STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676408	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Creek Nursing and Rehabilitation	3729 Ira E Woods Avenue Grapevine, TX 76051

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45831 Based on interview and record review, the facility failed to extend to the resident representative the right to make decisions on behalf of the resident for one (Resident #1) of five residents reviewed for resident representative rights. The facility failed to contact Resident #1's representative/responsible party before administering her PRN medication. On 11/14/2024, Resident #1's MAR revealed LVN A administered to Resident #1 a dose of her prescribed Lorazepam (a medication used to treat seizures or decrease anxiety). LVN A failed to contact the RP prior to administering the Lorazepam as instructed in Resident #1's electronic medical record where it states in capital letters, CALL [RP] BEFORE GIVING ANY PRN MEDICATION. This failure could place residents at risk of receiving medication or treatment without consent. Findings included: Record review of Resident #1's undated face sheet reflected the resident was a [AGE] year-old female who admitted to the facility on hospice on 08/01/24. Resident #1 diagnoses included anxiety (feeling of fear, dread, and uneasiness that can be a normal reaction to stress), dementia (decline in mental ability), malignant neoplasm of unspecified lung (lung cancer) and intrahepatic bile duct carcinoma (type of cancer that originates in the bile ducts located within the liver). Resident #1's family member was listed as her emergency contact, RP, and POA for financial and health care. Record review of Resident #1's quarterly MDS assessment, dated 08/20/24, reflected a BIMS score of 8, indicating the resident had moderate cognitive impairment. Record review of Resident #1's quarterly care plan, dated 08/13/24, reflected she needed hospice care due to a terminal diagnosis. The care planned goals included keeping the resident comfortable as exhibited by relief of pain within 30 minutes of intervention, and the interventions included hospice services as ordered. Record review of Resident #1's current, undated order summary report reflected give report to each shift to the [Family Member], DPOA every shift with a start date of 09/05/2024. (continued on next page)

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

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's November 2024 MAR reflected: LORazepam Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth every 4 hours as needed for Anxiety. Start Date 10/12/2024 1500 [3:00 PM], D/C Date 11/14/2024 1612 [4:12 PM]. The MAR further showed the below administration of the medication: 11/14/2024 RN A administered the medication at 3:02 PM. Record review of Resident #1's Progress Notes written on 11/14/24 at 3:02 PM by RN A reflected the following Medication Administration Note: LORazepam Oral Tablet 0.5 MG - Give 1 tablet by mouth every 4 hours as needed for Anxiety. Record review of Resident #1's Progress Notes written on 11/14/2024 at 3:45 PM written by RN B reflected the following Nurses Note: Resident is alert, oriented and talking about PRN medication. Her vitals were monitored. Informed her [RP] about PRN medication, vitals status and notified to hospice nurse. Resident is on continue monitoring. Record review of Resident #1's Progress Notes written on 11/14/2024 at 3:48 PM by the DON reflected the following Nurses Note: 2-10 PM assigned nurse informed this writer that as per [FM], resident was given PRN medication without indication. Did assessment for any adverse reactions or health risk. Resident was up and awake, vitals were stable, [RP] was at bedside and aware of the situation. Collaborated with morning and evening staff. Give 1:1 education to the staff to improve and to foster a safer environment for resident. MD and hospice were informed and no new orders received. Will continue to monitor closely for any change in condition. During an interview on 11/27/24 at 09:05 AM, Resident #1's RP stated Resident #1 admitted to the facility on hospice due to Stage IV liver cancer. The RP stated the facility must call her before they administered Resident #1 any of her PRN medications. The RP stated she was a nurse and wanted to be notified to ensure Resident #1 in fact needed the medication. The RP stated RN A did not adhere to her request. During an interview on 11/27/24 at 11:10 AM, Resident #1 stated when she needed something, no one has ever told her no. Resident #1 stated her care was so far, so good. Resident #1 stated her Hospice Aide gave her showers two times a week. Resident #1 stated if she needed incontinence care, she had a button she pushed. Resident #1 stated she tried to stay as clean as possible. Resident #1 stated as far as she knew, she received all her medications. During an interview on 11/27/24 at 1:15 PM, the Hospice RN stated Resident #1 admitted to hospice on 07/22/24 due to bile duct carcinoma. She stated from day one, the RP requested that the facility and hospice called her for everything. She stated if staff observed any symptoms, the RP wanted to be called prior to administering any PRN medications. The Hospice RN stated when the facility administered Resident #1's Lorazepam on 11/14/24, they failed to notify the RP first , and the RP was upset. She stated the facility had it typed in Resident #1's records in all caps CALL THE [RP] BEFOREHAND. During an interview on 11/27/24 at 2:10 PM, RN B stated during the shift report, RN A told her she administered Resident #1 Lorazepam PRN because she was anxious and not feeling well. RN B stated in PCC it was documented that you must give the RP a report at the end of each shift. RN B stated she then called the RP to provide her an entire shift report, and the RP became upset because RN A had not notified her before she administered the PRN Lorazepam to Resident #1. RN B stated although Resident #1 was on hospice, it was still the RP's right to request to be informed beforehand. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/27/24 at 3:30 PM, the DON stated the RP wanted to be contacted prior to any PRN medications being administered to Resident #1. The DON stated the RP did not want the nurses to use their judgment. She stated RN A was new, and the RP was upset because RN A failed to call her beforehand. The DON stated the RP told her on 11/14/24 that Resident #1 received the PRN Lorazepam without her being notified beforehand. She stated she informed the RP that what she told her would be addressed. The DON stated RN A informed her that Resident #1 was agitated, so she administered the PRN Lorazepam and failed to notify the RP. The DON stated the RP told her that she had not observed any agitation on the in-room video camera. The DON stated RN A failed to inform the RP and did not realize it until the shift change report with RN B. The DON stated RN B then called and provided the RP the shift change report, and the RP came to the facility. The DON stated she and the Administrator completed an Incident Report, conducted an internal investigation, and decided to make the nurse PRN. The DON stated even if a resident was on hospice, it was still the RP's right to be contacted as often as they wish to make decisions on behalf of the resident. On 11/27/24, multiple attempts were made to contact RN A. A returned telephone call was not received prior to exiting. Record review of the facility's undated Documentation of Medication Administration Policy reflected the following: .3. Documentation of medication administration includes, as a minimum . .h. resident response to the medication, if applicable (e.g., PRN, pain medication, etc.) Record review of the facility's undated Resident Rights Policy reflected the following: .1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to . .o. be notified of his or her medical condition and of any changes in his or her condition.