), Resident #2 (conducted by CNA C and CNA D), and Resident #3 (conducted by CNA A and CNA E) on 03/12/25 from 11:20AM to 1:15PM revealed the mechanical lift transfers were completed without incident. Facility staff were observed to follow the facility's policies and procedures related to mechanical lift transfers.</p> <p>During interviews with multiple sampled residents (Resident #2, Resident #4, and Resident #5) on 3/12/25 from 11:30AM to 2:40PM, they each reported they required transfers via mechanical lift. Each of these residents reported two staff members were always present and assisted during the mechanical lift transfers. These residents all denied any incidents and/or injuries had occurred as a result of the mechanical lift transfers.</p> <p>During interviews with multiple staff members (CNA A, LVN B, CNA C, CNA D, CNA E, CNA F, and LVN G) on 03/12/25 from 11:40AM to 2:40PM, they each reported being in-serviced on the facility's mechanical lift transfer protocol. These staff members were able to explain, in detail, how to complete a mechanical lift transfer (including the requirement of having at least two staff members present) per the facility's written policies and procedures. These staff members reported they had completed return demonstration competency checks to check for understanding.</p> <p>The Administrator was informed the of the past noncompliance at the Immediate Jeopardy level on 03/26/25 at 3:27PM.</p>		