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	06/01/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm 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** Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision and assistive devices to prevent accidents for one of five residents (Resident #1) reviewed for quality of life. CNA A and CNA B failed to transfer Resident #1 in accordance with the facility's policy when they failed to ensure her right wheelchair brake was locked and secured prior to completing a mechanical lift transfer. This failure could place residents at risk for accidents/injuries, including falls.Findings included: Record review of Resident #1's Face Sheet, dated 06/01/26, reflected she was a [AGE] year-old female who was admitted to the facility on [DATE], with diagnoses including dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), muscle wasting and atrophy (the loss of muscle mass that can occur due to various factors), and unsteadiness on feet (trouble keeping one's balance). Record review of Resident #1's MDS Assessment, dated 04/24/26, reflected she had a BIMS score of 02, indicating she had severe cognitive impairment. Resident #1 was identified as needing substantial/maximum assistance (indicating the helper did more than half the effort) for chair/bed-to-chair transfers. Record review of Resident #1's Physician's Orders, dated 06/01/26, reflected she required a mechanical lift for transfers, with the assistance of two individuals. Record review of Resident #1's Care Plan, dated 06/01/26, reflected she required a mechanical lift for transfers due to lower extremity weakness and/or modified weight bearing status. Observation on 06/01/26 at 10:15AM of a mechanical lift transfer for Resident #1 from her bed into her wheelchair, conducted by CNA A and CNA B, reflected prior to Resident #1 being transferred out of bed via mechanical lift, CNA B advised CNA A that the wheelchair brake on the right side of Resident #1's wheelchair was broken and would not lock. CNA A advised CNA B to hold the wheelchair securely during the transfer, since the right wheelchair brake would not lock. CNA B did as advised, and CNA A and CNA B proceeded with the mechanical lift transfer without incident, with the right side of Resident #1's wheelchair brake unlocked. Observation of Resident #1's wheelchair on 06/01/26 at 11:29AM (along with the Maintenance Director) revealed both sides of Resident #1's wheelchair were able to be securely locked. There were no noted concerns regarding the functionality of Resident #1's wheelchair. During an interview with CNA A on 06/01/26 at 11:00AM, she stated during the mechanical lift transfer for Resident #1, CNA B advised her that the wheelchair brake on the right side of Resident #1's wheelchair was broken and would not lock. CNA A stated she advised CNA B to hold the wheelchair securely during the transfer. She stated this was standard practice (one person would work the mechanical lift while the other person held the wheelchair securely) and wheelchair brakes were not required to be locked during mechanical lift transfers. She stated following the mechanical lift transfer, the Maintenance Director adjusted the wheelchair brakes, and now both were in proper working order. CNA A stated she worked PRN at the facility for the past two years, and had not been trained on mechanical lift transfers. She stated she never had any incidents involving mechanical lift transfers while at the facility. During an interview with CNA B on 06/01/26 at 11:10AM, she stated during the mechanical lift transfer for Resident #1, the wheelchair brake on the right side of Resident (continued on next page)

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1's wheelchair was different than the brake on the left side of the wheelchair. She stated the wheelchair brake was not moving into place correctly at the time of the mechanical lift transfer. She stated upon voicing this to CNA A, she was advised to hold the wheelchair securely during the transfer. CNA B stated she did as advised, and the mechanical lift transfer was completed without the right side of Resident #1's wheelchair being locked. CNA B stated the expectation was for wheelchairs to be completely locked prior to performing mechanical lift transfers. She stated she and CNA A should have stopped the transfer and notified maintenance and/or therapy of the issue, so the wheelchair brake could be fixed prior to completing the transfer. She stated she had been in-serviced on mechanical lift transfers at the facility, but she only worked at the facility for one week which was why she followed the instruction of CNA A. CNA B stated the risk of not locking both wheelchair brakes prior to a mechanical lift transfer was the potential for the wheelchair to move and cause the resident to fall. During an interview with the Administrator on 06/01/26 at 11:18AM, he stated he was notified of the incident involving Resident #1's right wheelchair brake not being locked during the mechanical lift transfer. He stated the expectation was for wheelchair brakes to be securely locked prior to mechanical lift transfers being completed. He said the risk of not locking both wheelchair brakes prior to a mechanical lift transfer was the potential for the wheelchair to move and cause the resident to fall. The Administrator stated nursing and therapy staff completed annual in-services on mechanical lift transfers; evidence of in-servicing for CNA A was requested at that time but was not provided. During an interview with the Maintenance Director on 06/01/26 at 11:29AM, he stated he was notified that the right side of Resident #1's wheelchair was unable to be locked during a mechanical lift transfer this morning. He stated he fixed Resident #1's wheelchair, and both sides were now able to be securely locked. Record review of the facility's Mechanical Lifts: General Guidelines policy, dated 05/05/23, reflected, .I. Prepare equipment by:. 3.) Ensure the receiving surface is stable and locked.