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	01/25/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42283 Based on observation, interview, and record review the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for one of five residents (Resident #15) reviewed for reasonable accommodations. The facility failed to provide assistance to Resident #15 after answering her call light. This failure could place residents at risk of not being able to contact staff and their needs not being met. Findings included: Record review of Resident #15's quarterly MDS Assessment, dated 11/14/23, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: heart failure, hypertension, renal insufficiency, septicemia, diabetes, hyperlipidemia, cerebrovascular accident, Non-Alzheimer's dementia, anxiety disorder, and depression. Her BIMS score was 7 out of 15, which revealed she was severely cognitively impaired. Record review of Resident #15's care plan, undated, reflected resident was at risk of dehydration. Interventions included assist with fluids as needed, encourage oral rehydration, and offer fluids between meals and with medications. Observation of Resident #15's room on 01/24/24 at 11:00 AM revealed she was on isolation precautions for COVID-19. Her door was open, and she was observed laying in her bed. Her call light was on. LVNA and CNA B asked the state surveyor to answer Resident #15's call light. LVN A walked to Resident #15's door and did not come inside. LVN A asked the state surveyor to answer Resident #15's call light. LVN A informed the state surveyor a CNA would come inside the room to check on Resident #15. CNA B walked to Resident #15's door and did not come inside. CNA B asked the state surveyor to answer Resident #15's call light. CNA B waited approximately two minutes then came inside Resident #15's room to answer the call light. After leaving Resident #15's room, CNA B informed LVN A she was going on a break. Interview with Resident #15 on 01/24/25 at 11:06 am revealed she was on isolation precautions for COVID-19. She stated she turned her call light on to request hot tea to help soothe her sore throat. She stated CNA B came inside her room to answer her call light. She stated CNA B asked her what assistance was needed. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #15 on 01/25/24 at 2:35 pm revealed she did not receive the hot tea she requested on 01/24/24. She stated she requested hot tea because she had sore throat. She stated she did not receive anything to drink until her lunch tray was delivered. She stated she felt ignored by staff because she did not receive hot tea. Interview with LVN A on 01/25/24 at 2:39 pm revealed she did not answer Resident #15's call light because she was in the middle of another task. She stated she looked around the facility for help. She stated she informed CNA B to answer Resident #15's call light. She stated she observed CNA B enter Resident #15's room. She stated she was unaware CNA B asked the state surveyor to assist Resident #15. She stated she was unaware CNA B did not provide Resident #15 with hot tea. She stated she did not follow up with Resident #15 because she was not assigned as her nurse. She stated facility staff were supposed to respond to Resident #15's call light and provide assistance. She stated Resident #15 was at risk of not having her needs met because her request was not made. Interview with the DON on 01/25/24 at 3:53 PM revealed the purpose of a call light was for the resident to call for assistance. She stated her expectation was for staff to answer call lights or to find someone that could. She stated any staff at the facility could answer a resident's call light. She stated CNA B was supposed to answer Resident #15's call light. She stated if Resident #15 requested hot tea, then CNA B should have provided hot tea. She stated CNA B should not have gone on break before providing Resident #15 with hot tea. She stated she was unaware Resident #15 requested hot tea for her sore throat. She stated she was unaware Resident #15 did not receive anything to drink until her lunch tray arrived. She stated once Resident #15's call light was on, the goal was to fulfill her needs. She stated unanswered call lights could put residents at risk of not receiving assistance. Interview with CNA B on 01/25/24 at 5:01 pm revealed she went into Resident #15's room to check on her during rounds. She stated LVN B informed her Resident #15's call light was on. She stated once inside the room, Resident #15 did not make any requests. She stated she turned the call light off. She stated she did not want to answer any more questions from the state surveyor, then hung up the phone. Record review of the facility policy titled Call Lights, Responding To, dated 05/05/23, revealed The staff will respond to call lights or other requests for assistance to meet the patient's/resident's needs.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42283 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure food was properly stored in the refrigerator and freezer located in the kitchen. This failure could place residents at risk for food-borne illness. Findings Included: Observation of the facility's refrigerator on 01/23/24 at 8:30 AM revealed: - 1 box of homestyle ring donuts open and exposed to air; and - 1 box of turkey bacon open and exposed to air. Observation of the facility's freezer storage on 01/23/24 at 9:37 AM revealed: -1 box of sweet yeast steakhouse roll dough open and exposed to air; - 1 cup of unidentified green colored food on the floor; and - a piece of clear tape on the floor. In an interview with the Dietary Supervisor on 01/25/24 at 1:45 PM, revealed she completed a walk-through of the kitchen daily. She stated she checked the kitchen (refrigerator and freezer) daily to ensure food was stored properly. She stated she checked the freezer floor weekly and daily to ensure there was no food on the floor or spills. She stated she completed weekly sanitation audits to ensure the floor in the freezer was cleaned. She stated items in the refrigerator and freezer were supposed to be sealed to prevent spoilage, spills, or freezer burn. She stated improper food storage could cause residents to be exposed to food borne illnesses. Record review of the facility policy titled Food Safety in Receiving and Storage, dated 06/20/23, revealed Food will be received and stored by methods to minimize contamination and bacterial growth. Review of the Food and Drug Administration Food Code, dated 2017, reflected, .3-305.11 Food Storage. (A) . food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination .