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	02/26/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35747 Based on interview and record review, the facility failed to ensure prompt efforts were made to resolve grievances residents had and ensure that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued for one (Resident #99) of five residents reviewed for grievances. The facility failed to document any attempts to resolve Resident #99's grievance when she expressed concern that CNA G refused to provide incontinent care. This failure could place residents at risk of a diminished quality of life and unmet care needs. Findings included: Review of Resident #99's Face Sheet, dated 02/26/25, reflected she was a [AGE] year-old female who admitted to the facility on [DATE], with diagnoses including diverticulitis of large intestine with perforation and abscess with bleeding (a serious condition that can occur when a small pouch in the colon wall becomes inflamed and/or infected) and anxiety disorder (a mental health condition that involves excessive fear, worry, or dread). Review of Resident #99's MDS Assessment, dated 12/23/24, reflected she was cognitively intact. Resident #99 was identified as being occasionally incontinent of bladder and frequently incontinent of bowel. Review of Resident #99's Care Plan, dated 12/26/24, reflected she was identified as being incontinent of bladder and bowel. A documented approach for this care area was for staff to assist with toilet use and provide incontinent care as indicated. Review of Grievance Reports from 01/01/25 to 02/24/25 reflected no evidence that a grievance related to the allegation made by Resident #99 had been filed. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #99 on 02/24/25 at 2:00PM, she stated within the past several weeks, there was a singular instance when CNA G, who worked the night shift, refused to change her brief. Resident #99 stated she told ADON E about the issue, and ADON E stated she would take care of it. During a telephone interview with ADON E on 02/24/25 at 2:53PM, she stated Resident #99 did tell her about an instance in which CNA G refused to change her brief on an overnight shift. She stated Resident #99 felt as though this was a customer service issue; she did not report feeling as though she had been abused or neglected. ADON E stated she spoke with CNA G regarding this customer service issue and the need to provide timely incontinent care, but she did not file a formal grievance. ADON E stated looking back, she should have filed a grievance on behalf of the resident. During an interview with the Administrator on 02/24/25 at 3:30PM, he stated prior to today (02/24/25), he had not been made aware of the incident in which CNA G allegedly refused to provide incontinent care for Resident #99. The Administrator stated once ADON E became aware of the alleged incident, she should have filed a grievance form on behalf of Resident #99. The Administrator stated the risk of a grievance not being filed included the facility not being able to investigate and resolve resident concerns/complaints. The surveyor attempted to contact CNA G via telephone on 02/24/25 at 4:22PM. The surveyor left a voice message requesting a return telephone call. Review of the facility's Complaints/Grievances Process policy, dated 11/06/23, reflected, .Procedures: 1. Grievances/Complaints are accepted by the following, but not limited to: A. Administrator B. Department manger or his/her designee C. Supervisors D. Unit Managers E. Ombudsman 2. Upon receipt of the grievance the receiver completes all appropriate sections of electronic Grievance form under Portal Links or a paper form .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35747 Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that included instructions needed to provide effective and person-centered care for the resident that met professional standards of care within 48 hours of the resident's admission for one (Resident #99) of five residents reviewed for baseline care plans. The facility failed to complete a baseline care plan for Resident #99. This failure could place newly admitted residents at risk of not receiving effective and person-centered care and services. Findings included: Review of Resident #99's Face Sheet, dated 02/26/25, reflected she was a [AGE] year-old female who admitted to the facility on [DATE], with diagnoses including diverticulitis of large intestine with perforation and abscess with bleeding (a serious condition that can occur when a small pouch in the colon wall becomes inflamed and/or infected) and anxiety disorder (a mental health condition that involves excessive fear, worry, or dread). Review of Resident #99's MDS Assessment, dated 12/23/24, reflected she was cognitively intact. Review of Resident #99's electronic medical records on 02/25/25 reflected no evidence that a baseline Care Plan had been completed. During an interview with MDS Coordinator F on 02/26/25 at 10:10AM, she stated she was responsible for completing baseline Care Plans for residents within 48 hours of their admission to the facility. She confirmed there was no evidence to suggest that a baseline Care Plan for Resident #99 had been completed following her admission. MDS Coordinator F stated the risk of not completing a baseline Care Plan for a resident within the required timeframe was that the facility would receive a citation from the State. Review of the facility's Care Plan Process, Person-Centered Care policy, dated 05/05/23, reflected, . Procedures: .1: Develop and implement the baseline person-centered care plan within 48 hours of a resident's admission .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based on interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #99) of 40 resident reviewed for pharmacy services. The facility failed to ensure the 400 Hall nurses' medication cart had an accurate narcotic count for Resident #99. This failure could place residents at risk for medication errors, drug diversion, and delays in medication administration. Findings included: Record review of Resident# 99's face sheet dated 02/26/25 reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Admitting diagnoses included diverticulitis of large intestine with perforation and abscess with bleeding, cough, depressive episodes, allergy, GERD, without bleeding, nausea with vomiting, sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection), anemia, unspecified and HT Record review of Resident #99's Admission MDS Assessment, dated 12/23/24, reflected the resident BIMS score of 15 indicating no cognitive impairment. Record review of Resident #99's care plan did not indicate the resident was taking pain medications. Record review of Resident #99's physician's orders dated February 2025, reflected an order for the resident to receive Hydrocodone-Acetaminophen Oral Tablet 10-325 MG. Give 1 tablet by mouth every 6 hours as needed for pain. Acetaminophen with codeine #3 (Tylenol with codeine #3). Give 1 tablet by mouth every 4 hours as needed for pain. Record review of Resident #99's medication administration record reflected, Hydrocodone-Acetaminophen Oral Tablet 10-325 MG was last administered on 01/22/25 and Acetaminophen with codeine #3 was last administered on 2/15/25. Review of the narcotic log for Resident #99 reflected the count sheet for Acetaminophen with codeine was 19 and the medication card contained 20 tablets and the narcotic sheet for Hydrocodone-Acetaminophen 10-325 MG was 20 and the card contained 19 tablets. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/26/25 at 10:35 AM with LVN C, she stated she had not administered any pain medication to Resident #99. LVN C stated she was switched to work on the hall after the start of the shift and ADON D was the one who completed the narcotics count with the night nurse. LVN C stated she did not complete a narcotic count after taking over the cart from the ADON D. LVN C stated she would inquire from the ADON if she administered the pain medication. LVN C stated she last worked on the hall on 02/24/25 and she did not realize the count was wrong. LVN C stated she was supposed to make sure the name of the resident, the medication and the count all matched. LVN C stated with any narcotics discrepancies, she was expected to report immediately to the DON. In an interview on 02/26/25 at 10:42 AM with ADON D, she stated she had not administered any pain medication to Resident #99. ADON D stated when she completed the count during the change of shift, the count was correct, but per the records, did not reveal to be correct. Then the ADON stated she would inform the DON of the discrepancy. The ADON stated during narcotic count she was supposed to check and make sure the medication and number of the narcotics in the narcotic sheet were a match. In an interview on 02/26/25 at 10:56 AM with Resident #99, she stated she was not in pain, and she had not taken any pain medication on 02/26/25. Resident #99 stated she took a hydrocodone-Acetaminophen 10-325 mg tablet about two weeks ago due to pain from surgery, and since then she had not taken any pain medication. An interview on 02/26/25 at 2:35 PM with the DON revealed she had been made aware of the narcotic discrepancy on hall 400 nurse medication cart, and she was already in the process of in-servicing the staff. The DON stated she talked with Resident #99, and the resident stated she had taken Norco and not Tylenol #3 when she had requested for a pain medication about two weeks ago. The DON stated when she talked with the nurse on duty, the nurse had given the resident the Norco and signed in the wrong narcotic sheet. The DON stated the charge nurse had failed to realize the inconsistency and get it corrected timely. The DON stated she expected the charge nurse to make sure the medication, the resident name and narcotic count matched when they completed narcotic count during shift change to prevent narcotics discrepancy. Review of the facility's policy undated and titled medication management program reflected, . Security and Safety Guidelines . 9. Controlled substances are accounted for each patient/resident on a Controlled Substance Record . A. Substances are counted by authorized staff members at each change of shift. B. Drug count discrepancies are reported immediately for the Director of Nursing or designee.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based on observations, interviews, and record reviews, the facility failed to ensure a medication error rate below 5%, for 45 medication administration opportunities with 11 errors resulting in a 24% medication error rate, for 2 of 6 residents (Residents #52 and #65) reviewed for medication administration. 1. The facility failed to ensure MA A administered a medication as ordered to Resident #52 by crushing Nifedipine ER (used to treat hypertension (high blood pressure) and angina (chest pain)); a medication that should not be crushed. 2. The facility failed to ensure MA B administered Resident #65 medication per physician orders, medications scheduled at 7 am were administered at 11:18 am This deficient practice placed residents at risk for not receiving therapeutic effects of their medications and possible adverse reactions. The findings included: Record review of Resident #52's admission record dated 02/26/2025 revealed an admitted [DATE] with diagnoses which included Muscle wasting and atrophy, Dysphagia, HTN, hypertensive heart disease without heart failure, schizophrenia, and Type 2 diabetes mellitus. Record review of Resident #52's quarterly assessment MDS dated [DATE] revealed Resident #52 had a BIMS score of 05, indicating severe cognitive impairment. Record review of Resident #52's care plan edited on 12/26/24 revealed, resident had hypertension, goal will not experience any complications r/t blood pressure through next review period, approach, Administer medications as ordered. Record review of Resident #52's physicians orders dated February 2025 revealed the physician prescribed for Resident #52 to receive the following medications: Famotidine 10 mg 2 tablets Divalproex sprinkle 125 mg 2 capsules Benztropine 1 mg 1 tablet Atenolol 50 mg 1 tablet Clopidogrel 75 mg 1 tablet Glimepiride 2 mg 1 tablet Nifedipine ER 60 mg 1 tablet, NOT TO CRUSH (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/26/25 at 11:01 AM, revealed MA A crushed and administered the following medications to Resident #52: Famotidine 10 mg 2 tablets Divalproex sprinkle 125 mg 2 capsules Benztropine 1 mg 1 tablet Atenolol 50 mg 1 tablet Clopidogrel 75 mg 1 tablet Glimepiride 2 mg 1 tablet Nifedipine ER 60 mg 1 tablet In an interview with MA A on 12/24/25 at 11:04 am, MA A stated the resident always took crushed medications and he had been taking Nifedipine ER crushed. MA A stated per the medication instructions, the medication was not supposed to be crushed. She stated the medication was extended-release meaning required to be released gradually, and if it was crushed the medication could be absorbed at once which could lead to medication overdose or side effects. MA A stated she would inform the charge nurse to get the medication switched. Record review of Resident #65's admission record dated 02/26/25 revealed an admitted [DATE] with diagnoses which included, Cognitive communication deficit, chronic kidney disease stage 3, dementia, psychotic disturbance, mood disturbance, and anxiety, osteoarthritis, vitamin deficiency, hyperlipidemia, HTN acute on chronic diastolic (congestive) heart failure, pain, personal history of malignant neoplasm of prostate (cancer of the prostate gland) and Type 2 diabetes mellitus. Record review of Resident #65's quarterly assessment MDS dated [DATE] revealed Resident #65 had a BIMS score of 07 indicating severe cognitive. Record review of Resident #65's physicians orders dated February 2025 revealed the physician prescribed Resident #65 to receive the following medications: Amlodipine 5 mg at scheduled to be administered at 7am Isosorbide mono ER 30 mg scheduled to be administered at 7am Finasteride 5 mg scheduled to be administered at 7am Memantine 10 mg scheduled to be administered at 7am Montelukast 10 mg scheduled to be administered at 7am Nebivolol 5 mg scheduled to be administered at 7am (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pantoprazole 40 mg scheduled to be administered at 7am Tamsulosin 0.4 mg scheduled to be administered at 7am Clopidogrel 75 mg scheduled to be administered at 7am Aspirin 81 mg scheduled to be administered at 7am Observation on 02/24/25 at 11:18 AM revealed MA B administered the following medications to Resident #65. Amlodipine 5 mg 1 tablet Isosorbide mono ER 30 mg 1 tablet Finasteride 5 mg 1 tablet Memantine 10 mg 1 tablet Montelukast 10 mg 1 tablet Nebivolol 5 mg 1 tablet Pantoprazole 40 mg 1 tablet Tamsulosin 0.4 mg 1 tablet Clopidogrel 75 mg 1 tablet Aspirin 81 mg 1 tablet In an interview on 02/26/25 at 11:05 AM with MA B, she stated she did administer the medications late mainly because there was a lot of residents to administer medications to who were scheduled at the same time. MA A stated she was supposed to follow the five rights of medication administration; that was the right medication, time, dosage, patient, and route. MA A stated she had informed the DON not getting the medication completed on time, and so far, nothing had been done. MA A stated Resident #65 was on blood pressure medications thus requiring the medications to be administered on time to prevent increase in blood pressure. MA A stated last month, the staff was in-serviced on making sure the medications were administered on time. In an interview on 02/26/25 at 02:22 PM with the DON, she stated MA B had informed her regarding the medications being late and the issue will be addressed in the management meeting. The DON stated she expected the staff to follow the medication administration protocol of administering medications one hour before and one hour after the scheduled time, and following the physician orders. The DON stated MA A was not supposed to crush extended-release medications because it would alter the potency of the medications. The DON stated the staff were in-serviced on medication administration on 2/21/25. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy undated, titled management medication program, reflected The facility implements the management medication program to meet the pharmaceutical needs of the patients and residents, according to the established standards of practice and regulatory requirements.Preparing for medication pass.7. Medications are administered not more than one (1) hour before to one (1) hour after the designated medication pass time. Administering the medication pass.F. Crush oral medications in accordance to the facility policy.