

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 07/02/2025
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment for 1 of 5 facility shower room and hallway (MU) were reviewed for environment. 1. The facility failed to ensure shower chairs and shower curtains were thoroughly cleaned and stored away from Memory care residents, staff, and visitors. 2. The facility failed to discard used water bottles located on shower chair on the memory unit. These failures could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life. An observation on 07/02/2025 at 12:06 PM the facility hydration cart was left open unattended with the ice exposed and the metal scoop. After waiting for approximately 4 minutes, CNA-M was observed coming out of a resident's room [ROOM NUMBER] minutes later.</p> <p>An observation on 07/02/2025 at 12:39 PM of the memory unit, revealed 3 shower chairs shower chairs, stored in the hallway outside of the shower room where staff, residents, and visitors ambulated. Shower chair #1 was observed with light brown smear stains and shower chair #3 was observed with 1 large industrial size shower curtain and an empty 16.9-ounce clear water bottle. Another observation revealed an unattended housekeeping cart with used mop water and trash assessable to residents on the memory unit.</p> <p>In an interview on 07/02/2025 at 12:45 PM, LVN-B was advised about the 3 shower chairs located in the hallway with a large shower curtain tossed across the chair and an empty water bottle. LVN-B said that the chairs were stored in the hallway, due to recent construction on the shower room. She stated that facility staff have not used the shower on the unit for approximately 2 weeks. LVN-B-said there are residents that ambulate independently on the unit. LVN-B said the staff are sanitizing and cleaning the shower chairs before and after use, despite the stain on the chair. LVN-B said she had not reported the stains on the shower chair to leadership for cleaning or replacing. She stated housekeeping and the nursing staff were responsible for ensuring the residents environment was safe, clean, and sanitary as well as free of hazards. LVN-B did not provide a response when questioned about the potential risks to residents and visitors associated with storing large equipment in the hallway.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/02/2025 at 3:45 PM, the DON stated the shower room on the unit was under construction, however, the shower chairs, shower curtain should be stored in a safe location to prevent hazards for those walking through the hallway. The curtain observed tossed across the shower chair and empty water bottle placed with it was considered to be easy access for resident that ambulate and infection from cross contamination. The DON said the shower chairs, shower curtain, and housekeeping cart had been moved to a storage room on the unit away from residents and visitors, therefore, eliminating hazards. The DON said she was not made aware of the shower chair that was stained and would follow up with the ADMIN.</p> <p>In an interview on 07/02/2025 at 4:05 PM the ADMIN stated staff were responsible for cleaning shower chairs, discarding trash, ensuring the hallways were clear for passage. She stated she expected the nursing staff to follow the protocol for keeping the environment safe and clean, free of barriers that could lead to injuries, and sanitary hydrating carts.</p> <p>On 07/02/25 12:45 PM the policy for a safe, clean sanitary, homelike environment was requested from the ADM. The facility did not provide policy for environment prior to exit.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident who needed respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 2 of 5 residents (Residents #21 and #33) reviewed for respiratory care. 1. The facility failed to change and date Residents #21, bag nasal Cannula and CPAP mask when not in use and date and change oxygen and nasal cannula tubing and humidifier bottle every week.2. The facility failed to bag and date Residents #33's bag and date CPAP mask when not in use to prevent infection prevention. These failures could place residents at risk for respiratory infections.</p> <p>Record review of Resident # 21's face sheet dated 07/02/2025 reflected she was an [AGE] year-old female admitted on [DATE]. Her current DX included: Chronic Systolic Congestive Heart Failure (reduced blood to the hear), Acute Respiratory Failure with Hypoxia (lungs are unable to move oxygen in the blood), Obstructive Sleep Apnea (sleep disorder that interrupts breathing).</p> <p>Record review of Resident # 21's Admissions MDS dated [DATE] reflected a BIMS score of 15, indicating she was cognitively intact (no impairment). Resident has impaired vision and wears glasses. Resident requires partial/moderate assistance with ADLs. Resident was being treated with oxygen therapy.</p> <p>Record review of Resident # 21's care plan dated 06/25/2025 reflected "Respiratory risk;Maintain patent airway planner, Bedside Care Tasks Completed to Evaluate and Manage Disease processes; Administer oxygen as prescribed or per standing order;02: Check ears and nares for Signs and Symptoms of skin irritation every shift;02: Clean concentrator filter weekly on Sunday Change oxygen tubing and humidifiers weekly on Sunday 11-7 shift, if used;Keep HOB elevated - cannot lay flat without SOB;Cardiac Risk related to Hypertension (high blood Pressure) • Monitor for symptoms of Pulmonary Embolism. Shortness of breath, chest pain which may be worsened by deep breaths, coughing up sputum, possibly flecked with blood; Follow facility Standards of Care (SOC) interventions unless otherwise care planned;Monitor and report changes in condition or increase in cardiopulmonary(related to heart and lungs) symptoms Monitor for symptoms of Pulmonary Embolism (blood clots): - Shortness of breath - Chest pain that may be worsened by deep breaths &dash; Coughing.&rdquo;</p> <p>Record review of Resident # 21's MD order dated 06/20/2025 reflected "02 at 3L/M per NS every shift for oxygen use document SOB, inability to lay flat or low 02 in PN;Order dated 06/20/2025 reflected 02: clean concentrator filter weekly on Sunday change oxygen tubing and humidifier weekly on Sunday 11P-7A shift if used. Every night shifts every Sunday for infection control purposes; Order dated 06/25/2025 Ipratropium-Albuterol Inhalation solution 0.5-2.5 (3) MG/3ML ipratropium-Albuterol) 3 ml inhale orally three times a day or sob for 7 Days 06/20/2025;order dated 06/26/2025, CPAP; CPAP on during sleep. Face mask size medium setting 7 cm (7 cmH2O (centimeters of water pressure) every evening and night shift for respiratory.&rdquo;</p> <p>During an observation of Resident #21's room, on 07/02/2025 at 12:06 PM her incentive spirometer was on bedside table, CPAP mask unbagged lying on the CPAP machine, and NC lying on her bed and undated. Resident was not in her room at the time of the observation.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 07/02/2025 at 1:30 PM Resident #21 was observed sitting in a chair eating lunch and was wearing her nasal cannula to receive oxygen. She stated that the staff have not cleaned her CPAP machine or her incentive spirometer (An incentive spirometer is a hand-held device that helps people to take slow, deep breaths. It's like exercise equipment for the lungs to keep them strong and working well.) since being admitted to the facility.</p> <p>Record review of Resident #33's face sheet dated 07/02/2025 reflected he was a [AGE] year-old male that was admitted on [DATE]. His DX included: Acute Respiratory Failure with Hypoxia (lungs are unable to move oxygen in the blood), Obstructive Sleep Apnea (sleep disorder that interrupts breathing).</p> <p>Record review of Resident #33's MDS dated [DATE] reflected a BIMS score of 12 indicating he was moderately cognitively impaired. The MDS was not completed to address other areas, as he was a new admit.</p> <p>Record review of Resident #33's CP dated 07/01/2025 reflected Respiratory Risk with COPD related Administer oxygen as prescribed or per standing order Created on: 06/28/2025. Administer nebulizer treatment, per order&hellip; 02: Clean concentrator filter weekly on Sunday Change oxygen tubing and humidifiers weekly on Sunday 11-7 shift, if used. ADL Deficit AEB: Recent decline in ADL self-performance; fluctuating ADL status, self-performance; fluctuating AOL (Arterial Occlusive Lesion). It refers to a blockage or narrowing of an artery, often in the context of cardiovascular disease.) status R/T: weakness, SOB, and chronic neck pain&hellip;. Monitor/document/report to MD PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function&hellip;. cardiac Risk related to Hypertension (high blood Pressure) &bull; Monitor for symptoms of Pulmonary Embolism. Shortness of breath, chest pain which may be worsened by deep breaths, coughing up sputum, possibly flecked with blood&hellip; Follow facility Standards of Care (SOC) interventions unless otherwise care planned, &hellip;Monitor and report changes in condition or increase in cardiopulmonary(related to heart and lungs) symptoms Monitor for symptoms of Pulmonary Embolism (blood clots): - Shortness of breath - Chest pain that may be worsened by deep breaths &ndash; Coughing.</p> <p>MD orders dated 06/27/2025 reflected ipratropium-Albuterol Inhalation Solution 2.5-0.5 MG/3ML (ipratropium-Albuterol) 1 vial inhale orally every 6 hours as needed for Shortness of breath/Dyspnea (difficulty breathing. There was not an order found for CPAP.</p> <p>During an observation and interview on 07/02/2025 at 12:32 PM with Resident #33 he was observed sitting in a chair eating lunch and was wearing his nasal cannula to receive oxygen which was not dated. Resident's oxygen concentrator was observed with small white flakes and particles externally and on the filter attached to the right side of the machine. Resident refused to answer questions about oxygen care and maintenance at the facility. Resident CPAP mask was observed lying on the nightstand unbagged.</p> <p>During an interview on 07/02/2025 at 12:06 PM, LVN A stated the nurses were responsible for changing out the oxygen equipment at least once a week or as needed. LVN A stated the oxygen equipment was supposed to be changed out and dated every Sunday. LVN A was working on the hall with Residents #21, #33. LVN A stated the equipment should be checked each shift; however, she did not notice the residents' equipment was not dated and bagged when the resident left for therapy. LVA A said the incentive spirometer did not need to be bagged when not in use. LVN A stated it was important to change the equipment at least clean it weekly to prevent infection from traveling to the residents .</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the ADON on 07/02/82025 at 1:45 PM revealed all nursing staff should make sure that the nasal cannulas and C pap mask are in bags when not in use. He said the nasal cannula and humidifier bottles were supposed to be changed out on Sunday nights by the night nurse. He said the night nurses were also responsible for ensuring the bags were placed on the concentrators and on the C pap machines. He said a negative effect of not ensuring these devices were bagged could expose the residents to bacteria in the devices.</p> <p>In an interview on 07/02/2025 at 3:45 PM the DON stated it was standard practice for oxygen equipment to be changed and dated once a week and as needed. The DON stated it was important to check the equipment at least once a week to keep it clean and ensure that it was working properly. The ADON stated it was the nurses' responsibility to check and change the oxygen equipment once a week and as needed on Sunday's during the 11P-7A shift. The ADON said there were not protocols for cleaning and bagging the spirometer. The DON stated the expectation was for all nurses to check the oxygen equipment daily, during each shift and the ADON and DON were responsible for monitoring patient respiratory care. The ADON said the expectation was for the ADON and DON to monitor respiratory care services. The Administrator agreed with the expectation. The DON stated not changing out the equipment at least once a week could place the residents at risk of infection.</p> <p>In an interview on 07/02/2025 at 4:05 PM with the Administrator she stated that she expected the nursing staff to follow the facility procedures and MD orders for respiratory care and treatment.</p> <p>Review of facility in services revealed trainings on abuse and neglect, and nursing following and entering MD orders precisely.</p> <p>On 07/02/25 12:45 PM the policy for oxygen storage and maintenance for residents was requested from the ADM and DON. The facility provided the policy for Fire safety and storage of oxygen cylinders related to fire and safety. A second request was made to the Administrator requesting the respiratory care policy. The facility did not provide a copy that addressed respiratory care, CPAP storage, and tubing care and labeling prior to exit.</p>		