

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675977	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/14/2025
NAME OF PROVIDER OR SUPPLIER  Village Creek Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3825 Village Creek Rd Fort Worth, TX 76119	

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 0756  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.  (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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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, and interview, the facility failed to ensure any drug regimen irregularities reported by the Pharmacist Consultant were acted upon, for 1 of 5 residents (Resident #10) reviewed for medication regimens. The facility failed to 's Pharmacy Consultant recommended the facility include anti-psychotic side-effect monitoring for Resident #10's Risperdal and Perphenazine medication orders on 06/18/25 and 07/23/25. This failure could place residents receiving medications at risk for adverse consequences and could cause a decline in their physical, mental, and psychosocial condition. Findings included: Record review of Resident #10's Quarterly MDS Assessment, dated 07/16/25, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. He had a BIMS score of 13 indicating no cognitive impairment. His active diagnoses included anxiety disorder (a group of mental health conditions characterized by excessive fear, worry, and anxiety that interfere with daily life), depression (a mood disorder that causes persistent feelings of sadness and loss of interest), and schizophrenia (a serious mental health condition that affects how people think, feel, and behave). His MDS indicated he was taking antipsychotic medications on a routine basis. Record review of Resident #10's physician's orders, dated 08/13/25, reflected the following: -Perphenazine Oral Tablet 16 MG, Give 1 tablet by mouth at bedtime for m/b impulsive behavior related to Unspecified Mood [Affective] Disorder with a start date of 03/19/25. -Risperdal Oral Tablet 2 MG, Give 1 tablet by mouth two times a day for m/b auditory hallucination related to Unspecific Mood [Affective] Disorder with a start date of 03/19/25. Record review of Resident #10's August 2025 MAR reflected he received both Perphenazine and Risperdal every day as ordered. Record review of Resident #10's undated care plan reflected the following: Focus: Psychotropic Medications: [Resident #10] has DX: Depression w/hx suicidal ideations, anxiety, mood disorder and receives daily medication therapy and is at risk for clinical complications. Interventions/Tasks: Administer medications as ordered. Monitor/document for side effects and effectiveness. Monitor/record/report to MDS prn side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person. Record review of Resident #10's Pharmacy Recommendations Form, dated 06/18/25, reflected the following: Risperdal and Perphenazine require anti-psychotic side effect monitoring. Record review of Resident #10's Pharmacy Recommendations Form, dated 07/23/25, reflected the following: Risperdal and Perphenazine require anti-psychotic side effect monitoring. Interview on 08/14/25 at 12:03 PM, with Resident #10 revealed he had no concerns about his medications and did not think he had experienced any side effects from them. Interview on 08/14/25 at 9:21 AM, LVN F revealed she was Resident #10's nurse and was very familiar with him and his care. She stated she knew Resident #10 had an order for and was administered Risperdal and Perphenazine daily. She said she monitored the resident for side-effects of those medications daily. She stated she thought Resident #10 had an order for side-effect monitoring. She stated normally when a medication order was added to a resident's chart, which required side-effect monitoring, that order for side-effect monitoring was also added. LVN F said she reviewed Resident #10's orders and did not see an order for side-effect monitoring. Interview on 08/14/25 at 9:39 AM, the ADON revealed the facility had standing orders when it came to side effect monitoring of any medications that required them, including anti-psychotics such as Risperdal and Perphenazine. She stated anti-psychotic medications required side-effect monitoring. She stated the nurse, who put the order into the resident's chart, should have also added the side-effect monitoring order as well. The ADON said she was responsible for completing and following-up on the pharmacy recommendations each month. She stated when she reviewed the pharmacy recommendations for Resident #10, she thought she saw the order for the side-effect monitoring for the two medications, so she checked them off. She stated she should have noticed the side-effect monitoring order was not there, and she should have added it then. Interview on 08/14/25 at 10:17 AM, the DON revealed normally the nurse, who added the new medication order, would also add the side-effect monitoring for it as well if it were an anti-psychotic medication. She said she reviewed Resident #10's orders, and she saw the side-effect monitoring order for his Risperdal and Perphenazine medications were missing. She said the ADON also reviewed new orders for residents and could have caught that the order was missing and added it. She stated the ADON was also responsible for following-up on the</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>(continued on next page)</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure each resident's drug regimen was free of unnecessary medication for 1 of 5 residents (Resident #10) reviewed for unnecessary medication. The facility did not monitor Resident #10 for side-effects related to the use of the anti-psychotic medications Risperdal and Perphenazine. This failure could place the residents at risk for adverse consequences of medication. Findings included: Record review of Resident #10's Quarterly MDS Assessment, dated 07/16/25, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. He had a BIMS score of 13 indicating no cognitive impairment. His active diagnoses included anxiety disorder (a group of mental health conditions characterized by excessive fear, worry, and anxiety that interfere with daily life), depression (a mood disorder that causes persistent feelings of sadness and loss of interest), and schizophrenia (a serious mental health condition that affects how people think, feel, and behave). His MDS indicated he was taking antipsychotic medications on a routine basis. Record review of Resident #10's physician's orders, dated 08/13/25, reflected the following: -Perphenazine Oral Tablet 16 MG, Give 1 tablet by mouth at bedtime for m/b impulsive behavior related to Unspecified Mood [Affective] Disorder with a start date of 03/19/25. -Risperdal Oral Tablet 2 MG, Give 1 tablet by mouth two times a day for m/b auditory hallucination related to Unspecific Mood [Affective] Disorder with a start date of 03/19/25. Record review of Resident #10's August 2025 MAR reflected he received both Perphenazine and Risperdal every day as ordered. Record review of Resident #10's undated care plan reflected the following: Focus: Psychotropic Medications: [Resident #10] has DX: Depression w/hx suicidal ideations, anxiety, mood disorder and receives daily medication therapy and is at risk for clinical complications. Interventions/Tasks: Administer medications as ordered. Monitor/document for side effects and effectiveness. Monitor/record/report to MDS prn side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person. Interview on 08/14/25 at 12:03 PM, with Resident #10 revealed he had no concerns about his medications and did not think he had experienced any side-effects from them. Interview on 08/14/25 at 9:21 AM, LVN F revealed she was Resident #10's nurse, and she was very familiar with him and his care. She stated she knew Resident #10 had an order for and was administered Risperdal and Perphenazine daily. She stated she monitored the resident for side-effects of those medications daily. She said she thought Resident #10 had an order for side-effect monitoring. She stated normally when a medication order was added to a resident's chart, which required side-effect monitoring, that order was also added. She said she reviewed Resident #10's orders, and she did not see an order for side-effect monitoring. Interview on 08/14/25 at 9:39 AM, the ADON revealed the facility had standing orders when it came to side-effect monitoring of any medications that required them, including anti-psychotics such as Risperdal and Perphenazine. She stated anti-psychotic required side-effect monitoring. She stated the nurse, who put the order into the resident's chart, should have also added the side-effect monitoring order as well. She stated she went through residents' new orders as well to check to make sure they were all correct. The ADON said if she had seen that the side-effect monitoring order was missing, she would have added it to Resident #10's orders. Interview on 08/14/25 at 10:17 AM, the DON revealed normally the nurse, who added the new medication order, would also add the side-effect monitoring for it as well if it were an anti-psychotic medication. She said she reviewed Resident #10's orders, and she saw the side-effect monitoring order for his Risperdal and Perphenazine medications were missing. She stated the ADON also reviewed new orders for residents and could have caught that the order was missing and added it. She stated the purpose of having an order to monitor for side-effects of a medication was to ensure there were no side-effects affecting the resident from the medication. She said by taking the medication, the resident could experience side-effects from taking an anti-psychotic; if those were not monitored, the medication may need to be changed. She stated staff were trained to know to include the side-effect monitoring orders with any medication that required it. Record review of the facility's current, undated Psychotherapeutic Drug Management policy reflected: .X. Nursing Responsibility: H. The medication will be written on the Medication Administration Record (MAR) with the following information: i. Medication, dose, and time of administration ii. Manifestations for the drug i.e. hitting others etc iii. Side</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on observations, record reviews, and interviews the facility failed to ensure all drugs were stored in locked compartments for 1 of 6 carts (Cart #3) reviewed for medication storage. The facility failed to ensure Cart #3 was secured when not in use. This failure could place residents at risk of gaining access to medications not prescribed to them, leading to allergic reactions or overdoses. Findings included: Observation on 08/13/25 at 2:44 PM revealed Medication Cart #3 was stored at the nurse's station. Observation of the lock revealed it was in the secured position, but a check of the drawers revealed drawer #2 was able to be opened. The other drawers on the cart were locked and were not able to be opened. RN A obtained the keys to the cart, unlocked the cart, and then re-locked the cart; however, drawer #2 on the cart continued to be unlocked. Observation of the contents of drawer #2 revealed it contained the prescription medication cards for the residents of the 200 Hall. The medications included blood pressure medications, anti-viral medications, sleep medications, potassium pills, thyroid medications, diabetic medications, cardiac medications, and anti-nausea medications. RN A moved the cart to the interior of the nurses' station and called for maintenance to check the cart. Interview on 08/13/25 at 2:46 PM with RN A revealed the medication cart should always be secured when staff were not physically present to prevent residents from accessing the medications in the cart. She stated the risk to residents was a resident taking a medication not prescribed for them and having unwanted side-effects. In an interview on 08/14/25 at 10:32 AM with the DON she stated her expectation was for the nurses and medication aides to lock their carts when they were not standing at the cart passing medications. She stated the risk of a medication cart not being secured was a resident gaining access to medications not prescribed for them and having a reaction to the medication. She stated maintenance was unable to fix the drawer on Cart #3, so the cart was exchanged for a different cart until the drawer could be fixed or replaced. Record review of the facility's Storage of Medications policy, dated August 2020, reflected: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. 2. Medication rooms, carts, and medication supplies are locked when they are not attended by persons with authorized access.</p>		

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F 0925  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.  (continued on next page)

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to maintain an effective pest control program so that that the facility is free of pests and rodents in 1 of 6 resident rooms (Resident #73) reviewed for pest control. The facility failed to ensure Resident #73's room was free of ants. This failure could place residents at risk of having pests in their rooms and insect bites. Findings included: Record review of Resident #73's Quarterly MDS Assessment, dated 07/26/25, reflected the resident was an [AGE] year-old female initially admitted to the facility on [DATE]. The MDS reflected the resident had moderate cognitive impairment with a BIMS score of 8. The MDS also reflected diagnoses of metabolic encephalopathy (condition where brain dysfunction occurs due to issues with the body's metabolism), adult failure to thrive (a syndrome characterized by weight loss, decreased appetite, poor nutrition, and inactivity, often accompanied by other symptoms like dehydration, depression, impaired immune function, and cognitive decline), and coronary artery disease (damage or disease in the heart's major blood vessels caused by the build-up of plaque). Record review of Resident #73's care plan revised on 08/07/25 reflected the resident had an ADL self-care performance deficit related to impaired cognition (decline in mental abilities that can affect memory, attention, reasoning, and problem-solving), encephalopathy, acute kidney failure (the kidneys inability to filter waste products from the blood), hypertension (high blood pressure), muscle weakness, and malnutrition (lack of proper nutrition). Interventions included the resident would require assistance with ADLs (essential tasks necessary for maintaining personal health and hygiene). Record review of Resident #5's Quarterly MDS Assessment, dated 07/22/25, reflected the resident was a [AGE] year-old female initially admitted to the facility on [DATE]. The MDS reflected the resident's cognition was intact with a BIMS score of 15. The MDS also reflected diagnoses of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), depression (a mood disorder that causes persistent feelings of sadness and loss of interest), and anxiety (intense, excessive, and persistent worry and fear about everyday situations). Record review of Resident #5's care plan revised on 06/10/25 reflected the resident had an ADL self-care performance deficit related to diagnoses of schizophrenia, depression, malnutrition, anxiety, tremor, right hand contracture, and neuropathy. Interventions included 1 staff participation requirement. Observation and interview on 08/12/25 at 11:43 AM with Resident #73 revealed a line of approximately 40 ants on the floor beside Resident #73's bed. Resident #73 stated she had not been bitten by the ants. Resident #73 also said that she had not seen ants before in her room. There were crumbs on the resident's floor, and it appeared the ants were going towards the crumbs. There were no ants observed on the resident or her bed. Observation and interview on 08/12/25 at 11:48 AM with Resident #5 revealed she saw ants about a week ago beside her roommate's bed. Resident #5 stated she had not seen ants in the past week. Interview on 08/12/25 at 12:08 PM with the Maintenance Director revealed the pest control company visited the facility every other Thursday. He stated he did not think the resident's room had been treated for ants recently because there had not been a request for that room to be treated for ants. He stated if just a few ants were seen, he would log it into the pest control book. He then said that if a trail of ants were seen, he would call the pest control company and have them come out immediately to the facility to treat the area. He also stated the facility policy stated that if ants are found in a resident's room, the residents would be moved to another room, showered, assessed by a nurse, and treated if necessary. He revealed he would examine where the ants were coming from as well and report this to the Regional Director and the Administrator. The Maintenance Director stated the pest control company had been contacted about the ants and would be coming to the facility that afternoon to prevent any risk to the residents such as ant bites. Interview on 08/12/25 at 12:24 PM with the Administrator revealed Resident #73 had been taken by the staff to be showered. She stated the resident would be assessed for injuries as well. She also revealed she had notified the pest control company, and they would be arriving later in the afternoon. The Administrator said she moved both residents to another room to prevent any injuries from occurring to the residents. Interview on 08/14/25 at 1:49 PM with CNA B revealed she had not observed ants in Resident #73's room. She stated if she saw ants or other pests, she would report it to her nurse and the maintenance director by using the computer system that the facility utilized for reporting maintenance issues. She also revealed she would follow-up with her ADON if results were not seen timely, so they could check the resident for bites for the safety of the resident. She stated pests like ants could bite residents if not treated and eliminated. She stated she saw a pest control person treating the</p>		