STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676135	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Village North Special Care Ctr	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 3 residents (Resident #147), reviewed for pharmaceutical services. MA A failed to dispose of Resident #147's used Fentanyl Transdermal Patch, 12 micrograms/hour (applied to the skin to treat moderate to severe chronic pain around the clock. Fentanyl is extremely potent. 2 to 3 milligrams of this drug can lead to death due to decreased breathing which can quickly lead to coma and death.) per facility policy. This failure could place residents at risk for obtaining Fentanyl patches out of the trash and overdosing on them. Findings included: Record review of Resident #147's face sheet, dated 06/20/25, reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included colon cancer and a Stage IV pressure ulcer. Record review of Resident #147's June 2025 Physician Orders reflected, 06/14/25 Fentanyl Transdermal Patch, 72 Hour use (replace patch every 72 hours), 12 micrograms/hour. Record review of Resident #147's Care Plans, dated 06/06/25, reflected: Pain Facility interventions included: Administer pain medication as ordered. An observation on 06/18/25 at 9:00 AM of Medication Pass with MA A revealed she removed Resident #147's used Fentanyl patch, dated 06/14/25, and threw it in the trash. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 06/18/25 at 9:24 AM with MA A revealed she said she was supposed to throw used Fentanyl patches in the trash. She said she did not know if she was trained to do anything else. An interview on 06/19/25 at 1:19 PM with RN B revealed she was the nurse assigned to Resident #147. She said the MA was supposed to obtain a nurse witness and place the used Fentanyl Patch in the drug buster solution kept in the medication room. RN B said she asked MA A about the used patch, and she said she disposed of it with another nurse in the drug buster solution. Interviews on 06/18/25 at 2:17 PM and 06/19/25 at 3:09 PM with the DON revealed used Fentanyl patches were not supposed to be thrown in the trash, because someone could pull it out of the trash and use it. The DON said the MA was supposed to get a nurse witness and place the used Fentanyl patch in the drug buster solution. The DON said in-services were completed with staff in the past, unknown date, but currently they did not have anyone assigned to oversee and monitor the process for Fentanyl destruction. An interview on 06/19/25 at 1:42 PM with LVN C and ADON D revealed they showed MA A the process to destroy and Fentanyl patch and they destoryed it with her. A follow-up interview on 06/19/25 at 2:10 PM with MA A revealed following the Surveyor's observation and interview with her; she removed the used Fentanyl patch from the trash. She said she took it to LVN C and ADON D to find out what to do with it. She said LVN C and ADON D showed her the process and the used Fentanyl patch was disposed of in the drug buster solution. A record review of the facility policy, Fentanyl Disposal Instruction, not dated, reflected: Upon removal of a Fentanyl Patch, a CMA or Licensed nurse are required to take the patch to another licensed staff member to witness placement in a bottle of RX Destroyer and co-sign for removal and destruction. No exceptions!

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to provide coffee that was palatable to meet the needs of each resident for 2 of 2 residents (Resident #187 and confidential resident), reviewed for Dining services. The facility did not serve beverages that was palatable. Resident #187 and an anonymous resident said the coffee tasted bad. This failure could place residents who drank beverages from the kitchen at risk of a diminished quality of life. Findings included: Observation on 6/18/25, at 1:30pm of a test tray consisted of Salisbury steak and gravy, au gratin potatoes, capri blend vegetables, wheat dinner roll, lemon bar, and a cup of coffee. Surveyor said the coffee did not taste good and tasted bitter. Interview on 6/17/2025 at 11:30am with Resident #187 said the coffee was lousy and too strong. Resident #187 said the coffee does not taste good. Resident revealed for a couple of months the coffee has tasted bad. Interview on 6/17/2025 at 11:45am with anonymous resident stated wanted to remain confidential. Resident stated the coffee was bad and did not like the coffee. Residents revealed they told staff. Resident revealed the coffe had tasted bad for a couple of months. Interview on 06/19/25 at 12:04 PM with the Dietitian Consultant revealed the duties include to monitor kitchen & kitchen sanitation. The Dietitian Consultant revealed one resident this week told her they did not like the coffee. The Dietician Consultant said the coffee dispenser was changed out within last six months. The Dietitian Consultant revealed there was not a negative nutritional outcome. The Dietitian Consultant revealed if the resident did not like the coffee the resident would likely switch to tea or some other drink. Interview on 06/19/25 at 2:15 PM with the Dietary Manager revealed awareness of some residents not liking the coffee. The Dietary Manager revealed within the last year the facility began using a new coffee machine. The Dietary Manager revealed the coffee was the same brand of coffee used in the prior coffee dispenser. The Dietary Manager revealed residents not having satisfaction with the coffee could affect the resident by not being able to enjoy the coffee and residents would not feel happy . Record Review of the past three months of grievances and resident council did not show any discussion of liking or disliking the coffee. Record Review of the Dining Services revealed no policy on resident satisfaction of the food or beverages.