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	05/16/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 (Residents #30) of 8 residents reviewed for dignity. The facility failed to ensure Residents #30 had the right to a dignified existence when staff stood over the resident while feeding the resident. This failure could affect the residents by placing them at risk for a loss of dignity, decreased self-worth and decreased self-esteem. Finding included: Review of Resident #30's face sheet, dated 05/15/24, revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included dementia a condition of cognitive impairment, severe protein-calorie malnutrition, depression, pain in shoulder, blood clots, age related joint pain, difficulty communicating, and difficulty swallowing. Review of Resident #30's quarterly MDS assessment, dated 03/09/24, revealed a BIMS score of 07 indicating severe cognitive impairment. Functional abilities and goals reflected, eating with supervision, or touching assistance; The helper will provide verbal cues and/or touching/steading and/or contact guide assistance. The assistance maybe provided through out or intermittently while eating. Review of Resident #30's care plan reflected a focus of risk for nutritional and hydration deficits related to malnutrition and difficulty swallowing. Mechanically altered diet started on 03/11/24. Goals: reduce risk of malnutrition and dehydration as evidenced by no significant weight fluctuations, no new signs of malnutrition, adequate fluid intake and output and no decline in related labs. Interventions: follow facility standard of care interventions unless otherwise care planned, residents' preference or physician orders. Explain and reinforce resident the importance of maintaining the diet ordered. Encourage resident to comply and explain consequences of refusal, obesity/malnutrition risk factors. Registered dietitian to evaluate and make diet change recommendation as needed. (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

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 05/16/2024
NAME OF PROVIDER OR SUPPLIER: Presbyterian Village North Special Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE: 8600 Skyline Dr Dallas, TX 75243	

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Observation on 05/15/24 at 12:39 PM, revealed Resident #30 seated in a wheelchair in the dining room at a round table. Aide G, who was wearing a facility name badge and clear plastic gloves, stood over Residents #30's right side close to her shoulder area feeding Resident #30 her lunch. Resident #30 had in front of her a plate with white cut up meat with white gravy, mashed potatoes, and green vegetables. On a separate plate were 2 cookies and a small ice cream container open with a spoon in it. 2 cups with lids and straws were also in front of Resident #30. Aide G took a spoon full of potatoes and fed Resident #30 standing over her. After a few bites of the meat and other items on the plate, Resident #30 was offered a spoon of ice cream. After a few bites of ice cream, Aide G walked away from Resident #30's table with the finished plate of food and scraped the leftover food in the trash can/food bin and placed the dirty dish with others dirty dishes and she placed the dirty used utensils in the dirty utensil bin. Aide G then returned to stand in the same spot next to Resident #30's right side and offered her the cookies. No hand hygiene or change of gloves was done by Aide G. Aide G continued to feed Resident #30 her cookies and ice cream while standing next to Resident #30. Interview with Aide G on 05/15/24 at 12:48 PM revealed that she was employed at the facility for [AGE] years. She said that she helped in the facility as an aide wherever she was needed. She stated that she was standing while feeding Resident #30 because she had nowhere to sit. She said that it looks good to other people when she sits down while feeding someone. She said that usually she sat down but with Resident #30 she did not. She said that she liked to wear gloves when feeding residents because they sneeze, and it goes everywhere. She did not state the risk to the resident for standing over her while being fed nor why she did not perform hand hygiene or change her gloves. She said it looked good for the resident to sit down when being fed. Interview with charge nurse LVN A on 05/15/24 at 01:15 PM, revealed that she expected the staff feeding residents to sit down to help promote residents' dignity. She said that it was important to be at the same eye level to help the resident feel comfortable and to feel free to communicate their needs while getting assistance eat. LVN A stated it was important to sit at eye to help residents feel respected and promote dignity and it promoted a respectful environment. She said staff needed to be mindful of resident's dignity. Interview with the DON on 05/15/24 at 03:48 PM, revealed that Aide G was not under her department and DON could not speak on her training. She said that she was not aware if Aide G was in serviced on resident rights and dignity. She said that she expected all direct care staff to sit down at eye level with residents while feeding them. She said it was important to take the time while feeding residents to communicate and talk with them. She said the risk to resident was concern of her dignity. Record review of an email sent by the administer on 05/20/24 at 04:56 PM, stated that she had reached out to corporate and Human Resources because Aide G was not employed at the nursing facility center. The administrator said that Aide G was employed by a different department on campus as part of Get Fit Program. She said the residents paid for her services by contract through the business office. Record review of the facility's policy titled, Privacy and Dignity, revised 10/2010, reflected, To ensure that care and services provided by the Facility promote and/or enhance privacy, dignity, and overall quality of life . V. The Facility promotes independence and dignity in dining . (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the facility policy titled, Resident Rights, revised 12/2016, reflected, All residents have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility including those specified in this policy. The Facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment, that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The Facility will protect and promote the rights of the resident and provide equal access to quality of care regardless of diagnosis, severity of condition, or payment source.

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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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35747 47030 Based on interviews and record reviews, the facility failed to ensure residents had the right to request, refuse, and/or discontinue treatment, and to formulate an advance directive for 1 (Resident #71) of 10 residents reviewed for advanced directives. Resident #71 was administered CPR by LVN H on [DATE], in not honoring the resident's advance directives. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 4:48PM. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of more than minimal harm that is not immediate jeopardy and a severity level of isolated because the facility was continuing to implement their Plan of Removal. This failure could affect residents with an accessible DNR and could result in residents not getting their Do Not Resuscitate wishes honored. The findings included: Record review of Resident #71's Admission Record, dated [DATE], revealed the resident was an [AGE] year-old female, who admitted to the facility on [DATE] with diagnoses including myocardial infarction (heart attack), congestive heart failure, heart disease, and atrial fibrillation. Resident #71's Admission Record did not indicate her code status. Further review revealed the resident expired on [DATE]. Record Review of the Care Plan meeting, held on [DATE] at 10:30AM, with Resident #71 and Resident #71's Responsible Party, the Social Worker, and the Director of Rehabilitation. During that meeting, Resident #71, and Resident #71's Responsible Party voiced that they wanted Resident #71 to be Do-Not-Resuscitate (DNR) Code Status. This was reflected in Resident #71's progress notes. Record review of Resident#71's progress note, Effective Date: [DATE] 11:00, .Author: LVN H progress note revealed Resident#71 unable to breath in the middle of receiving care jointly provided by CNA and resident's family member. A ran to notify LVN H that Resident#71 is not breathing or possibly having seizure per resident's Responsible Party. LVN went to resident's room and saw resident gasping for air, LVN H rushed to get a crash cart to start CPR and informed resident's Responsible Party that 911 call will be activated, resident's Responsible Party objected to both initiating CPR and calling 911 paramedics that Resident #71 did not want to be resuscitated or revived LVN H advised resident's Responsible Party that DNR PAPERS ARE NOT IN FILE When resident's Responsible Party left the room and Resident #71 continue gasping for air, LVN H started CPR, activated 911 call, CPR in progress, (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	AED applied, 911 paramedics arrived, and care was transferred to 911 paramedics, resident's Responsible Party had a heated argument with 911. paramedics for them to stop the ongoing CPR. Resident#71 was pronounced at 1215 by the paramedics, Resident #71's body left facility at [3:33PM] for [name of funeral home] Funeral Home . In an interview with the social worker on [DATE] at 12:53 PM revealed, during Care Plan meetings, it was standard for code status was discussed. The SW revealed usually a DNR can be completed same day. The SW revealed the care conference for Resident #71 was held on [DATE] at 10:30am that included Resident #71 and Resident #71's Responsible Party. The SW allowed the surveyor to review an email in her laptop showing the email that she scanned DNR to the physician at 5:05pm on [DATE]. The SW revealed she did receive the physician signed DNR (which was the official, signed DNR order) via email on [DATE] at 5:35pm but she had already left work. The SW revealed if a resident did not have accurate orders on file in the electronic health record, there was a risk that the resident could code and then anything can happen. In an interview with the Administrator on [DATE] at 12:58 PM revealed if a resident voices desire to be DNR, the SW gets involved and notifies family when completed. The Administrator revealed the SW was responsible for initiating and completing the DNR Form and submitting it to the physician for review and signature. The Administrator revealed usually DNRs were done quickly and could be as quick as next day. The Administrator revealed the DNR was done quickly to honor wishes of family. The Administrator revealed the risk of not completing DNR timely would mean families wishes were not honored. In an interview with the DON on [DATE] at 1:06 PM revealed if the resident does not have a DNR already they were a Full Code. The DON revealed within 3 days of admission, the facility had a care conference and discussed Code Status and guides the resident. The SW puts order in to EHR and upload the DNR. The DON revealed the DNR would be initiated soon, but not sure how quickly it can be done. The DON revealed the reason to do it right away was because condition can change quickly. The DON revealed the risk of not having DNR completed was if a resident codes, the nurse will do CPR- which would be a violation of their rights. The DON revealed the expectation was to have the DNR completed as soon as practicable. The DON revealed the physician emailed the completed DNR to the SW, but SW had left for the day and the nursing team were unaware of the signed and completed DNR. The DON revealed the nursing staff did not have access of the DNR. During an interview on [DATE] at 1:23 PM via telephone with Resident #71's Responsible Party began to cry saying this was a hard conversation. The Responsible Party said she does not feel the facility honored her wishes. The Responsible Party said the facility admitted they did wrong. The Responsible Party said during the Care Conference, the DNR form was filled out and facility staff indicated they would send it to the physician for signature. The Responsible Party said the Director of Therapy and the Social Worker guided the Responsible Party in completion of the DNR. The Responsible Party said the physician emailed the signed copy back the same day, but the social worker had already left for the day and no-one else had access to the signed DNR. The Responsible Party said the facility told her this would not occur again, as they will ensure others have access to the fax. The Responsible Party said the paramedics worked on Resident #71 for 30 minutes. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview with the Administrator - Executive Director (who was the interim Administrator at the time of the incident) on [DATE] at 1:36 PM revealed he remembered Resident #71. The said he was the Manager on Duty on the day of the death. He revealed one of the facility customer service staff alerted him a family was upset. He told the family he would follow up on the fully executed DNR the physician. The Administrator - Executive Director expectation of completing the DNR was that it be completed fully, quickly and put into the system. The Administrator Executive director revealed the facility must have the completed DNR, or the resident was Full Code. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 4:00 PM. The Administrator was notified. The Administrator was provided with the IJ template on [DATE] at 4:48 PM. The facility's Plan of Removal included: [Facility Name] Immediate Jeopardy Plan of Removal Resident Code Status - DNR Status [DATE] All residents desiring to be DNR status without a current DNR order are at risk to receive CPR. Actions to correct and remove IJ: 1. Verify code status for all residents. The social worker will complete this by noon [DATE]. 2. Any resident/resident POA wanting to be DNR status will have the DNR election form completed, and the physician will be contacted for the DNR order. The Social Worker and support staff will complete this for current residents by end of day on [DATE] per the DNR Order policy. The staff member (Social worker, Weekend Nurse Supervisor or designee) completing the DNR Election form will: a. upload the completed form into the Electronic Health Record (EHR) under the Code Status category b. enter the physician order for the In House DNR into the EHR, c. make a progress note in the EHR to show on the shift report when form is completed, d. make a progress note in the EHR when the DNR order has been received and resident/family notified been completed 3. Residents also wanting an Out of Hospital DNR will be contacted by the Social Worker on the process for completing this form, witnesses and other requirements. An appointment to complete the documents will be completed at their earliest convenience. The Social Worker or designee completing the OOH-DNR form will: a. upload the completed OOH-DNR form into the Electronic Health Record (EHR) under the Code Status category (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	b. enter the physician order for the OOH-DNR into the EHR, c. make a progress note in the EHR to show on the shift report that the OOH-DNR has been completed and orders are on the chart, d. Completion of this will be based on the residents/responsible parties' response and availability to complete. 4. Resident Care Plans on advanced directives will be updated to reflect any change in code status by the staff member ((Social Worker, Weekend Nurse Supervisor, Charge Nurse, or designee) obtaining the Physicians Order. Complete implementation of the current DNR Order policy will be completed by [DATE]. This includes: 1. Identification of Code Status by completion of the DNR Election form will be initiated prior to admission or the day of admission - this will be completed by the admissions team (Admissions Coordinator, PAC Admin Assistance, Care Transitions Nurse, or Clinical Liaisons). a. The admission team will send the form to the patient or their responsible party prior to admission through the electronic document signature system. The admission team will call patient or Responsible Party if response is not received within 24 hours prior to admission. b. Any admission that does not have the DNR Election form completed by the time the charge nurse completes the admission assessment will have the form completed by the admitting nurse. The admitting nurse will make sure DNRs are completed updated for admissions or DNR changes requested after hours and on the weekends. i. If the patient is not able to make a decision and not accompanied by a Responsible Party, a nurse can obtain the consent via phone as long as another witness is present, and the Responsible Party has a copy of the CPR election form and document this in the EHR. c. Once consent for DNR is obtained from the patient or RP, the nurse will get the DNR order from the patient's primary physician. If the primary physician is not available, the nurse will call the medical director to obtain the order. 2. Social Worker will initiate OOH-DNR process if requested on the DNR Election form. Completion of the OOH-DNR form will be based on the residents/responsible parties' response and availability to complete. 3. Re-Education of the Director of Nursing was conducted by the Corporate Compliance Director on [DATE]. Re-education of all nursing staff, the social worker, administrator, physicians, admissions personnel and medical directors on the DNR Order policy at all-staff meetings to be held on [DATE] and [DATE]. Reeducation conducted by the Director of Nursing and Administrator at all staff meetings. 4. Staff who are not present during the in-services will be in-serviced individually before they can begin their next shift at work. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	5. New admission code status is reviewed during the daily start up meeting and Code Status is discussed in each care plan meeting and care plan updated as needed. 6. A DNR is considered complete when the physician/medical director signs the order to support the request. 7. In the event a code incident occurs while awaiting the DNR completion, the in-house DNR form will be used, and the physician or medical director will be called for consent via phone as long as another witness is present. When completed, the DNR will be honored. Reviews: 1. Weekly the Social Worker will pull all orders from the EHR for Code Status and review for accuracy. The administrator will meet with the Social Worker weekly to audit and verify this review has been completed. This will be ongoing for the next two months. 2. Reports to the QAPI committee on the number of DNRs, OOH-DNRs and those with full code status will include those identified outside the current DNR Order policy for discussion and revision of plan 3. A Corporate Designee will audit the Facility Code Status compliance weekly until stable and monthly for the next six months, quarterly thereafter if stable and report findings to the governing body. The new policy on DNR order and form is attached. The facility's Plan of Removal was accepted on [DATE] at 3:13 PM. The following actions were taken: 1. Review of the facility's code status printed report from the minimum data set in the health records for all residents reflected code statuses were up-to-date and current. 2. Review of the facility's DNR orders and the Care Plan report revealed 1 family/resident requested to complete a DNR election form. The physician order was entered into the EHR under the Code Status category. A progress note that was entered in the EHR that showed on the shift report for each resident when completed. A progress notes in the EHR when the DNR order was received, and the resident/family notified it was completed. 3. Two residents/families met with the Social Worker to complete the OOH DNR. The Social Worker uploaded the completed OOH DNR into the EHR under the Code Status category. The Social Worker entered the physician order for the OOH DNR into the EHR. Social Worker made a progress note in the EHR that showed up on the shift report when the form was completed. Social Worker made a progress note in the EHR when the OOH DNR order had been received and received and the resident/family was notified it had been completed. Review of these documents were conducted and verified by the survey team. 4. Resident care plans showed advanced directives were updated to reflect any change in code status by the staff member (social worker, admissions nurse, weekend supervisor, charge nurse or designee) obtaining the physician's order. Review of all resident care plan updates were conducted and verified by the survey team. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of an in-service conducted on [DATE] and [DATE], titled CPR Election Form, Policy and Procedure reflected staff (with signatures) had been educated on the facility's DNR Election Form. On [DATE] interviews with multiple staff members across various departments and shifts revealed the staff members were recently in-serviced properly on DNR Election Form Policy and Procedure. Each staff member was aware of the steps of completion of the DNR Election Form. No concerns were noted from these interviews. [DATE] at 9:21 AM Admissions Coordinator- was able to verbalize the new process for the DNR election form and policy. [DATE] at 9:26 AM Care Transitional Nurse works in the admission dept. was able to verbalize the new process for the DNR election form and policy. [DATE] at 9:34 AM (PAC) Administrative Assistant- was able to verbalize the new process for the DNR election form and policy. [DATE] at 9:58 AM LVN F works Monday through Friday 7a-3p weekdays was able to verbalize the new process for the DNR election form and policy. [DATE] at 10:05 AM LVN E 7a-3p was able to verbalize the new process for the DNR election form and policy. [DATE] at 10:11 AM LVN H 7a-3p weekdays was able to verbalize the new process for the DNR election form and policy. [DATE] at 10:30 AM LVN I 7a-3p weekdays was able to verbalize the new process for the DNR election form and policy. [DATE] at 10:42 AM LVN A 7a-3p weekdays was able to verbalize the new process for the DNR election form and policy. [DATE] at 11:06 AM Clinical Liaison was able to verbalize the new process for the DNR election form and policy. [DATE] at 11:09 AM RN J 3p-11p was able to verbalize the new process for the DNR election form and policy. [DATE] at 11:39 AM 11p-7a was able to verbalize the new process for the DNR election form and policy. [DATE] at 11:14 AM Weekend Nurse Supervisor was able to verbalize the new process for the DNR election form and policy. [DATE] at 12:07 PM called back was able to verbalize the new process for the DNR election form and policy. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Re-education of medical director on the DNR Order policy at all-staff meetings held on [DATE] and [DATE]. Reeducation conducted by the Director of Nursing and Administrator at all staff meetings. Review of these in-services was conducted and verified by the survey team. The Administrator was informed the Immediate Jeopardy was removed on [DATE] at 2:00PM. The facility remained out of compliance at a severity level of more than minimal harm that is not immediate and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review, the facility failed to ensure that all drugs and biologicals used in the facility are labeled in accordance with professional standards, including expiration dates and with appropriate accessory and cautionary instructions for 2 (Resident #22 and Resident # 323) of 8 residents reviewed for storage of drugs and Biologicals. The facility failed to ensure that MA D secured Resident # 22's medication before walking away from the medication cart. The facility failed to ensure that Resident #323's self-administration medications were secured and not left on the bedside table after administration. These failures could cause accidental ingestion of medication by a resident not prescribed the medication and could cause access, loss, and diversion of medications. Finding included: Resident #22 Review of Resident # 22's face sheet dated [DATE] reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included high blood pressure, bone infection, type 2 diabetes, kidney diseases, lower back pain, double vision, high cholesterol, and abnormal cancerous cells of the parts of the uterus (malignant neoplasm of parts of uterus). Review of Resident #22's order summary on [DATE] reflected: Coreg Oral Tablet 12.5 MG (Carvedilol) Give 1 tablet by mouth two times a day for HTN Hold if SBP. Allopurinol Tablet 100 MG. Give 2 tablet by mouth one time a day for Gout. Lisinopril Oral Tablet 10 MG. Give 2 tablet by mouth one time a day for HTN Hold for SBP Glucophage Tablet 1000 MG (Metformin HCl). Give 1 tablet by mouth two times a day for DM. Ferrous Sulfate Oral Tablet 325 (65 Fe) MG (Ferrous Sulfate). Give 1 tablet by mouth in the morning for Anemia Give with food/snack. Lidocaine External Patch. Apply to rt knee topically one time a day for arthritis rt knee and remove per schedule. GlycoLax Powder (MiraLAX) Give 17 gram by mouth one time a day for constipation mix in ,d+[DATE] ounce of fluid. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Presbyterian Village North Special Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 8600 Skyline Dr Dallas, TX 75243	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Docusate Sodium Capsule 100 MG. Give 1 capsule by mouth two times a day for constipation. Cholecalciferol (Vitamin D) Tablet 1000 UNIT Give 2 tablet by mouth one time a day for supplement. Norvasc Oral Tablet 10 MG (Amlodipine Besylate) Give 1 tablet by mouth one time a day for HTN HOLD FOR SBP less than 110. Observation and interview with MA D during medication administration on [DATE] at 08:45 AM, revealed MA D took Resident #22's medication cards of Allopurinol, Lisinopril, Glucophage and bottles of Ferrous Sulfate, Docusate Sodium, and Cholecalciferol and placed them in a clear medication cup on top of medication cart. She then measured GlycoLax Powder and placed it in a larger separate clear cup and placed it on top of medication cart. She then took Lidocaine External Patch and placed it on the top of medication cart. MA D then stated that Resident #22 was missing her blood pressure medication Norvasc. She said that she would check the medication room and the emergency kit for Norvasc. MA D then walked away from the medication cart with medications for Resident #22 on top of the medication cart with surveyor standing next to the medication cart in the hallway outside of Resident #22's room. MA D stated that she forgot because surveyor was standing next to the cart and she was nervous. She said that she was responsible for making sure that the medication cart and all medication were secure before walking away from the medication cart. She said that it was against the facility policy to leave medication on top of the medication cart. She said the risk to residents would be a resident who had altered mental status could take the medication and swallow it and they would have adverse effects. Interview with the DON on [DATE] at 03:48 PM, revealed she expected all nursing staff and medication aides to follow facility protocol and secure medications when unattended. The DON said the risk of not keeping medication locked was that anyone could come and use the medication and could harm themselves. Resident #323 Review of Resident # 323's face sheet dated [DATE] reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included high cholesterol, chronic pain, aftercare following joint replacement, leakage of heart valve, and glaucoma (this is an eye condition that can cause blindness). Review of Resident #323's quarterly MDS assessment dated [DATE], reflected a BIMS score of 15, indicating cognitively intact. Resident #323 could be understood, and she could understand others. Review of Resident #323's care plan reflected the following: Focus; impaired visual function related to glaucoma. Created [DATE]. Goal was to reduce risk of sudden avoidable visual declines and visual safety. Interventions included the following: follow facility protocols and standards of care interventions unless otherwise care planned, resident preference and physician orders. Administer eye drops per physician orders. Arrange for consultation with eye care practitioner as required. Monitor/document/report to physician any sudden eye problems or change in ability to perform ADLS, decline in mobility, double visions, sudden visual loss, pupils dilated, gray or milky. Review of Resident #323's medication administration record dated [DATE] reflected the following: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Latanoprostene Bunod OphthalmicnSolution 0.024 % (Latanoprostene Bunod). Instill 1 drop in both eyes in the evening for glaucoma. Last administered on [DATE] 2. Vyzulta Ophthalmic Solution 0.024 % (Latanoprostene Bunod) Instill 1 drop in left eye at bedtime for Glaucoma unsupervised self-administration. Last administered [DATE]. 3. Pilocarpine HCl Ophthalmic Solution 1 % (Pilocarpine HCl) Instill 1 drop in left eye two times a day for glaucoma. Last administered [DATE] at 08:00 AM. 4. Triamcinolone Acetonide Cream 0.1 % Apply to affected areas topically every day and evening shift for itching unsupervised self-administration to affected [area]. Last applied [DATE]. Review of Resident #323's assessment for Self-medication administration completed on [DATE] reflected Resident #323 was safe to self-administer medication. Observation and interview with Resident #323 on [DATE] at 11:41 AM revealed Resident #323 was lying in her bed with bedside table over her bed. A clear Ziploc bag contained 3 eye drops (named above) and the medicated cream named above was on the bedside table. Resident #323 said that she was allowed to keep medication in her room, and she had access to it to self-administer. She said that she could use the medication without having to call for assistance unless she needed help with the cream to be applied on her back. Resident #323 said that she kept the medication on her table, and it was easily accessible to her. She said the facility was aware that she had the medication at the bedside for her to self-administer. Resident #323 did not state if she had a lock box in the room for the medication. Interview with LVN F on [DATE] at 09:20 AM, revealed she used the assessment Self-Medication Administration tool on the MAR to screen Resident #323 that she could safely administer her own medications. LVN F said that it was the facility policy that if a resident could demonstrate safe self-medication administration, then they could administer medications such as eye drops and nose sprays by themselves. She said residents that self-administered medication kept it in their rooms in a drawer with a key. Interview with the DON on [DATE] at 03:48 PM, revealed residents were given an assessment to access safe self-medication administration. She said Resident #323 had demonstrated safe medication administration and could self-administer her own facility approved medications. The DON said Resident #323 was alert and oriented and could self-administer medication. The DON said that any residents that self-administered were given a metal lock box with a key in which their medications would be kept. She said she expected residents that self-administered medications to keep it locked in the lock box. The DON said the risk of not keeping medication locked was that anyone could come in the room and use the medication and could harm themselves. Interview with the Administrator on [DATE] at 03:38 PM, revealed that she expected nursing staff to secure medication per facility policy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy, Self-Administration of Medication , revised ,d+[DATE] reflected that, . If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re-assessed periodically based on changes in the resident's medical and/or decision-making status . Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer are stored on a central medication cart or in the medication room. A licensed nurse transfers the unopened medication to the resident when the resident requests them . The nursing staff routinely checks self-administered medications and removes expired, discontinued, or recalled medications . Record review of facility policy titled Medication Labeling and Storage revised in February 2023, reflected . compartment (including but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others .

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35747 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety for 1 (Resident #5) of 8 residents reviewed for refrigerators in the rooms. The facility failed to monitor Resident #5's refrigerator temperature and to clean out undated foods. These failures could affect residents by placing them at risk for food-borne illness. Finding included: Review of Resident #5's face sheet, dated 05/15/24, reflected an [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Parkinson's diseases a condition that affects the central nervous system that effects movement and often including tremors, difficulty sleeping, low blood pressure, narcolepsy with cataplexy is a condition of daytime sleepiness with sudden temporary muscle weakness or loss of muscular control, healed fractures, repeated falls, and difficulty communicating. Review of Resident #5's MDS dated [DATE] revealed a BIMS score of 0 indicating severe cognitive impairment. Functional ability and focus reflected personal hygiene dependent on staff. The helper does all the effort and resident does none of the effort to complete the activity. Observation and interview on 05/13/24 at 10:25 AM, revealed upon entry to Resident #5 room, a small black refrigerator placed on the floor near the entry way. The door to the refrigerator was slightly open. Resident #5 was seated in his wheelchair eating raspberries and blue berries on his bedside table. Resident #5 could answer basic questions. A private Caregiver B was in the room with Resident #5. Caregiver B stated that Resident #5's refrigerator was too full and could not close properly. Caregiver B opened the refrigerator door wider to reveal an open yogurt cup, half eaten sandwiches, varies dessert plates with clear wraps on them. Caregiver B stated that she was not aware who was responsible for monitoring the refrigerator nor the temperature in the refrigerator. She said that there was no thermometer in the refrigerator to say what the temperature was. Caregiver B said that she did not know how long the resident had the refrigerator. Interview with private Caregiver C on 05/14/24 at 12:30 PM, revealed Resident #5 had the refrigerator for 8 months. He said Resident #5's family member brought it to the facility 8 months ago. He said that Resident #5's family member brought items like fruits and other snacks that Resident #5 liked, and all perishables were put in the refrigerator. Caregiver C said that as of 05/13/24 the facility placed a thermometer and a log to start monitoring the refrigerator temperature. Caregiver C said that he was instructed by the facility on 05/13/24 to start dating the food without manufacture expiration date on it and after 3 days to discard the food. He said the refrigerator had been cleaned out and door was closed. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 05/14/24 at 10:45 AM, revealed that she was not aware that Resident #5 had a refrigerator in his room. She stated that he might have gotten it over the weekend. She said that upon finding out about the refrigerator on 05/13/24, she did an in-service and it was cleaned out, a thermometer was placed in the refrigerator and the night shift nursing staff would monitor and document the temperature in the log in Resident #5's room. The DON said that the facility staff may not have noticed the refrigerator because the door to Resident #5 was always closed because Resident #5 had private caregivers. She said the risk to the resident was not knowing the temperature of refrigerator and resident eating the food could cause gastric illness. Interview with the Administrator on 05/15/24 at 03:38 PM, revealed that she expected all staff to follow facility policy. Review of the temperature log in Resident #5's room reflected: 05/13/24 reading 36 degrees. 05/14/24 reading 40 degrees. Record Review of the Facility policy titled Refrigerators and Freezers revised 12/24 revealed Monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures .Refrigerators and freezers will be kept clean, free of debris, and mopped with sanitizing solution on a scheduled basis and more often as necessary . Review of the Food and Drug Administration Food Code, dated 2022, reflected, .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety 48520