| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676135 | A. Building<br>B. Wing | 09/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Presbyterian Village North Special Care Ctr | 8600 Skyline Dr<br>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 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>(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 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the interdisciplinary team determined self-administration of medication was safe for 1 (Resident # 1) of 8 resident's reviewed for medication self-administration. The facility failed to prevent Resident #1 from possessing and administering an inhaler without an assessment to determine if she could safely self-administer the medication. This failure could place all residents who self-administer medications at risk of not receiving the therapeutic dose of their medication as ordered. Findings included: Record review of Resident # 1's face sheet dated 09/17/25, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Metabolic Encephalopathy (a condition where the brain's function is impaired due to an imbalance in the body's metabolism), hypertension (high blood pressure), and malignant neoplasm of lower lobe left lung (lung cancer). Record review of Resident #1's admission MDS assessment dated [DATE], revealed Resident #1 was cognitively intact with a BIMS score of 13 and required partial to moderate assistance with most ADLs. Record review of Resident #1's care plan dated 09/03/25, revealed the resident had a recent decline in ADL self-performance related to Lupus, COPD, weakness and debility. Interventions included limited assistance and supervision by staff with ADLs. Record review of Resident #1's assessments in her EHR, revealed there was not an assessment for self-administration of medication. Record review of Resident #1's physician orders dated 08/30/25, revealed there was not an order for the resident to self-administer her own medications. In an observation and interview on 09/16/25 at 11:05 AM with Resident #1, revealed she was sitting in a chair next to the over bed table with personal items and a rescue inhaler that was on the over bed table at her beside and was unsecured. The inhaler observed on the over bed table was Albuterol Sulfate 90mcg/actuation (a rescue inhaler used to treat or prevent bronchospasm (narrowing of the airways). There were no further instructions listed on the inhaler. Resident # 1 stated it was a rescue inhaler that she kept with her. In an observation and interview on 09/16/25 at 3:35 PM with Resident #1, revealed a rescue inhaler was positioned on the over bed table and not secured. Resident #1 stated that she brought the inhaler with her from home and the instructions said she could use it as needed up to 4 times per day, but that she only allows herself to use it twice per day. She stated she takes Trelogy (a prescription medicine used long term to treat COPD) once per day and the one on the table was a rescue inhaler. In an interview on 09/16/25 at 3:45 PM with RN Charge Nurse A, revealed that she had been employed with the facility since May of 2025. She stated she took care of Resident #1 and did not have any residents on her hall that self-administered their own medication. She stated there is a risk if residents had medications at the bedside, they would have to have an assessment completed and an order from the physician. During the interview with RN Charge Nurse A, she reviewed the MAR for Resident #1 and stated that there was a PRN order for the Albuterol but according to the MAR, Resident #1 had never requested the medication. RN A stated that the negative effects of any resident having medications at their bedside could cause harm, which could include an overdose of their medications. In an interview on 09/16/25 at 4:02 PM with ADON B, revealed she had worked at the facility for 7 years. She stated if a resident wanted to self-administer their medications, there was an assessment that needed to be completed and an order from the physician. If the resident was cognitive and determined able to self-administer, they would be given a lock box with a key and would have to let the staff know when they administered the medications so they could be recorded in the medical record. She stated that currently there were no residents that self-administered their own medications. ADON B stated the negative effect could be that the nurse was not aware and if you don't know what they are taking, you cannot do an accurate assessment. In an interview on 09/16/25 at 4:12 PM with the DON, revealed she had worked at the facility for 3 years. She was not aware of any residents who self-medicated and stated that if they did, they would need to have an assessment, an order and then issued a lock box. She stated that a negative effect could be that the resident would be given double doses or over medicated. Review of the facility's policy titled Self-Administration of Medications revised February 2021 revealed in part the following: Policy Heading-Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation: 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administration of medications is safe and clinically appropriate for the resident. 8. Self-administered medications are stored in |