STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676388	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pavilion at Creekwood	2100 Cannon Dr Mansfield, TX 76063

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 - Some	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** 33552 Based on interviews 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 five (Residents #1, #2, #3, #4, and #5) of five residents reviewed for pharmacy services related to new admissions. 1. The facility failed to follow physician orders and provide Resident #1 with Clozapine, an antipsychotic medication to treat her schizoaffective disorder for two weeks (03/04/24 through 03/17/24). 2. The facility failed to follow physician orders, acquire, and administer Resident #2 with Buspirone, Gabapentin, Oxybutynin Chloride, Trazadone, Venlafaxine, and Hydroxyzine on 05/03/24, the day after she admitted to the facility. 3. The facility failed to follow physician orders, acquire, and administer Resident #3 with Calcitriol, Calcium Acetate, Cholestyramine Light Power, Creon, Culturelle, Donepezil, Eliquis, Latanoprost, and Budesonide on 05/09/24, the day after she admitted to the facility. 4. The facility failed to follow physician orders, acquire, and administer Resident #4 with Docusate Sodium, Ezetimibe, Isosorbide Mononitrate, Losartan, Premarin, Symbicort, Baclofen, Quetiapine Fumarate/Seroquel, Carvedilol, Culturelle, and Rosuvastatin on 05/10/24, the day after she admitted to the facility. 5. The facility failed to follow physician orders and provide Resident #5 with daily Flonase allergy spray since her admission (approximately two months). The failures could place residents at risk for exacerbation of health conditions, worsening of conditions, and physical/emotional discomfort. Findings included: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: The Pavilion at Creekwood		STREET ADDRESS, CITY, STATE, ZIP CODE: 2100 Cannon Dr Mansfield, TX 76063	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Record review of Resident #1's Face Sheet (not dated) reflected she was a [AGE] year old female who admitted to the facility on [DATE] with diagnoses that included depression (a depressed mood or loss of pleasure or interest in activities for long periods of time), schizoaffective disorder (a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations, or delusions, and symptoms of a mood disorder, such as mania and depression), extrapyramidal and movement disorder (drug induced movement disorder), and neurocognitive disorder with Lewy bodies (a type of progressive dementia that leads to a decline in thinking, reasoning, and independent function). Resident #1 was noted to have discharged from the facility on 04/03/24. Record review of Resident #1's admission MDS assessment dated [DATE] reflected her BIMS score was 05, which indicated severe cognitive impairment. Resident #1 had an additional diagnosis of non-Alzheimer's dementia. Resident #1 had no signs or symptoms of delirium, no negative mood issues, and no behavioral symptoms. Resident #1 was dependent on assistance from staff for her ADLs, had no range of motion limitations, and used a walker to ambulate. Resident #1 had no previous falls for six months prior to admission to the facility or during the admission assessment period. Resident #1 received anti-psychotic and anti-depressant medication. The MDS indicated Resident #1's antipsychotic medication was not received since admission. Record review of Resident #1's care plan initiated on 02/16/24 and last revised on 03/28/24 did not address her need for antipsychotic medication, related behaviors, and interventions specific to her needs. Record review of Resident #1's March 2024 physician orders reflected she was prescribed the antipsychotic, Clozapine 200 mg two tablets once a day (Clozapine is an atypical antipsychotic indicated for the treatment of severely ill patients with schizophrenia who fail to respond adequately to standard antipsychotic treatment for schizoaffective disorder). The diagnosis listed for Resident #1's Clozapine was schizoaffective disorder (a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression), start date 02/19/24-open ended. Record review of Resident #1's February 2024 MAR reflected she received Clozapine from 02/19/24 through 02/29/24. Resident #1's March 2024 MAR reflected she did not receive Clozapine from 03/04/24 through 03/17/24, for approximately two weeks. Under each entry it reflected, Not administered: Drug/Item not available, waiting on pharmacy. There was no order in Resident #1's clinical chart to discontinue the medication. The medication administration resumed on 03/18/24 through the end of her stay at the facility on 04/02/24. Record review of nursing progress notes related to Resident #1's Clozapine and lack of administration and availability reflected: -[Recorded as Late Entry on 03/07/2024] This nurse has interacted several times with [MD A] and [MD B] via text messages regarding the medication clozapine. The pharmacy will not dispensed until MD fills out a REM's form on line to update her status, lab with WBC's was sent as well to MD. [Physician A] responded that PSYCH should get involved in doing so. I addressed this matter with the ADON. The SW will contact PSYCH to eval and treat. (continued on next page)

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F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

-03/17/2024 -STAT labs results sent to MD and pharmacy to have Clozapine re-filled. This nurse called [Pharmacy name]'s pharmacist to ensure the medication delivery, however the pharmacist stated that the psychiatrist has to sign a consent on line in order for [Pharmacy name] to fill and deliver the medication.

-03/18/2024-Resident remained on skilled services, AOX2 with mild confusion, refused food but will drink juice, still waiting for clozapine from pharmacy.

-03/18/2024 -Patient medication Clozapine taken care of by Psych Dr Pharmacy stat medication out. Drug was given to patient will monitor for adverse behaviors.

Record review of Resident #1's Psychiatric Subsequent assessment dated [DATE] reflected she was being seen for psychosis, paranoia, hallucinations, resistance to ADL/medications, and paranoia. The assessment reflected, Staff reports recent delays in receiving patient's ordered clozapine. Following, increased negative symptoms of psychosis were reported to occur. Once this provider was contacted by the facility, a verbal order was given for collection of CBC with Differential. Following results, Clozapine REMS website was updated with results on 3/17, and clozapine was restarted. Prior to initiation of the exam, staff reports continued, but [sic] decreased symptoms of psychosis (patient has received Clozapine X 3 days at this time). Staff reports patient has been 'more talkative and appetite had overall improved .Psychosis: Staff reports RECENT increased symptoms of delusional thoughts, catatonia, and negative symptoms of psychosis. Patient exhibited disorganized thought progress and reported visual hallucinations during exam. Per staff, sx are ongoing, but have decreased once Clozapine restarted.

(Note: Clozaril/Clozapine: Discontinuing Treatment-For abrupt treatment discontinuation .Monitor all patients carefully for the recurrence of psychotic symptoms and symptoms related to cholinergic rebound such as profuse sweating, headache, nausea, vomiting, and diarrhea. Re-Initiation of Treatment:

When restarting clozapine in patients who have discontinued clozapine (i.e., 2 days or more since the last dose), re-initiate with 12.5-mg once daily or twice daily. This is necessary to minimize the risk of hypotension [low blood pressure], bradycardia [slower than normal heart rate], and syncope [fainting]. If that dose is well tolerated, the dose may be increased to the previously therapeutic dose more quickly than recommended for initial treatment; https://clozaril.com/important-safety-information/- retrieved 05/23/24)

Record review of a facility grievance dated 03/17/24 from Resident #1's RP and communicated to the DON reflected a concern with the resident's medication Clozapine not being dispensed. The DON and ADON C were assigned responsibility for the investigation and the findings determined the medication required a REMS form to be completed on the medication database. MD A had been unable to complete it and requested psyche to complete it. Psyche services were notified and stated they had been working on it. The result was new stat labs were ordered due to the labs being out of date range for the medication and had to be less than a week old for the medication to be approved through the pharmacy. The medication was noted as being received on 03/18/24 and given as ordered.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the DON on 05/17/24 at 3:15 PM revealed it was her first week of employment when Resident #1 admitted to the facility. The DON stated that one night (date unknown), someone in the therapy department contacted her because during one of the therapy sessions earlier that day, Resident #1's RP called and said she was out of her Clozapine. The DON did not know how the RP knew the resident was out of her Clozapine but was able to verify it was true. The DON stated that with Clozapine, she found out that there was a national database where the physician had to go into the database and update the patient's information and ensure labs were completed within seven days of the prescription being filled. The DON stated MD A tried to get the order filled but could not log into the database and he thought MHMR was working on it because that was who had seen her prior to admission. The DON stated, So by the time he [MD A] told me, we thought maybe psyche services could help up. I called the NP and got stat labs done. The labs prior had been too far gone. The DON said she was not aware of the situation for about four days after the issue had been brought up from the RP, but she did an investigation on the issue and communicated with the RP. The DON stated going forward, At new admission, it is going to be a flagged and have a plan in place before we admit [a resident with a restricted medication]. An interview with the ADM on 05/17/24 at 3:29 PM revealed he had worked the grievance related to Resident #1 and the unavailability of her antipsychotic medication Clozapine. The ADM stated that prior to her admission, Resident #1 was in a rehab hospital where they decreased her dose. The RP was upset and disagreed, and felt it was impeding her therapy progress as a result. However, the rehab hospital had concerns that the dose was too high and felt she was more stable on a lower dose and at less risk for falls. The ADM stated when Resident #1 admitted to the facility, the medication Clozapine was not on her transfer orders so the RP tried to bring the medication from home and that was what the facility used until it ran out. The ADM stated ADON C was the person who would know more because she was the one trying to get in touch with the rehab hospital to see if they every administered Clozapine during her stay and why it was not on the transfer orders. The ADM stated, I do know when she was on the medication, she seemed to have more falls but her [RP] was certain it was holding her back by not getting it. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with ADON C on 05/17/24 at 9:45 AM revealed when Resident #1 admitted to the facility, she had a bottle of Clozapine but there was no order for it on the transfer orders from the rehab hospital. ADON C stated the facility did not inventory medications that residents admitted with because most of them are on cards/sheets and not loose in bottles so she did not know how many pills of Clozapine Resident #1 admitted with. She stated the day after admission, Resident #1's RP came to her office and said the medication was not listed on Resident #1's MAR. She contacted the rehab hospital who verified Resident #1 was supposed to be on it. Then ADON C added it to the MAR and put the sheet of Clozapine the RP had for Resident #1 on the medication cart to be administered, which was done until she ran out. ADON C stated when Resident #1 got down to her last pill of Clozapine, the charge nurse called the pharmacy for a refill, but they denied it because the resident did not have a current CBC lab with diff nor did she have an REMS form completed (a federally required risk management strategy document that can include one or more elements to ensure that the benefits of a drug outweigh its risks). ADON C stated she did not know what the REMS form was, Just something they [a doctor] have to do online. Then ADON C stated the charge nurse reached back out to MD A to see what he could do but he was not able to access the REMS form online. When ADON C left for vacation during that time frame, she said she returned back to work and the medication for Resident #1 was available and present in the facility. She was not sure, but thought the psychiatrist completed the form to get it filled. ADON C stated, We had to do a stat CBC with diff and then send it in. She was out [of Clozapine] quite a few days, over a week I believe. With that med, there could be a danger to suddenly stopping it like a change in state of mind or something. ADON C stated that while at the facility, Resident #1 had a lot of falls but she did not know when they started and felt she had done better without the Clozapine when it was not available as she was able to participate in more therapy. She did not feel like going without the medication did any harm to Resident #1. However, if she could have done things differently, the facility would have liked to know that medication required the REMS form and the current labs before the pharmacy would fill it. 2. Record review of Resident #2's Face Sheet (not dated) reflected she was an [AGE] year old female who admitted to the facility on [DATE] at 9:49 PM. Resident #2's active diagnoses included sepsis (a serious condition in which the body responds improperly to an infection), hypertension (when the pressure in your blood vessels were too high, congestive heart failure (a complex clinical syndrome characterized by inefficient myocardial performance, resulting in compromised blood supply to the body), cellulitis of left lower limb (a deep bacterial infection of the skin), acute kidney failure (when your kidneys suddenly become unable to filter waste products from your blood), pain, enterocolitis (an inflammation that occurs throughout your intestines) due to clostridium difficile, and depression (a depressed mood or loss of pleasure or interest in activities for long periods of time). Record review of Resident #2's admission MDS dated [DATE] reflected her BIMS score was 12, which indicated mild cognitive impairment. Resident #2 received antibiotic, antidepressant, diuretic, and opioid medications. Record review of Resident #2's May 2024 Physician orders reflected all medications were ordered by MD G on the date of admission (05/02/24) and included Buspirone 10 mg two tablets three times a day for depression, Gabapentin 300 mg three times a day for pain, Oxybutynin Chloride 5 mg three times a day for pain, Trazadone 150 mg once a day for depression, Venlafaxine 37.5 mg once a day for depression, and Hydroxyzine 25 mg three times a day on 05/03/24. Review of Resident #2's May 2024 MAR reflected she did not receive the following medications on 05/03/24 because they were documented as unavailable, the day after admission by MA D: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Buspirone (PM and HS doses) -Gabapentin (evening dose) -Oxybutynin Chloride (PM and HS dose) -Trazadone (daily dose) -Venlafaxine (daily dose) -Hydroxyzine (PM and HS dose) Record review of Resident #2's nursing progress notes at the time of admission on 05/02/24 through 05/03/24 reflected no documentation in the clinical chart to indicate the medications were not available and what follow up was being done by the facility. 3. Record review of Resident #3's Face Sheet (not dated) reflected she was a [AGE] year old female who admitted to the facility on [DATE] at 5:12 PM. Resident #3's active diagnoses included pleural effusion (a buildup of fluid between the layers of tissue that line the lungs and chest cavity), pneumonia (an infection in the lungs caused by bacteria, viruses, or fungi), acute respiratory failure with hypoxia (a condition where there was not enough oxygen in the tissues of the body), chronic pancreatitis (prolonged abdominal pain with intermittent pain-free periods, weight loss, and relief of abdominal pain when leaning forward), end stage renal disease (kidneys cease functioning on a permanent basis), pain, depression (a depressed mood or loss of pleasure or interest in activities for long periods of time), anxiety (a feeling of fear, dread, and uneasiness), atrial fibrillation (a type of arrhythmia, or abnormal heartbeat), and hypertension (when the pressure in your blood vessels is too high). Record review of Resident #3's admission MDS dated [DATE] reflected a BIMS score of 10, which indicated moderate cognitive impairment. Resident #3's MDS reflected she did not take any high-risk medications. Record review of Resident #3's May 2024 Physician orders reflected all medications were ordered by MD G on the date of admission (05/09/24) and included Calcitriol, Calcium Acetate, Cholestyramine Light powder 4 gram three times a day for chronic pancreatitis, Creon (lipase-protease-amylase) capsule delayed release one capsule orally three times a day for chronic pancreatitis, Culturelle one capsule once a day for chronic pancreatitis, Donepezil 5mg once a day for anxiety, Eliquis 2.5 mg twice a day for atrial fibrillation, Latanoprost one drop once a day for lack of coordination, and Budesonide suspension for nebulization 0.5 mg/2 mL one tab inhalation once a day for pneumonia. Review of Resident #3's May 2024 MAR reflected she did not receive the following medications because they were documented as unavailable on 05/10/24, the day after admission: -Calcitriol (daily dose) -Calcium Acetate (AM, PM, and HS dose) -Cholestyramine Light powder (AM and PM dose) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Creon (AM, PM, and HS dose) -Culturelle (daily dose) -Donepezil (daily dose) -Eliquis (PM dose) -Latanoprost (daily dose) -Budesonide suspension for nebulization (daily dose) Record review of Resident #3's admitting nursing progress note dated 05/09/24 reflected the resident came from the hospital and admitted with a diagnosis of shortness of breath related to pneumonia and medications were verified. There was no documentation in the clinical chart to indicate the medications were not available and what follow up was being done by the facility. 4. Record review of Resident #4's Face Sheet (not dated) reflected she was a [AGE] year old female admitted to the facility on [DATE] at 7:31 PM. Resident #4's active diagnoses included metabolic encephalopathy (problems with the metabolism cause brain dysfunction), essential hypertension (occurs when you have abnormally high blood pressure that's not the result of a medical condition), asthma (a condition in which a person's airways become inflamed, narrow and swell, and produce extra mucus, which makes it difficult to breathe), gastro-esophageal reflux disease (when stomach contents move up into the esophagus), constipation (difficult time passing stool), osteoarthritis (degenerative joint disease), acute kidney failure (when the kidneys become unable to filter waster from the blood), pain, hypertensive urgency (marked elevation in blood pressure), hypothyroidism (when the thyroid does not create and release enough thyroid hormone into your bloodstream), and hyperlipidemia (an elevated level of lipids/fats in the blood). Record review of Resident #4's admission MDS dated [DATE] reflected it was still in progress and being finalized. Review of Resident #4's May 2024 Physician orders reflected the following medications were ordered by MD B on the date of admission (05/09/24) and included Carvedilol 25 mg twice a day for hypertensive urgency, Culturelle one capsule once a day for GERD, docusate sodium [OTC] capsule 100 mg twice a day for constipation, Ezetimibe 10 mg once a day for hypertensive urgency, Isosorbide mononitrate extended release 30 mg once a day for hypertensive urgency; Losartan 100 mg once a day for hypertensive urgency, Montelukast 10 mg once a day for asthma, Quetiapine Fumarate/Seroquel 25mg once a day for metabolic encephalopathy, Rosuvastatin 20 mg once a day for hyperlipidemia, Premarin (conjugated estrogens) 0.5 gram once a day for kidney failure, Symbicort 2 puffs inhalation twice a day for morbid obesity. Review of Resident #4's May 2024 MAR reflected she did not receive the following medications because they were documented as unavailable on 05/10/24, the day after admission: -Carvedilol (PM dose) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Culturelle (daily dose) -Docusate sodium (PM dose) -Ezetimibe (daily dose) -Isosorbide mononitrate (daily dose) -Losartan (daily dose) -Montelukast (daily dose) -Quetiapine Fumarate/Seroquel (daily dose) -Rosuvastatin (daily dose) -Premarin (daily dose) -Symbicort (AM and PM dose) Record review of Resident #4's admitting nursing progress note dated 05/09/24 reflected the resident came from the hospital at 7:45 pm and had a marked increase in delirium and was very confused with ESBL so she was on contact isolation and aspiration precautions. There was no documentation in the clinical chart to indicate the medications were not available and what follow up was being done by the facility. 5. Record review of Resident #5's Face Sheet (undated) reflected was an [AGE] year old female admitted to the facility on [DATE] at 9:11 PM with active diagnoses that included pneumonia (an infection in your lungs caused by bacteria, viruses or fungi), respiratory failure with hypoxia (when there is not enough oxygen in the blood), bronchitis (inflammation of the lining of bronchial tubes, which carry air to and from the lung)and allergic rhinitis (stuffy nose). Record review of Resident #5's admission MDS assessment dated [DATE] reflected her BIMS score was 10 which reflected moderate cognitive impairment. Resident #5 did not have any special respiratory treatments or procedures prior to or during the assessment period. Record review of Resident #5's current physician's orders for May 2024 reflected a prescription for Flonase Allergy Relief OTC spray/suspension; 50 mcg/actuation one spray each nare once a day for allergic rhinitis (start date 03/25/24 open ended). Record review of Resident #5's March, April and May 2024 MARs reflected that since the day after admission on 03/26/24 through 05/17/24, her medication Flonase was not given per physician's orders. The statement documented on the MAR entries for those administrations were, Not Administered: Drug/Item unavailable-Comment: Waiting on Pharmacy C/N Notified. Record review of Resident #5's nursing notes from date from 03/26/24 through 05/17/24 reflected no documentation that Flonase was not available and what follow up was being done by the facility. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. An interview with the DON on 05/17/24 at 3:15 PM revealed when a resident admitted to the facility, the medication transfer orders came from the hospital and the accepting charge nurse at the facility notified the facility physician that had been assigned to the resident. Then the charge nurse would notify the pharmacy to get the medications delivered. The pharmacy delivered medications to the facility on ce a day in the afternoon, but the DON was not sure. She stated the pharmacy would also do stat deliveries which was four hours 24/7. The DON stated she had never had any issues with the pharmacy delivering medications on time for the residents. The DON stated there was in E-kit as well if there was going to be delay in pharmacy delivery for certain medications such as pain medications. If that occurred, the charge nurse had to call the pharmacy, get a code and then could retrieve the medication from the E-kit. If a resident admitted to the facility and the pharmacy had already come out for the day and the medication was not available in the E-kit, the DON stated, We would just call and notify them [pharmacy] and arrange for them to deliver or we can call [local drug store pharmacy] to get them delivered. The DON stated the ADONs were supposed to check the residents' MARs in the mornings and they should be looking for medications that were not administered late and address it. She said the medication aides or nurses were supposed to contact the pharmacy for a refill when a resident was down to their last five or seven doses. The DON stated if a medication was not able to be filled, the charge nurse was supposed to contact the physician to either put a hold on the medication or find out what an alternative was. An interview with ADON C on 05/20/24 at 9:45 AM revealed many of the medications not available to be administer were for the residents who were new admissions. ADON C stated, They come in at 6:00PM and the nurses put orders in at 8:00 PM for bedtime, but don't always start it until the next day. She said the pharmacy came at midnight and medications for those new admissions were usually available the next morning. ADON C stated the pharmacy made routine deliveries twice a day, one around six in the evening and another after midnight. She stated whatever was ordered after 2 pm, came with the overnight delivery around midnight and were able to be given the following day. ADON C stated there were no morning or afternoon pharmacy deliveries to the pharmacy. With the medication aides, ADON C stated if the medication was not available during their med pass, they were supposed to tell the charge nurse and then document it was not available. Then the charge nurse was supposed to go to the E-kit to see if the medication was available. If that medication was not available in the E-kit, the nurse had to call the pharmacy and have them send out the prescription as soon as possible. ADON C stated the fasted time frame the pharmacy could deliver was for a stat request which was two to four hours turnaround time. ADON C stated for the new admissions, a lot of times the DON or the MDS Coordinator would look at the new admissions pending and send clinicals out to the nursing management team, but ADON C said she did not always look at them. She said the facility did not order medications until the residents actually admitted because the orders could change. ADON C stated the facility got the transfer orders when the resident arrived and the charge nurse contacted the assigned physician to get clarification and then entered the orders into the system on the MAR. An interview with the C-RN on 05/20/24 at 10:00 AM revealed once the charge nurse entered in an order in the system on the MAR, they system automatically sent it to the pharmacy. If it was after hours and had to be stat delivered, the charge nurse just had to call the pharmacy and tell them to deliver it stat. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the ADM on 05/20/24 at 10:05 AM revealed after investigator intervention, the facility had in-serviced all the medication aides and nurses on medication administration and pharmacy procedures. He stated they went over the five rights of medications, E-kits and how to access it, and talked to the medication aides about what to do when a medication was not available and to notify the nurse, and for nurses to contact the pharmacy and how to get over the counter medications when they were not available. The ADM for OTC meds, there was a central supply staff who had a list of needed OTC meds (such as Resident #5's Flonase) and all the nurse or med aide had to do was write the medication on the list and he could go out and purchase it immediately. An interview with MA D on 05/17/24 at 12:13 PM revealed the medication aides were responsible for ensuring the residents medications did not run out. MA D stated, We want to pay attention to how many pills are left and how many sheets (blister packs) and there was a re-supply order button on the e-MAR and then you report it to the nurse. MA D stated when medications ran low, she tried to notify the charge nurse a day or two before it ran out and the med aide could reorder it via the e-MAR as long as there was a prescription rx number. If there was no rx number available, the charge nurse had to handle the refill or the ADON. MA D stated if a medication continued to not be available, the med aide was supposed to keep following up with the charge nurse and if necessary, get the ADON involved. MA D stated the potential harm of a resident not having medication available, Could be that what the medication is for is not going to be effective. MA D stated for new admission, what she had learned was the charge nurse was supposed to give the initial dose, not the medication aide. With over the counter medications not available, MA D stated the charge nurse was supposed to contact the physician and see if he could write/change the order to one they had as a house stock (already in house) because certain medications were usually expensive for one person when you can use the house stock and it is the same. For example, MA D stated for Resident #3's order for Culturelle which was a probiotic, the facility did not usually supply it because it was so expensive and the house stock medication that did the same thing was called Acidophilus and that was why did not have it initially available to give to her. MA D stated she thought they got that figure out and she was getting the medication now. With the new admission of Resident #2, MA D stated the charge nurse should have checked the E-kit if the medications were not available from the pharmacy in time, and then if they were not there, the charge nurse should notify the ADON. MA D stated, But the nurse really should have handled it. It is all on the nurse, if I was a nurse, I would have written a note and asked for help. An interview with MA E on 05/17/24 at 12:46 PM revealed the medication aides were responsible for re-ordering medications on already existing prescriptions if they were a scheduled dose, but there were some medications the system would not let them order. When that happened, the medication aide was supposed to notify the charge nurse who would re-order it. MA E stated the potential harm of a resident running out of or not having medications available could be that they may get agitated. MA E stated medications were supposed to be re-filled when a resident got down to their fourth pill. If a resident needed an OTC medication that was not available on admission, there were other options to use from the house stock from central supply, so the med aide just had to let the charge nurse know and they would get authorization from the physician. MA E stated the charge nurse was supposed to give the first dose of all medications for new admissions, so if the medication was not available, the charge nurse would know and would be responsible to handle it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676388	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER: The Pavilion at Creekwood		STREET ADDRESS, CITY, STATE, ZIP CODE: 2100 Cannon Dr Mansfield, TX 76063	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 05/17/24 at 1:03 PM with LVN F revealed the charge nurse was supposed to handle all new admissions and the latest to put in a new order for pharmacy delivery same day was by 5 PM. After 5 PM the pharmacy would not send it out until the following day anywhere from 10 PM to one in the morning (over 24 hours wait time), It is a long wait. LVN F stated there were no morning pharmacy deliveries so if the medication did not come in during the night from 10pm-2am, then they would have to wait until the next overnight delivery. She stated stat meds, however, could be requested and delivered with two to four hours any time of the day and a stat med was determined by the ADONs and DON. For OTC meds not available, LVN F stated the nurse would have to get an order from the physician to change it to an in-house stock supply. LVN F stated the potential harm to a resident of not having prescription medications available were, Plenty in rehab section, so many surgeries so there are blood clots, also pain, seizures and heart attacks if we don't give it and unnecessary suffering because some patients are so aware of their medications and they suffer emotionally feeling like we are not taking care of them. When a medication was not available, LVN F stated the charge nurse was supposed to document it in the clinical chart under a nursing note. LVN F stated, Unfortunately it doesn't happen very[TRUN

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on interview and record review, the facility failed to ensure that each resident's drug regimen must be free from unnecessary drugs, without adequate indications for its use for one (Resident #4) of three residents reviewed for psychotropic medications. The facility failed to ensure Resident #4 was prescribed Seroquel (quetiapine fumarate) without adequate indications for its use. The failure could affect residents by placing them at risk for possible adverse side effects, a decreased quality of life and continued use of possible unnecessary medications. Findings included: Record review of Resident #4's Face Sheet (not dated) reflected she was a [AGE] year old female admitted to the facility on [DATE] at 7:31 PM. Resident #4's active diagnoses included metabolic encephalopathy (problems with the metabolism cause brain dysfunction), essential hypertension (occurs when you have abnormally high blood pressure that's not the result of a medical condition), asthma (a condition in which a person's airways become inflamed, narrow and swell, and produce extra mucus, which makes it difficult to breathe), gastro-esophageal reflux disease (when stomach contents move up into the esophagus), constipation (difficult time passing stool), osteoarthritis (degenerative joint disease), acute kidney failure (When the kidneys become unable to filter waster from the blood), pain, hypertensive urgency (marked elevation in blood pressure), hypothyroidism (when the thyroid does not create and release enough thyroid hormone into your bloodstream) and hyperlipidemia (An elevated level of lipids/fats in the blood). Resident #4 did not have a clinical diagnoses for a mental health disorder. Record review of Resident #4's admission MDS dated [DATE] reflected it was still in progress and being finalized. Review of Resident #4's May 2024 Physician orders reflected Quetiapine Fumarate/Seroquel 25mg once a day for metabolic encephalopathy (start date 05/09/24). Record review of Resident #4's admitting nursing progress note dated 05/09/24 reflected the resident came from the hospital at 7:45 pm and had a marked increase in delirium and was very confused with ESBL so she was on contact isolation and aspiration precautions. Record review of Resident #4's initial care plan dated 05/11/24 and completed by the MDS Coordinator (LVN H) reflected, Approach Start Date: 05/11/2024- Review and confirm admitting orders with attending. Obtain diagnoses for all medications. The care plan did not address Resident #4's use of the antipsychotic medication Seroquel. Record review of Resident #4's May 2024 MAR reflected she was administered Seroquel daily after admission from 05/11/24 through 05/17/24. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's hospital transfer orders dated 05/09/24 reflected Seroquel was started while she was at the hospital, however, no diagnosis was listed on the hospital transfer orders for the indication of the medication's use. Hospital records indicated that Resident #4 admitted on [DATE] for altered mental status and had become more confused the week prior to admission. Resident #4's medications listed prior to hospital admission did not include the antipsychotic Seroquel. Her diagnosis given in the hospital for the reason for admission was acute metabolic encephalopathy due to a UTI and she was placed on an antibiotic. Record review of Resident #4's Consent for Psychoactive Medications dated 05/09/24 reflected she was prescribed Seroquel for the diagnosis of anti-depression [sic] and the specific condition to be treated was delusions and prolonged treatment was indicated as needed. An interview with LVN F on 05/20/24 at 1:03 PM revealed when a resident admitted to the facility with an antipsychotic, the charge nurse was responsible to find a diagnosis from the face sheet and figure out the reason why a doctor would prescribe it. LVN F stated, I usually pick a pre-existing diagnosis. She stated there were three new nurses working at the facility and not every nurse could determine which diagnosis was best for a medication, which could explain why some diagnoses for medications were not appropriate. LVN F stated the charge nurse had to use a diagnosis for a medication already listed on the face sheet, they could not create a new diagnosis, even if they knew what the medication was being used to treat. LVN F stated metabolic encephalopathy was not an appropriate diagnosis for antipsychotic medication. LVN F stated, Again, it is not an excuse, we have three just out of school nurses. Doing the proper training is a challenge, they only give three shift for training of the new nurses for such a fast-paced environment. She then stated, If I do not see an appropriate diagnosis, I have to use a dumb one, but what can I do if I am not allowed to use the right one? I can request the doctor or NP to fix the diagnosis and they will coordinate with the ADON and DON. An interview with ADON C on 05/20/24 at 1:40 PM revealed the psyche doctor usually saw residents after admission and would determine what the diagnosis for an antipsychotic was for, Because sometimes we have the diagnosis, sometimes we don't. If they (residents) don't have a diagnosis, our job it to get the consent from the family and let them know and sometimes the doctor will discontinue it if they think the hospital was using it for sleeping, if not, then they will approve and refer to psyche. ADON C stated when the charge nurse went into the system, they could see the diagnosis from the hospital, but she did not know who actually put the diagnoses into the facility's e-charting system to begin with. She said if there was no appropriate diagnosis for a medication, the nurse just chose one and then the physician could go back in and correct it as well as the MDS Coordinator Nurse. ADON C stated, Some come with the right diagnosis, some don't. She said there was also a stand up meeting that had just been resumed with the arrival of the new DON and they had just had their third one since and they covered all new admission and psyche medications, as well as a number of other areas. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the MDS Coordinator LVN H on 05/17/24 at 2:03 PM revealed she was new to the position and the wrong diagnosis listed for an antipsychotic by the facility was probably one by the charge nurse who did the admission. LVN H stated, For us (MDS coordinators), we do the care plans, we look through the chart to see what it (medication) is used for, that is where we get a diagnosis used for the patient, that is how we know what it is being used for. We try to beat the patient here from the hospital, admissions sends over information and we get all their diagnosis in so when the admitting nurses are putting the medications in, they can put in the appropriate diagnosis. LVN H stated MDS coordinators inherited that task during admissions and she felt some of the charge nurses needed more education to know which diagnoses were correct and the ones to choose for antipsychotic medications. Record review of the facility policy titled, Pharmacy Services Policies and Procedures-Use of Psychotropic Drugs, revised 04/17/24, reflected in part, Policy: 2. Based on comprehensive assessment of a resident, the facility will ensure that- A. Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed in the clinical record .Procedures: .3. The facility will not use diagnoses alone to warrant the use of an anti-psychotic medication; .5. For a resident admitted to the facility already on a psychotropic medication, the medical record must show documentation of the diagnosed condition for which a medication is prescribed if know, and .C. The attending physician in collaboration with the consultant pharmacist will re-evaluate the use of the psychotropic medication and consider whether the medication can be reduced or discontinued.