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	01/05/2025

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on interviews and record reviews, the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 (Resident #2) of 3 residents reviewed for quality of care. RN C failed to assess and notify the physician when Resident #2 fell in the bathroom on 10/05/24. The resident required hospitalization and suffered a clavicle fracture. On 01/03/25 at 1:40 PM, an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 01/05/25, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents who require assistance and supervision at risk for injuries, hospitalization , and death. The findings were: Record review of Resident #2's admission MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included arthritis, osteoporosis, and seizure disorder. Resident #2 had a BIMS score of 14 meaning her cognition was intact. The MDS further reflected Resident #2 required moderate assistance (Helper does less than half the effort) for toileting and ambulating. The resident used a walker. Record review of Resident #2's Progress notes reflected: 10/06/24 2:48 PM Late Entry Note (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10/5/24 at 9:35 PM Floor CNA notified this nurse that resident stated, she fell but right now resident is on the toilet. Upon entering resident's bathroom, resident was noted sitting up on the toilet. This nurse asked resident what happened. Resident stated she slid and fell , but she got herself up. When I asked how she got herself up from the floor, Resident was not able to account for how she got herself up from the floor. Resident denied pain. Pain meds was given 5 minutes before the incident happened. Resident awake, alert, oriented, ambulatory, and able to make needs known. Education provided to the resident on the importance of call light usage and waiting for help before ambulation. Resident was on the toilet she was told to call when she was finished. Call light within reach. Written by RN C 10/06/24 1:09 AM Resident called the husband that she was in excruciating pain. The husband called the facility and said he was coming to take the wife to the hospital. Resident was encouraged to take pain medication which she declined. Vital signs were obtained, Blood Pressure 122/78, Pulse 72, Temperature 97.8, Oxygen Saturation 97% Room Air, Respirations 18. Husband arrived to the facility and requested that the wife be sent to the ER. Patient was sent to the hospital. DON and physician was notified. Written by LVN D Record review of Resident #2's Care Plans, dated 10/01/24, reflected: Resident is at risk for falling related to impaired mobility, muscle weakness, and incontinence. Facility interventions included: Encourage resident to use environmental devices such as hand grips, hand rails, etc. Keep call light in reach at all times. Provide an environment free of clutter. Review of Resident #2's Hospital Records, dated 10/06/24 reflected: Resident was a [AGE] year-old female who presented to the emergency department with a fall. Patient was in an inpatient rehabilitation facility. She was ambulating to the bathroom with her walker when she lost balance and fell to the floor. She did not remember specific(s) of the fall but was assisted back to bed by staff. She began experiencing progressive pain and was subsequently transported to our facility. CT scan revealed the resident had a right clavicle fracture. Record review of the facility Provider Investigation Report for Resident #2, dated 10/07/24 reflected: 10/05/24 9:35 PM Family member reported that Resident #2 was left on the toilet for hours in pain after she fell self-transferring to toilet. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	MD and family notified, assessed for pain and injury, sent to hospital for treatment, staff interviews. Allegation: Unconfirmed Investigation Summary for Resident for 10/05/24: CNA reports that resident called around 9:45 PM, and she was in the bathroom on the commode. Resident reported that she had had a fall when she ambulated to the bathroom with her walker. Resident reported that she was able to get herself up and to the bathroom. CNA reported the fall to the RN who went in to see the resident. Resident had taken a pain pill shortly before she reported the fall. She denied pain to the RN. Resident was not finished using the restroom, so the RN instructed her to call for assistance when she was done. CNA reported that the emergency light came on shortly after 10:00 PM, and she answered the light. She assisted the resident to the wheelchair and back to bed. CNA reported that resident did not complain of pain during the transfer to the wheelchair or to the bed. CNA stated she was making rounds a little before midnight and resident asked her to hand her the cell phone. Resident used her cell phone to call her husband. CNA heard resident tell her husband about the fall. Resident told the CNA that her husband was coming to the facility. Family arrived around 15-20 minutes later. Family visited with his wife and then asked the charge nurse to send her to the ER to be evaluated. Family told the charge nurse that the resident was complaining of pain to her shoulder. LVN went in see the resident. The resident refused pain medication. The LVN called the physician and prepared the paperwork and to send the resident to the ER. Resident was transferred to the ER via EMS around 1:00 AM. Written by the DON Interview conducted with RN C: RN reported that around 9:45 PM the CNA reported that resident was in the bathroom and reported that she had fallen while taking herself to the bathroom. RN went into the room to find resident on the commode. Resident told her she fell earlier while ambulating to the bathroom. Resident told her she was able to get herself up and continue to the bathroom. RN states she had medicated the resident with Tylenol #3 around 9:30 PM. Resident denies pain at that time. RN states she instructed the resident to use the call light when she was finished in the bathroom, and a staff member would assist her back to bed. Interview conducted with CNA R who worked the 2:00 - 10:00 PM shift on 10/05/24. CNA R reported that around 9:45 PM, she responded to the emergency light for the resident, and she was sitting on the commode. Resident reported to the CNA that she had fallen while she was ambulating to the bathroom. CNA R asked her who got you up?, resident stated I got up by myself and came into the bathroom. CNA R stated she immediately went to get the RN, who came right into the room. Interview conducted with CNA E: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA E was the aide assigned to the resident on the 10:00 PM - 6:00 AM shift on 10/05/24. CNA E stated she answered the light shortly after 10:00 PM and the resident was in the bathroom. She assisted the resident to the wheelchair and back to bed. The resident did not complain of any pain and had no changes in her transfer. She checked on her around 2 hours later and the resident asked for her cell phone to call her husband. CNA E stated she overheard the resident tell her husband that she had had a fall. CNA E stated the resident told her that her husband was on his way up to the building. CNA E stated in about 15 minutes the family was here and rang the bell. CNA E let him in. The family spoke to his wife and reported to the charge nurse that she was in pain. CNA E stated the charge nurse went into the room. The husband was upset and wanting her sent to the ER. Interview conducted with LVN D: LVN D was working 10:00 PM - 6:00 AM with the resident. LVN D reported that around 12:30 PM, the family was in the facility to see his wife. He reported to the nurse that she was in excruciating pain to her shoulder. LVN D went in to see the resident, who refused pain medication. Family stated he just wanted her to go to the hospital to be evaluated. LVN D notified the Physician and prepared the paperwork. EMS arrived around 1:00 AM and resident was transferred to the ER. Facility staff was in-serviced on abuse and neglect. Review of a facility in-service for RN C, dated 10/06/24, revealed RN C was in-serviced on ensuring a resident who had a fall was assessed and the physician was notified. An interview on 01/02/25 at 9:55 AM with the family of Resident #2 revealed the resident never returned back to the facility after being sent to the hospital. He said the facility did not call him when she fell . He said the resident did not call for help to go to the restroom. She used her wheelchair to take herself to the bathroom. She said she went to the restroom and fell . She pressed the emergency light and it took a while for them to answer. The family member said when he got to the facility the resident was in pain. The family member said the nurse did not ask the resident if she wanted to go to the hospital. An interview on 01/02/25 at 2:30 PM with RN C revealed on 10/05/24 Resident #2 would always call for help to transfer. RN C said the resident could barely walk. RN C said she gave the resident pain medicine 30 minutes before the fall. When she interviewed the resident, RN C said the resident told her she fell but was able to get back on the toilet. RN C said the resident did not tell her she was hurting. RN C also said the resident could not tell her how she fell . RN C said she could not establish for sure that the resident actually fell so she just gave the resident education about using her call light. RN C said she did not assess the resident. RN C said she only did a head-to-toe assessment if the resident was on the floor. RN C said it was necessary to assess a resident after a fall in case there was a fracture. A follow-up interview on 01/03/25 at 11:00 am with RN C revealed she did not call the physician after the reported fall because the physician would have asked her about the fall, and she did not have those answers. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on 01/03/25 at 3:00 PM with CNA E revealed she worked with Resident #2 on the 10:00 PM-6:00 AM shift on 10/05/24. CNA E said she did her rounds with the resident between 10:00 PM - 10:15 PM and assisted the resident to bed. CNA E said Resident #2 complained of pain in her shoulder and she told LVN F. An interview on 01/03/25 at 3:05 PM with LVN D revealed when she came on shift at 10:00 PM, she saw Resident #2 in bed. Her family member called LVN D at 11:00 PM and said she was in pain. LVN D said she went to the resident's room and assessed her. Resident #2 complained of pain so she went to get pain medicine for her. She said she did not see the resident fall. LVN D said the resident refused pain medicine and that she only wanted to go to the hospital. LVN D said the resident did not have swelling or bruising on her shoulder and she sent her to the hospital. An interview was attempted with CNA R for 2:00 PM-10:00 PM shift, but she did not return the call of the Surveyor. An interview on 01/02/25 at 4:10 PM with the DON revealed if a resident fell , the nurse was to do a full assessment. The assessment would include full range of motion, pain assessment, and to assess for bruises and fractures. The nurse was also supposed to check to see if the resident hit their head. The DON said she did not know RN C did not assess Resident #2 after she fell . The DON said the resident could not be assessed for injuries if an assessment was not be completed. The DON said she thought maybe RN C was not aware that the resident fell . The DON said if an incident was not thoroughly investigated then staff would not be educated, and it could happen again. A follow-up interview on 01/03/25 at 9:55 AM with the DON revealed she thought RN C notified the physician after the fall. The DON also said staff were in-serviced on completing and assessment and notifying the physician after a fall. Review of the facility policy, Fall Management, dated 05/05/23, reflected: Definitions: Fall refers to the unintentionally coming to rest on the ground, floor, or other lower level, but not because of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred . 5. Qualified staff evaluates patient/resident for injury from a fall, identify and treat for pain related to fall, and determine contributing causes, including ascertaining what the resident was trying to do before he or she fell , addresses the risk factors for the fall such as the resident's medical conditions(s), facility environment issues, or staffing issue; and determines interventions to prevent future falls and completes a Fall Investigation Worksheet . 7. Neurological evaluations will be performed for a resident who sustains an unwitnessed fall, regardless of the resident's cognitive status at the time of the incident. 8. The physician and family are promptly notified, and an incident report is completed . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This was determined to be an IJ on 01/03/25 at 1:40 PM. The Administrator and the DON were notified. The Administrator was provided with the IJ template on 01/03/25 at 2:45 PM. The following Plan of Removal was submitted by the facility and was accepted on 01/05/25 at 08:27 AM and reflected the following: Identified resident was no longer at the facility. Residents who had a fall in the last 14 days would have a medical record review by the Director of Nursing/Designee by 01/03/25 to validate assessments were completed and physician was notified. Residents identified without an assessment would have one completed by the Director of Nursing/ Designee by 01/03/25. Residents identified without physician notification would have notification completed by 01/03/25. All staff would be re-educated by the Director of Nursing/Designee by 01/04/25 on the fall management policy, which included: Qualified staff evaluated patient/resident for injury from a witnessed or unwitnessed fall and identify and treat for pain related to fall by conducting and documenting a head-to-toe assessment. Neurological evaluations would be performed for a resident who sustained an unwitnessed fall, regardless of the resident's cognitive status at the time of the incident. The physician and family would be promptly notified, and an incident report would be completed. Any staff not present would be in-serviced prior to their next scheduled shift. The Director of Nursing/Designee would review the 24-hour report and the Facility Activity Report beginning 01/04/25 to identify any documentation regarding a fall and validate that the resident had been assessed, physician notified, responsible party notified, and orders implemented. This would be completed in the Clinical Meeting Monday thru Friday. Ad Hoc QAPI was held on 01/03/25. The Medical Director was notified of the Immediate Jeopardy on 01/03/25. Monitoring of the facility's Plan of Removal included the following: Record review of Resident #2's clinical records revealed the resident did not return to the facility after her fall. Interviews were conducted on 01/05/25 from 1:10 PM to 4:57 PM with staff from various shifts. The staff included CNA A, LVN G, CNA H, CNA I, RN J, LVN K, LVN L, LVN M, CNA N, LVN O, and LVN P. RN C was not available for interview. RN C was in-serviced per in-service review. All staff were able to identify: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The nurse was responsible for assessing a resident after a fall. The nurse was to complete a head-to-toe assessment and range of motion assessment. Neurological assessments were to be completed for falls where a resident hit their head or for an unwitnessed fall. Nurses knew to assess residents even if they did not know for sure if a resident had a fall. The nurse knew to notify the doctor, DON, ADON and family member for all resident falls. An interview on 01/05/25 at 4:34 PM with the DON revealed her roles in the facility plan of removal included: She reviewed residents who had had a fall in the last 14 days to ensure assessments were completed and the physician was notified. She said there were no issues identified with her review. She said she all would review the 24-hour report and the Facility Activity Report to identify any documentation regarding a fall and validate that the resident had been assessed, physician notified, responsible party notified and orders implemented. This would be completed in the Clinical Meeting Monday through Friday. The DON said she did a 1:1 in-service with RN C regarding doing full assessments. An interview on 01/05/25 at 4:57 PM with the Administrator revealed he knew the definition of neglect. He said his role in the Plan of Removal was to ensure all steps were completed and that the monitoring was on-going. An interview was attempted on 01/05/25 at 4:26 PM with the Medical Director. The Medical Director did not return the call of the Surveyor. The Administrator and DON were informed the Immediate Jeopardy was removed on 01/05/25 at 5:30 PM. On 01/03/25 at 1:40 PM, an IJ was identified. While the IJ was removed on 01/05/25, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on interview and record review, the facility failed to provide adequate supervision and assistance to prevent accidents and injury for 1 of 3 residents (Resident #3) reviewed for accidents and supervision. CNA A and RN B failed to ensure that Resident #3 was not left alone in the shower chair in his room. As a result, Resident #3 fell out of the shower chair, obtaining a hematoma to his head and being sent to the hospital. On 01/03/25 at 5:00 PM, an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 01/05/25, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk of, neglect, serious injury, and death. Findings included: Record review of Resident #3's admission MDS dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included stroke, hemiplegia (paralysis on one-side of the body) or hemiparesis (weakness on one side of the body), and aphasia (condition that affects the ability to verbally communicate). Resident #3 had a BIMS score of 11 meaning his cognition was moderately impaired. The MDS further reflected Resident #3 was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers was required for the resident to complete the activity) on staff for tub/shower transfers. Record review of Resident #3's Progress notes dated 11/04/24 reflected: 11/04/24 at 9:46 PM At 7:17 PM RN B was verbally notified by CNA A that resident had an unwitnessed fall. She briefly stated she had just given him a shower; she then used the rolling shower chair to move patient from the bathroom closer to the bed. She stated she needed assistance and left the resident unattended for no greater than 5 minutes to get assistance to aid in transferring resident back to bed. Resident was then found lying on the floor face down. Resident was observed by RN conscious with a noticeable medium sized, swollen bump on the left side of his forehead. Resident was manually transferred to bed with the assistance of two CNA staff members. Vital signs were obtained Blood Pressure: 156/78 Heart Rate: 102 Respirations: 20, Oxygen level:96% Room Air. A head-to-toe assessment was completed with no visible new injuries other than the swollen forehead. Resident denied feeling any pain or discomfort but stated he did not remember just having a fall. ADON, Physician, and family notified. EMS was called for assistance, ambulance services arrived, report was given; and resident was transferred to the hospital for further observation. Written by RN B. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #3's care plan dated 10/14/24 and revised on 11/05/24 reflected he was at risk for falls due to impaired mobility on the left side, diabetes, incontinence, and decreased cognition. Facility interventions included: 11/05/24 - Staff education 10/14/24 - Encourage resident to use environmental devices such as hand grips, handrails, etc. Keep call light in reach at all times. Keep personal items and frequently used items within reach. Orient to changes in environment such as new furniture, room changes, etc. Provide an environment free of clutter. Provide proper, well-maintained, slip resistant footwear. 10/14/24 Resident requires assistance with activities of daily living. Facility interventions included: Transfers - Assist of 1-2 Bathing - Assist of 1 The care plan did not address fall risks related to showers chairs. Record review of the facility's Provider Investigation Report dated 11/11/24, for Resident #3 reflected: 11/04/24 7:15 PM Resident had a fall from his shower chair to the floor. The resident had a hematoma on the left side of his head. The resident was given a shower in a shower chair by CNA A. When the shower was over, CNA A dried off the resident and wrapped him up in towels and wheeled him to the side of his bed. She locked the wheels to the shower chair and then CNA A left the room to get another CNA to help transfer. When CNA A got back to the room, the resident had fallen out of the shower chair to the floor. Family and physician notified, resident assessed for pain and injury and sent to hospital for treatment. Staff were interviewed, and CNA A was suspended pending investigation. Resident fall risk assessment was updated, care plan updated. Staff in-serviced over abuse and neglect. Employee corrective action. Nursing staff was re-educated on fall management and not leaving residents unattended. 11/5/24 Interview with CNA A (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA A said on Monday night 11/04/24 she and another CNA used the hoyer lift to transfer the resident into the shower chair. The other CNA left, and CNA A gave the resident a shower. When CNA A finished the shower, she dried him off. CNA A said she placed three towels around the resident and then wheeled him (in the shower chair) to the side of his bed. She said she locked the wheels and told the resident she was going to get a CNA to help transfer him. CNA A said when she got back in the room a couple minutes later, the resident had fallen to the floor, and she left the room and went and got the nurse. Review of an in-service, Fall Prevention and Major Injuries, dated 11/05/24 reflected: Do not leave resident by themselves unsupervised in shower chair .Ensure to see the falling star on the door that is to let you know the resident is at risk for falls. Check POC (plan of care) for how the resident is transferred. 30 nursing staff were in-serviced. CNA A was not in-serviced. RN B was in-serviced. Review of an in-service, Abuse and Neglect, dated 11/05/24 reflected 32 staff were in-serviced. CNA A and RN B were not in-serviced. The findings of the investigation were unconfirmed. Record Review of the Corrective Action Form for CNA A, dated 11/08/24, reflected CNA A was in-serviced regarding not leaving a resident unassisted and fall risk. There was no documentation provided to show CNA A was in-serviced on neglect prior to 01/03/25. The facility provided their Mitigation Plan for the incident following the calling of the Immediate Jeopardy. The Mitigation Plan dated 11/05/24 reflected: What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: Practice issue is to be free of accident/hazards/Supervision and devices. Resident was sent to hospital 11/4/24 at approximately 7:17 PM for evaluation and returned to the facility on [DATE] at approximately 8:00 PM with a diagnosis of hematoma. Resident's fall risk assessment was updated to reflect current status and fall interventions were in place per the care plan. Residents' physician was notified for medication evaluation and a follow up appointment was made per ER discharge recommendations. Nursing staff was re-educated on the fall management policy and to not leave residents unattended. Staff involved was suspended pending investigation and incident was reported to HHSC. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	How other residents who have the potential to be affected by the alleged deficient practice are identified: Residents who require assistance with showering had the potential to be affected. Residents who had a fall in the past 14 days were to be reviewed by DON and/or designee to validate root cause had been identified and appropriate intervention was implemented. This was to be completed by 11/06/24. How the corrective action would be monitored to ensure the deficient practice would not recur: Licensed nurses would be re-educated on Root Cause Analysis, how to conduct a thorough investigation for a resident who falls to determine the root cause of the fall and implementation of an appropriate intervention to prevent further falls with care plan and profile updates to reflect new interventions. This education would be presented by the Director of Nursing and/or Designee and would be completed by 11/06/24. Re-education was provided on Abuse and Neglect and completed on 11/05/24. Facility Administrator would be responsible for the overall implementation and validation of this plan. Facility Medical Director will be informed of this plan and given progress updates. What quality assurance program will be put into place: Fall Incident reports would be reviewed monthly for trends by the Director of Nursing/designee. Leadership would conduct random rounds 3 times a week to validate fall risk interventions were in place and that residents were not left unattended during bathing. These reviews would be presented to the Quality Assurance and Performance Improvement Committee for review and recommendations for 3 months. Any discrepancies would be addressed at time of discovery. An interview on 01/02/25 at 11:07 AM with the family of Resident #3 revealed the resident had been discharged . The family member said she was notified by the facility that the resident had a fall after being left on the shower chair because the staff was not able to transfer him without help. The family member said they did not understand why the resident was left unattended. (continued on next page)

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	676388	A. Building B. Wing	01/05/2025

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on 01/03/25 at 12:30 PM with CNA A revealed on 11/04/24 she gave Resident #3 a shower in a shower chair. She said she needed to put him to bed, but no one was there to help her, and no one was answering the call light. CNA A said she left the resident in the shower chair and went to look for help to get him to bed. She said while she was gone (maybe two minutes) he fell out of the shower chair onto the floor. CNA A said she did not see the resident fall. She said she did not know if the resident usually had problems sitting in a shower chair because she did not usually take care of him. CNA A said the resident was not wobbly in the shower chair. CNA A said neglect was leaving a resident unattended and that she neglected Resident #3 when she left him in the shower chair unattended. CNA A said she was in a hurry and had another resident waiting on her. She said she had an in-service on neglect at the end of December 2024. She said she was not sure if she had received an in-service about leaving residents unattended but thought maybe she did. She said she did receive in-services after the incident, and she had not left any other residents unattended in a shower chair. An interview on 01/03/25 at 12:15 PM with RN B revealed she was working on 11/04/24 when Resident #3 fell . She said she was in a room and overheard 2 CNAs talking and she heard the word fall. The CNAs told her that Resident #3 fell out of the shower chair. RN B said CNA A had stepped away for a few minutes to get help to transfer him and he fell . RN B said the resident had a hematoma on his head and she sent him out to the hospital. RN B said Resident #3's left side was flaccid and he had muscle spasms. She said he had no control over the left side of his body and had a history of sliding out of a low bed because he was not able to use the left side of his body. She said staff had to stay with Resident #3 while he was in a chair because he would lean to his left side. RN B said neglect was a staff not doing something for a resident that they were supposed to do and it caused harm. She said she did not know when her last in-service for neglect was and that she had been at the facility for 3 months. RN B said Resident #3 was not neglected when he was left unattended because CNA A was trying to get help for him. RN B said she had not received any in-services about not leaving resident unattended in a shower chair. She said leaving a resident unattended could result in falls and harm. She said she did not remember receiving any in-services after the incident. An interview on 01/03/25 at 1:30 PM with the DON regarding Resident #3 revealed she was on vacation when the resident fell . She said she was told that he fell in the shower room. She said Resident #3 did not have problems sitting in a chair. She said neglect was failure to provide basic needs to the resident. The DON said CNA A neglected the resident when she stepped away and left Resident #3 alone. The DON said in-services on neglect and not leaving residents unattended had been completed with staff. She said a resident left unattended placed them at risk for falls and injuries. An interview on 01/03/25 at 1:35 PM with the Administrator regarding Resident #3 revealed CNA A gave the resident a shower, wheeled him to bed, locked the wheels, and left to go get help, (instead of using the call light) because the resident was a two person assist. The Administrator said neglect was not doing something you know you are supposed to do and in-services on neglect were provided to staff about every week. He said in this instance, CNA A did not neglect Resident #3 because she locked the wheels, covered him with towels. She was trying to get assistance with the resident. The Administrator said CNA A did not use the correct intervention. The Administrator said residents left unattended were at risk for falls and injuries. He said he had completed in-services with staff about not leaving residents unattended. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An follow-up interview at 01/04/25 at 10:25 AM with the DON revealed CNA A was not listed on the facility in-services because she was provided a 1:1 in-service. The DON said that the care plan for Resident #3 did not include information regarding not being left alone in a shower chair because staff were in-serviced that no resident could be left alone in a shower chair. The DON said leadership was conducting random rounds three times a week to validate that residents are not left unattended during bathing. Record review of the facility's Abuse, Neglect, Exploitation, or Mistreatment policy, not dated, reflected: POLICY: 1. The facility's Leadership prohibits neglect . 6. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. This was determined to be an IJ on 01/03/25 at 5:00 PM. The Administrator and the DON were notified. The Administrator was provided with the IJ template on 11/04/24 at 5:09 PM and a Plan of Removal was requested. The following Plan of Removal was submitted by the facility and was accepted on 01/05/25 at 08:27 AM and reflected the following: Resident #3 was sent to the ER for assessment and treatment on 11/4/24 and returned the same day with new orders. Resident #3's fall risk assessment was updated upon return and new interventions implemented and care planned. CNA A received disciplinary action and 1:1 education by the Director of Nursing on fall management including not leaving residents unattended during bathing by 11/06/24. A review of fall risk evaluations will be completed by the Director of Nursing/Designee on current residents to validate the assessments are accurate. Identified residents without a current fall risk evaluation will have one completed by 01/04/25 with appropriate interventions implemented, care planned and placed in the resident profile. A review of the falls from the previous 14 days to assess root cause and appropriate interventions was completed by the Director of Nursing/Designee by 11/06/24. Nursing Staff were re-educated by the Director of Nursing/Designee on 11/5/24 on Fall Management Policy and not leaving residents unattended during bathing including: Fall risk evaluations are completed by the licensed nurse at admission, readmission, quarterly and with significant change in condition. Fall interventions are updated as needed with fall risk evaluation update, care planned and placed in resident profile for nursing staff reference. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident care needs are updated with change and documented in care plans and resident profiles for nursing staff reference. Administrator and Director of Nursing were reeducated on Abuse and Neglect by the Clinical Consultant on 01/04/25. Nursing Staff were reeducated on Abuse & Neglect by the Director of Nursing/designee by 01/04/25. Nursing Staff and new hires not receiving this education by 11/06/24 will receive it prior to their next scheduled shift. The Director of Nursing/Designee will review fall risk evaluations for new admissions and readmissions in clinical morning meeting Monday - Friday, to validate accuracy and thoroughness and validate care plans and resident profiles have been updated as appropriate. This will be completed by the weekend supervisor on the weekends. The Director of Nursing/Designee will review fall risk evaluations weekly following the MDS calendar to validate accuracy and thoroughness and validate care plans and resident profiles have been updated as appropriate. The Director of Nursing/Designee will validate resident care needs have been care planned and documented in resident profiles following the MDS calendar weekly. The Director of Nursing/designee continued to complete rounds 3 times a week to verify appropriate fall interventions are in place and residents are not being left unattended during bathing. An Ad Hoc QAPI was held on 11/06/24. The Medical Director was notified of the contents of this plan on 11/05/24 and Immediate Jeopardy on 01/03/25. Monitoring of the facility's Plan of Removal included the following: Record review of Resident #3's clinical records revealed the resident had been assessed by nursing after the incident on 11/04/24 and was transferred to the hospital for treatment. Interviews were conducted on 01/05/25 from 1:10 PM to 4:57 PM with staff from various shifts. The staff included CNA A, LVN G, CNA H, CNA I, RN J, LVN K, LVN L, LVN M, CNA N, LVN O, and LVN P. All staff were able to identify: What neglect was and different types of neglect. The staff understood that a resident could not be left unattended in a shower chair ever. Staff knew how to identify if a resident was at risk for falls. Staff said if they needed assistance to transfer a resident from a shower chair they would wait for help and not leave the resident alone. Observations and interviews with residents on 01/05/25 from 1:10 PM to 4:57 PM revealed they were not left alone in the shower chair. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on 01/05/25 at 4:34 PM with the DON revealed her roles in the facility plan of removal included: Review fall risk evaluations for new admissions and readmissions in clinical morning meeting Monday - Friday, to validate accuracy and thoroughness and validate care plans and resident profiles have been updated as appropriate. Continue to complete rounds 3 times a week to verify appropriate fall interventions are in place and residents are not being left unattended during bathing. An interview on 01/05/25 at 4:57 PM with the Administrator revealed he knew the definition of neglect. He said his role in the Plan of Removal was to ensure all steps were completed and that the monitoring was on-going. An interview was attempted on 01/05/25 at 4:26 PM with the Medical Director. The Medical Director did not return the call of the Surveyor prior to exit. The Administrator and DON were informed the Immediate Jeopardy was removed on 01/05/25 at 5:30 PM. On 01/03/25 at 5:00 PM, an IJ was identified. While the IJ was removed on 01/05/25, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47030 Based on observations, record reviews, and interviews the facility failed to ensure that a resident who was diagnosed with a mental illness or psychosocial adjustment difficulty received appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being for one (Resident #1) of 5 residents reviewed for services for mental/psychosocial concerns, in that: LVN O failed to follow the facility's suicide policy when Resident #1 made an outcry of self-harm on 01/01/25. An IJ was identified on 01/03/25. The IJ template was provided to the facility on [DATE] at 5:09 PM. While the IJ was removed on 01/05/25, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place. This deficient practice placed residents with suicidal ideations at risk for not being monitored effectively and could affect other residents with psychiatric diagnoses in the nursing facility. Findings included: Review of Resident #1's Quarterly MDS assessment dated [DATE] revealed she was [AGE] year-old female who admitted to the facility on [DATE]. Her diagnoses included: stroke, Alzheimer's disease, CVA/TIA/Stroke, depression cognitive communication deficit. Her BIMS was a 05 indicating sever cognitive impairment. Section E indicated that Resident #1's had no potential indicators of psychosis. Section N indicated that Resident #1 was taking antidepressants. Review of Resident1's Care Plan, with an edited date of 12/07/24 reflected the following: - Focus section: [Resident Name] is taking Psychotropic Drug and is at risk for adverse consequences R/T receiving psychotropic medication for the treatment of: Use Problem Start Date: 01/09/2024 diagnosis of DEPRESSION. - Focus section: Resident has impaired cognition with expected decline in cognitive impairment over a period of time as a natural progression of the disease process Goal Target Date: 03/08/2025. Review of Resident #1's Physician Orders for December 2024 reflected the following orders: - Fluoxetine 20mg MG, - Remeron Tablet 7.5 MG (Mirtazapine), - Depakote Tablet delayed release 125MG (Divalproex Sodium), (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Donepezil 10 mg, and Psych evaluation and TX as indicated (active order since 01/06/2024). Review of Resident #1's nurses' note from 12/01/24 through 01/05/25 reflected the following: 01/01/2025 [Recorded as Late Entry on 01/01/2025 08:55 PM] [LVN O]. This nurse found patient sitting in wheelchair beside her bed screaming Help me. Nurse asked patient what the problem was, and patient stated she wanted to get the hell out of here. Nurse explained to patient that she cannot go anywhere without the doctor's consent. Patient stated she wanted to kill herself so she would be sent to the hospital. Nurse explained that I would not allow her to do anything to hurt herself. Patient stated she feels she is being held here against her will. Nurse advised that she would need to talk with the doctor about her going home. Patient is refusing her pain med, her regular meds and the clonazepam. [MD] notified of above, no new orders at this time. Will continue to monitor patient closely. 01/01/2025 [Recorded as Late Entry on 01/02/2025 03:45 PM] [LVN O] This nurse notified patient's [FM/RP] of patients status and the fact that she wants to kill herself. states that she cannot handle her and that she gets physically sick when dealing with her. Nurse advised [FM/RP] that we are watching her closely and will notify her of any changes. [FM/RP] stated understanding. An observation on 01/02/25 at 12:20 PM revealed that Resident#1 was observed repositioning herself from right to left and adjusting covers and her pillow. Resident #1 did not respond when HHSC Surveyor attempted to speak to her. An observation and interview on 01/03/25 at 10:30 AM revealed Resident #1 was observed laying her in her bed, the resident stated she felt better but wanted to sleep. In an interview on 01/02/25 at 2:06 PM Resident #1's FM/RP stated on the evening of 01/01/25 the facility notified her that the resident was screaming. FM stated, for my personal health I could not deal with her so I asked the facility could they not sedate her?. The FM stated that about two weeks ago the resident medication dosage was lowered and whenever there were changes in residents' medication the resident got more agitated. The FM stated that happened while she was at the assisted living, they lowered her medication, and the resident was screaming about several hours she calmed the resident over the phone. She stated that she was aware the resident slept a lot, but the resident had always been sleepy even before transferring to the facility. In an interview on 01/03/25 at 1:17 PM with CNA H (works 6AM-2PM Monday - Friday) revealed she knew Resident #1 and knew she screamed often and always wanted to go back to bed as soon as staff got her out bed for meals or activities. CNA H stated she was not aware that Resident #1 had mentioned she wanted to kill herself the other day (01/01/25) and was notified the day after . CNA H stated that if a resident mentioned they wanted to harm themselves, she would report it immediately to the nurse. CNA H stated that failing to monitor a resident with suicidal ideation could result in the resident hurting themselves. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 01/02/25 at 3:17 PM LVN S stated that during her shift change, it was not reported to her from LVN T that Resident #1 had stated she was going to kill herself . LVN S stated that she was notified Resident #1 had made suicide outcry to LVN O by the DON during her shift. LVN S stated that when she came in for her shift, staff got the resident up for breakfast and on the resident request staff put her back to bed and the resident had remained in bed for most of her shift. LVN S stated that if a resident made statements to hurt themselves, she would assign a CNA to monitor the resident, the call doctor who would send to the emergency room or have psych come assess the resident. LVN S stated she would also notify DON, ADON, Administrator and family. LVN S stated that items that residents could use to hurt themselves included call light chords, bedside tables and telephone cords. LVN S stated that failing to monitor a resident with suicidal ideation could result in the resident hurting themselves. In an interview on 01/02/25 at 3:50 PM LVN T stated when he received report from LVN O, he was not told that Resident #1 had mentioned she wanted to kill herself but that she had a new order for Clonazepam. LVN T stated that when he started his shift, Resident #1 was already asleep and remained asleep during his shift. LVN T stated that if a patient had suicidal ideation, he would immediately notify the DON, physician, Administrator, and family. LVN T stated that he would implement interventions per physician orders. LVN T stated that staff would complete 15 mins checks and monitor residents for up to three days. LVN T stated he did not monitor the resident for suicide ideation because he did not know that the resident had said she wanted to kill herself. LVN T stated if patient is not monitored the risk remains, they can kill themselves. In an interview on 01/02/25 at 2:40 PM with LVN O, revealed that on 01/01/25 during the evening shift, Resident #1 had said a lot of things. LVN O stated that Resident #1 had stated she wanted to get the hell out of here and wanted to kill herself. LVN O stated that Resident #1 had wanted to go to the hospital and wanted her (LVN O) to give her (Resident #1) medication to sleep so she would not wake up. LVN O stated that the Resident #1 wanted to get out of bed and to kill herself. LVN O stated she called Resident #1's daughter who said she could not deal with the resident and did not want to talk to her. LVN O stated that she was not able to get ahold of Resident #1's husband and Resident #1 felt that her husband had abandoned her. LVN O stated that she stayed with the resident the whole time during her shift. LVN O stated when she went to another resident, she left the resident with nurse LVN T. LVN O stated she did not notify the DON or the Administrator because she was more concerned with making sure Resident #1 did not hurt herself. LVN O stated she texted the MD about what the resident said, and he responded okay and gave her orders to renew clonazepam. When asked about the facility's suicide policy, LVN O did not say anything. In an interview on 01/02/25 at 4:33 PM, the Social Worker revealed she was notified about Resident #1's statement of wanting to kill herself, after psych services had assessed Resident #1. Social Worker stated she went to assess Resident #1 but Resident #1 did not want to talk . Social did not state who contacted psych services. Social Worker stated that if a resident verbalized the intent to harm themselves, she would have called the psych service provider to have the resident assessed, to ensure the was safe to remain in the building and if not, the resident would be transferred to the hospital. Social Worker stated that she believed the policy was to have the resident on 15-minute checks until the resident was seen by psych services. Social worker stated that her understanding was the staff reached out to the doctor. Social worker stated that if the residents was not properly assessed it can be serious that resident could hurt themselves. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview of 01/02/25 at 1:13 PM the DON stated she was not notified by LVN O that Resident #1 stated she wanted to kill herself. The DON stated HHSC Surveyor had made her ware of Resident #1's claim. The DON stated that her expectation was that LVN O followed policy which was to put the resident on 15-minute checks. The DON stated if LVN O would have called her (DON) then DON would have walked LVN O through on what to do. In an interview on 01/02/25 at 3:34 PM, the MD stated he received a message from LVN O stating that Resident #1 had refused medication and wanted to kill herself so she could go to the hospital. The MD stated that he told LVN O okay. HHSC Surveyor asked MD what he meant by okay and he stated he meant okay to send the resident to the hospital, because the resident had refused to take medication, and threatened to kill herself. The MD stated that the facility had a policy that if a resident verbalized, they wanted to hurt themselves, the resident would be sent to the hospital to be evaluated unless psych was available to evaluate the resident. The MD stated that he did not have knowledge of Resident #1 wanting to her hurt herself in the past. The MD stated he was aware that Resident #1 had a family issue that was causing the resident to become agitated. Review of policy Suicide Prevention and precaution management dated 05/2023 reflected the following: Policy Statement: The Facility will provide and/or arrange for transfer to the safest, practicable living environment for all patients/residents who voice suicidal thoughts, attempt suicide, or cause self-injury. The highest level of emotional and physical well-being of the patients/residents will be promoted using all available resources including but not limited to Physicians, Psychologists, Social Service Directors, Counselors, Psychiatrists, Inpatient psychiatric therapy, and family meetings. The Facility will complete a brief suicide ideation assessment on new admissions with a history of suicidal ideations that includes the following: Brief Suicide Intent Scale: A. On a scale of 1 to 10 how strong is your desire to kill or harm yourself? B. Have you thought about how you would kill or harm yourself? C. Have you ever tried to kill or harm yourself in the past? D. Does the individual have the means available to kill or harm themselves or others? 2. The above will be documented in the clinical record. Should the brief assessment scale reveal concerns related to the mental stability of the resident/patient, the staff will immediately notify the primary physician. The staff will also immediately notify the Administrator, DON, and Social Service Director who will visit with the patient/resident to determine if adequate safety can be provided by the facility. 3. If a patient/resident, who is voicing suicidal thoughts or attempts suicide, is a danger to self or others, additional interventions will be initiated including: A. Physician, Psychiatrist/Counselor/Psychologist and family are notified immediately. If the patient/resident doesn't have a psychiatrist, then a referral is made at this time. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	B. Suicide precautions are implemented immediately if a resident is deemed to be a threat to themselves or others to preserve the well-being of the patient/resident. to address the risk factors presented by the resident/patient. 5. Suicide precautions include the following: A. The resident/patient will eat on the unit without sharp utensils The Physician should be notified immediately of suicide ideations and for further orders. C. If it is determined that the facility cannot provide a safe environment due to the suicidal ideations of the resident/patient will be transported to an acute care setting for evaluation and treatment. 4. Suicide precautions will be implemented immediately for any resident/patient that presents with a significant level of depression or suicidal preoccupation and will be used Until evaluation or transfer can occur, certain items such as belts, drawstring pants, shoes with laces, sheets, etc. may be prohibited if they present a potential danger for the resident/patient. C. Call light cord is removed from patient/resident room. If available, a bell or other signaling device is given to replace the call light. D. Medication nurse observes patient/resident swallowing all medications and checks oral cavity to establish that patient/resident has swallowed all medications. E. If available, a wander device is placed on the patient's/resident's wrist or ankle. F. Patient's/Resident's door remains open when staff is not providing direct bedside care. Curtains are not drawn so as to obstruct immediate observation of the patient/resident from the hallway. G. A minimum of two staff members is assigned to escort patient/resident to any appointment/ activity outside of the facility. H. A licensed nurse will assess the resident/patient at least every four hours and document the assessment in the medical record. I. Family or responsible party will be notified of the suicide precautions. 6. For residents requiring one-to-one supervision: A. The resident/patient will be assigned a one-to-one staff member who will remain within six (6) feet of the resident/patient and always maintain constant visual contact with the resident/patient. B. During waking hours, the resident/patient will reside in a designated area. C. During sleeping hours, the resident/patient will sleep in an area where close observation can be maintained in accordance with 6.a. above. (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 01/05/2025
NAME OF PROVIDER OR SUPPLIER The Pavilion at Creekwood		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0742

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

D. The employee assigned to the patient will document every fifteen (15) minutes the observation of the resident/patient.

7. A physician order is required to discontinue suicide precautions.

8. Follow-up interventions:

A. Develop behavioral interventions for Care Plan.

B. Provide ongoing support and reassurance by all staff.

C. The patient/resident continues to attend psychiatric/counselor/psychological appointments until formally discharged .

9. Documentation guidelines:

A. When a physician orders suicide precautions, documentation is completed at least every fifteen (15) minutes and more often if needed.

B. Documentation includes date, time, the reason the patient/resident is placed on suicide precautions, patient/resident responses and behaviors, additional safeguards and supervision of patient/resident, the search for and removal of items that may be used in a suicide attempt and time family was contacted.

C. Date, time and reasons suicide precautions were discontinued, and signature.

10. Record that the Patient/Resident was checked every fifteen minutes for suicide precautions. Staff documents this by signing their initials in the column for their shift.

This was determined to be an IJ on 01/03/25 at 5:09PM. The Administrator was notified and provided with the IJ template. A Plan of Removal was requested.

The facility's plan of removal was accepted on 01/05/25 at 8:27 AM and included the following:

[Facility Name] Plan of Removal F742

1/3/25

Resident #[1] was assessed by psychiatry services on 1/2/25 and resident was not deemed a threat to herself, per psychiatry provider transfer to hospital not appropriate at this time and resident agreed. Social Services Director completed a suicide ideation assessment on 1/3/25 and resident was not deemed a threat to herself. Resident #[1] will continue to follow up with psychiatry while remaining in the facility

A review of the facility activity report and the 24hour reports from 1/1/25 were reviewed by the Director of Nursing/Designee to identify additional residents that have voiced suicidal ideation. None were identified.

(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 01/05/2025
NAME OF PROVIDER OR SUPPLIER: The Pavilion at Creekwood		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Licensed Nurses and Social Services Director will be re-educated by the Director of Nursing/Designee by 1/4/25 on suicidal precaution management including : If a resident voices or indicates in some manner suicidal ideations the licensed nurse will implement 1:1 supervision immediately and notify the social Services Director. If a safe environment cannot be maintained with 1:1 supervision, the resident will be transported to an acute care setting for evaluation and treatment. The Social Services Director will complete the Columbia Suicide Severity Rating Scale in the medical record Should the assessment reveal concerns, the Social Services Director will immediately notify the administrator, DON and primary physician for further orders. Licensed Nurses not receiving this education by 1/4/25 will receive it prior to their next scheduled shift. The Director of Nursing/designee will review the 24hour report and facility activity report in clinical morning meeting Monday - Friday beginning 1/5/25 to identify residents who have voiced or are indicating in some manner suicidal ideations and validate assessments and notifications were completed. This will be completed by the weekend supervisor on the weekends. Ad Hoc QAPI was held on 1/3/25. The Medical Director was notified of the Immediate Jeopardy and contents of this plan on 1/3/25. The facility's implementation of the IJ Plan of Removal was verified on 01/05/25 through the following: Review of Resident #1's Psychiatric Subsequent assessment dated [DATE] reflected the following: Staff reported current symptoms of loss of interest and psychomotor agitation. Patient stated I'm fine. When asked about current/recent sx of depression patient reported to have made statement regarding self-harm the night prior to exam, at this time patient denies any current suicide ideation, thoughts of self-harm or thought of believing she would be better dead. Primary treating dx. Anxiety, secondary dx. Major depressive disorder recurrent. Review of the Suicide Ideation Assessment completed by the Social Worker, dated 01/03/25 reflected that Resident #1 was not deemed a threat to herself. Resident #1 will continue to follow up with psychiatry while remaining in the facility. An observation on 01/04/25 at 2:30 PM revealed Resident #1 was sleeping in bed. (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 01/05/2025
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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's inservice titled Suicide Prevention and Precaution Management dated 01/02/25, presented by the DON reflected: review policy, including who to notify interventions needed If a resident voices or indicates in some manner suicidal ideations the licensed nurse will implement 1:1 supervision immediately and notify the social Services Director. If a safe environment cannot be maintained with 1:1 supervision, the resident will be transported to an acute care setting for evaluation and treatment. The Social Services Director will complete the Columbia Suicide Severity Rating Scale in the medical record Should the assessment reveal concerns, the Social Services Director will immediately notify the administrator, DON and primary physician for further orders. 63 staff (16 LVNs, 24 CAN, 8 RN, MD, Activity Director, Housekeeping Supervisor, 5 Med Aides, Social Worker Assistant, ADON, 2 MDS Nurses and the Social) had signed the inservice. Interviews were conducted on 01/05/25 from 1:10 PM to 4:57 PM with staff from various shifts. The staff included CNA A, LVN G, CNA H, CNA I, RN J, LVN K, LVN L, LVN M, CNA N, LVN O, and LVN P. All staff were able to verbalize policy, including who to notify and interventions needed If a resident voices or indicates in some manner suicidal ideations the licensed nurse will implement 1:1 supervision immediately and notify the social Services Director. If a safe environment cannot be maintained with 1:1 supervision, the resident will be transported to an acute care setting for evaluation and treatment. In an interview on 01/05/25 at 4:45 PM with the DON revealed she had reviewed the facility activity report and the 24hour reports from 1/1/25. The DON stated the purpose of the review was to identify additional residents that have voiced suicidal ideation. The DON stated no new residents were identified. The DON stated she would be responsible for reviewing the 24hour report and facility activity report in clinical morning meeting Monday - Friday beginning 01/05/25, the purpose was to identify residents who have voiced or are indicating in some manner suicidal ideations and validate assessments and notifications were completed. The DON stated that during the weekend, will be completed by the weekend supervisor on the weekends An interview was attempted on 01/05/25 at 4:26 PM with the Medical Director. The Medical Director did not return the call of the Surveyor. An IJ was identified on 01/03/25. The IJ template was provided to the facility on [DATE] at 5:09 PM. While the IJ was removed on 01/05/25, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.