| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676388 | A. Building<br>B. Wing | 08/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Pavilion at Creekwood | 2100 Cannon Dr<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record, the facility failed to provide treatment and care in accordance with professional standards of practice, the comprehensive resident-centered care plan for one (Residents #1) of five residents reviewed for quality of care. The facility failed to apply a dressing to cover Resident #1's recently infected wound (non-pressure related) on her left foot, when she was observed with it exposed to air on 08/05/25. \|This failure could place residents with wounds at risk of a decline in their healing progression as well as at risk for infection and discomfort. Findings included:Record review of Resident #1's Face Sheet dated 08/06/25 reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #1's diagnoses included dementia (a general term for a decline in mental ability severe enough to interfere with daily life), fracture of right femur (upper leg/thigh), malnutrition, atherosclerotic heart disease (plaque buildup in the arterial walls of the heart), peripheral vascular disease (a circulation disorder that affects blood vessels outside of the heart and brain), local infection of the skin and subcutaneous tissue (the deepest layer of skin, primarily composed of fat and connective tissue), muscle wasting and atrophy (the wasting or thinning of muscle tissue)-multiple sites, dysphagia (difficulty swallowing) and pain.Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 15 and no sign/symptoms of delirium, psychosis or rejection of care issues. Resident #1 had no range of motion issues and used a wheelchair for mobility. Resident #1 required substantial/maximal assistance for transfers and moderate assistance for bed mobility. Resident #1 had occasional pain which occasionally interfered with sleep and therapy activities with an intensity during the assessment period of three (out of ten). Resident #1 was at risk of developing pressure ulcers but had none at the time of the assessment. She had no other skin conditions and had applications of ointments/medications other than to feet.Record review of Resident #1's care plan initiated 06/20/25 and last updated 07/30/25 reflected Problem start date 07/21/25: [Resident #1] has a non-pressure ulcer on left foot between great toe and 2nd toe. Interventions included, Wound care as ordered. See treatment record.Record review of Resident #1's nursing progress noted dated 07/18/2025 and written by LVN A reflected, Resident noted with an open area on the left foot between the big toe and the second biggest. Area inflamed and small amount of exudate noted. MD notified new order to start Bactrim 800mg 1 tab BID x 10 days and wound care consult. Order noted, MAR updated initial dose given from E-Kit.Record review of Resident #1's Initial Wound Evaluation and Management Summary dated 07/20/25 reflected she had a non-pressure wound of the left, first toe-full thickness due to trauma/injury by footwear and was over ten days in duration and was noted to be present upon admission per staff. The healing potential was fair with an estimation of one to two months to heal. The care goal was to decrease necrosis (death of tissue within a wound) and ulcer area by offloading, optimizing moist wound healing, education and counseling and serial debridement. The wound was 2x2x0.1cm with a surface area of 4.00 cm, exudate was light serous with 30% thick adherent devitalized necrotic tissue. There was 10% slough and 60% granulation tissue with no signs of infection. A surgical debridement (a wound care approach where dead or damaged tissue is removed repeatedly over time to promote healing) procedure was completed to remove necrotic tissue and establish the margins of viable tissue. As a result of this procedure, the nonviable tissue in the wound bed decreased from 40 percent to 10 percent. A second visit from the wound doctor occurred on 08/06/25 where Resident #1's wound had decreased in size and was 1.8 x 1.5 x 0.1 cm with a surface area of 2.70 cm and wound progress was noted to be improved as evidenced by decreased surface area with no pain and no signs of infection. The Dressing Treatment Plan reflected: Primary Dressing- 1) Add Collagen Powder once daily and as needed if saturated, soiled, or dislodged for 30 days; 2) Sodium Hypochlorite Gel (Anasept) once daily for 30 days and as needed: if saturated, soiled or dislodged for 30 days; Secondary Dressing: 1) Add Gauze Island w/ bdr once daily and as needed: if saturated, soiled, or dislodged for 30 days.Record review of Resident #1's physician order dated 07/30/25 reflected, Dressing Treatment Plan: Primary Dressing-Collagen powder apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days; Sodium hypochlorite gel (anasept) apply once daily and as needed: if saturated, soiled, or dislodged for 30 days. Secondary Dressing- Gauze island w/ bdr apply once daily and as needed: if saturated, soiled, or dislodged for 30 days.An observation of Resident #1 on 08/05/25 at 12:14 PM, revealed she was in the facility's courtyard with a family member being pushed in a wheelchair. Her feet were observed to not have any socks or shoes on either foot. Resident #1's left foot had an open wound about a quarter in size next to |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure residents with pressure ulcers and at risk for pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for three (Residents #2, #3 and #4) of six residents reviewed for treatment/services for pressure ulcers.1. The facility failed to ensure pressure was offloaded from Resident #2's unstageable deep tissue injury on his left heel on 08/05/25. 2. The facility failed to ensure Resident #3's right heel air boot was in place to relieve and reduce pressure to a healing wound on 08/05/25.3. The facility failed to ensure pressure was offloaded on Resident #4's healing surgical incision site on her lower leg on 08/05/25.This failure placed residents at risk of worsening pressure and delayed healing, as well as discomfort and pain. Findings included:1. Record review of Resident #2's Face Sheet dated 08/06/25 reflected he was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #2's diagnoses included metabolic encephalopathy (a condition where brain dysfunction arises from a chemical imbalance in the blood caused by an underlying medical condition or illness), diabetes mellitus (a chronic condition where the body doesn't produce enough insulin or can't properly use the insulin it produces, leading to high blood sugar levels), atherosclerotic heart disease (plaque buildup in the arterial walls of the heart), muscle wasting and atrophy (loss of muscle mass and strength). Record review of Resident #2's admission MDS dated [DATE] reflected a BIMS score of 13, which indicated moderate cognitive impairment. He had no psychosis, delirium or rejection of care issues. Resident #2 had range of motion impairment on both sides of his lower extremities. Resident #2 was dependent on the physical assistance of staff for transfer and substantial/maximal assistance for bed mobility. Resident #2 was at risk of developing pressure ulcers and he had one unhealed and unstageable pressure injury presenting as a deep tissue injury upon admission. Resident #2 required pressure ulcer/injury care and applications of ointments/dressings. Record review of Resident #2's care plan dated 07/25/25 reflected, [Resident #2] has a DTI to his left heel related to immobility; At risk for Pressure Injury related to: impaired mobility, incontinence, diabetes, kidney failure, heart failure and fragile skin. Approaches included, Use pillows, pads, or other pressure-reduction devices to offset pressure from bony prominences.Record review of Resident #2's initial wound care visit dated 07/20/25 reflected he had an unstageable deep tissue injury of the left heel of undetermined thickness with a two-to-four-month time frame for healing, a goal to decrease the ulcer area, with approaches that included offloading. Resident #2's wound size was 7cmx10cmx not determinable, 70 cm in surface area, no exudate, skin with purple/maroon discoloration, blood filled blister, no pain and no signs/symptoms of infection. Recommendations included to float heels in bed, reposition per facility protocol and off-load wounds. A second visit was completed on 08/06/25 and the wound care doctor noted the resident's wound measurement were the same as the week prior and the wound progress was not at goal due to need more time. There was no pain or signs of infection on the second visit. Record review of Resident #2's physician order dated 07/25/2025 reflected, Elevate/Float Heels while in bed; Right plantar DTI- apply skin prep to area daily.Record review of Resident #2's nursing progress note dated 07/30/2025 reflected, Left heel DTI measuring 7cm x10cm- skin intact with purple/ maroon discoloration (blood filled blister), current wound care order continues. Resident continues wearing air boots in air boots as prescribed. An observation of Resident #2 on 08/05/25 at 2:08 PM, revealed Resident #2's feet were not offloaded and his heels were placed directly on a pillow at the foot of his bed. An interview with the DON on 08/05/25 at 2:09 PM, revealed she observed Resident #2 and he did not have his feet properly offloaded. An interview with LVN E on 08/05/25 at 2:12 PM, revealed he was the charge nurse from 6a-2p for Resident #2. He stated he had not touched Resident #2's feet that shift so he did not know who placed his feet and heels directly on a pillow. LVN E stated he was the one who had completed wound care on Resident #2's heel that shift, but he was not sure if he required air boots and he was only there to provide the wound care and did not check to see if they were offloaded properly. He checked Resident #2's chart and verified air boots were ordered to be in use. Record review of new physician's order dated 08/05/25 (after investigator intervention), reflected, Z-flex boots to offload heels while in bed, Frequency: Every Shift.Record review of Resident #2's revised care plan (completed after investigator intervention), reflected the care plan was updated by the facility and reflected he was resistant to care. The care plan update on 08/06/25 reflected, Problem Start Date: 08/06/2025-[Resident #2] has behaviors AEB: resident unsafely puts himself into bed and doesn't |