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Form Approved OMB
No. 0938-0391

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	02/04/2025

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on interview and record review, the facility failed to notify the resident, resident's representative, and ombudsman of the transfer or discharge and the reasons for the move, in writing and in a language and manner they understood for 1 of 2 residents (Resident #1) reviewed for discharge rights. The facility failed to ensure Resident #1 was notified in writing of the effective date of transfer, the reason for the transfer, the location to which the resident would be transferred, or the right of appeal of the transfer. The failure could affect all residents who were transferred or discharged to the hospital at risk of having their discharge rights violated. Findings included: Record review of Resident #1's Admission Record, dated 02/04/25, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE] and discharged on [DATE] to an Acute care hospital. Resident #1 was her own RP. Record review of Resident #1's None of the above MDS Assessment, dated 11/12/24, reflected she had a BIMS score of 15 indicating no cognitive impairment. Resident #1's had a diagnosis of dependence on renal dialysis. Resident #1's MDS did not address her use of peritoneal dialysis. Record review of Resident #1's Discharge Planning and Summary, dated 11/12/24, reflected the following: 1a. Discharge Goals/General Information, 1. Who initiated discharge? B. Facility, 1b. If facility, If this was a facility-initiated discharge, was advance notice given (either 30 days or, as soon as practicable, depending on the reason for the discharge) to the resident Did the notice include all the required components (reason, effective date, location, appeal rights .) and was it presented in a manner that could be understood; and if changes were made to the notice, were recipients of the notice updated? B. No. 2. Reason for Discharge: a. Necessary for the Resident's welfare and the resident's needs cannot be met in the facility . (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Progress Notes for November 2024 reflected on 11/12/24 at 3:10 PM as written by the MDS Coordinator: This nurse/Social Service [MDS Coordinator], [Previous DON], and [Previous ADON] go to residents' room yesterday to discuss liability of resident's perianal [sic, peritoneal] dialysis. Conversations were had that the family will not consent to any other forms of dialysis. In the end of the conversation the family request to have resident sent to [Hospital A]. Resident is sent to hospital with all her belongings. This nurse gave report to [hospital staff] in the ER. Resident [Family Member B] is update [sic] throughout the whole process. Interview on the phone on 02/03/25 at 9:44 AM with Resident #1's Family Member C revealed it was hard to find a facility that would accept Resident #1 due to her utilizing peritoneal dialysis. Family Member C said then they found this facility, who said they would accept her. Family Member C stated once she was admitted to the facility, the family had to go to the facility often to assist with the resident's peritoneal dialysis. Family Member C said he went to the facility and tried to find out what was going on and when he spoke with the Social Worker, she told him the facility was not prepared to assist the resident with her peritoneal dialysis, so the resident needed to leave. Family Member C said the Social Worker told him they would contact the hospital where Resident #1 transferred from and have her sent back. Family Member C said he never saw any paperwork about Resident #1's discharge or any notice given about the resident leaving the facility. Interview via phone on 02/04/25 at 11:19 AM with Resident #1 revealed she was doing okay today and was at a different facility now. Resident #1 said she was told by the Administration at the facility that because their staff were not trained, and they were not going to get any staff trained regarding her peritoneal dialysis, that she needed to leave. Resident #1 said her family had to keep coming up to the facility to assist with her peritoneal dialysis, so her Family Member C wanted to meet with the facility staff to find out what was going wrong. Resident #1 said that was when she was told she had to leave because the facility staff were not qualified to assist her with her peritoneal dialysis. Resident #1 said the day she left the facility to go to the hospital she was not given any paperwork about her discharge. Interview on 02/04/25 at 12:33 PM with LVN D revealed she was working the day Resident #1 discharged from the facility. LVN D said the previous DON told her the resident was leaving and was given a sticky note with an address on it for where the resident was going to go. LVN D said Resident #1 discharged during the next shift. and she was not sure if Resident #1 knew she was leaving that day or not. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/04/25 at 1:12 PM with the ADON revealed back in November 2024 she was in a different role and was responsible for social services provided to residents. The ADON said originally, Resident #1 was admitted to the facility with the understanding and agreement with the resident's family that the resident and the resident's family would be able to manage the resident's peritoneal dialysis. The ADON said after Resident #1 was admitted to the facility, it became clear that was no longer the case and the family and Resident #1 began asking facility staff to assist. The ADON said since the facility staff were not trained on how to assist Resident #1 with her peritoneal dialysis, the previous DON and previous ADON at the time went to Resident #1's family and Resident #1 to explain that since she needed more assistance with her peritoneal dialysis the facility would have to find an alternate placement for her. The ADON said Resident #1's Family Member C was frustrated with this decision and asked for Resident #1 to be sent back to the hospital where she had transferred in from. The ADON said it was then agreed upon that the facility would discharge her the following day (11/12/24), so the family began taking some of her belongings home with them that evening (11/11/24). The ADON said she did not provide Resident #1 with a discharge notice and normally would have done that. The ADON said she did not provide a discharge notice because the facility offered to assist Resident #1 with switching from peritoneal dialysis to hemodialysis, so the resident could remain in the facility. When they refused, she stated the facility had to initiate the discharge. The ADON said that was when Resident #1's family decided to send her back to the hospital she came from. The ADON said normally, when the facility initiated a discharge, there were conversations with the resident and family as far in advance as possible and notice was given then. The ADON said it would have been her responsibility to provide the discharge notice to the resident at that time. Interview on 02/04/25 at 2:52 PM with LVN F revealed Resident #1 left during her shift on 11/12/24. LVN F said she was only told that Resident #1 had to leave the facility because the staff were not trained to care for her peritoneal dialysis. Interview on 02/04/25 at 3:05 PM with the Administrator revealed the ADON was over social services at the time Resident #1 discharged from the facility. The Administrator said the ADON would have been responsible for issuing Resident #1 a discharge notice since the facility was no longer able to meet her needs. The Administrator said he was not sure what could happen if a resident was not provided a discharge notice. The Administrator explained that originally when Resident #1 was admitted , the family had expressed the facility staff would not have to assist Resident #1 with her peritoneal dialysis because she and the family could handle it on their own. The Administrator said a few days after Resident #1 admitted it became clear that was no longer the case but the staff at the facility were not trained on how to assist Resident #1 with her peritoneal dialysis. The Administrator said after that realization, the discussion of Resident #1 being discharged from the facility began. Record review of the facility's Transfer or Discharge, Facility-Initiated policy, dated October 2022, reflected: Notice of Transfer or Discharge (Planned), Except as specified below, the resident his or her representative are given a thirty (30)-day advance written notice of an impending transfer or discharge from this facility .2. The resident and representative are notified in writing of the following information: a. The specific reason for the transfer or discharge, including the basis under [symbol]483.15(c)(1)(i)(A)-(F); b. The effective date of the transfer or discharge; c. The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is being transferred or discharged ; d. An explanation of the resident's rights to appeal the transfer or discharge to the state .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice for 1 of 3 residents (Resident #1) reviewed for dialysis. The facility failed to ensure staff were trained on how to provide care and services to Resident #1 who utilized peritoneal dialysis after she was admitted to the facility. The failure could affect residents who received peritoneal dialysis treatments and could result in inadequate care of dialysis treatment. Findings included: Record review of Resident #1's Admission Record, dated 02/04/25, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE] and discharged on [DATE] to an acute care hospital. Resident #1 was her own responsible party. Record review of Resident #1's None of the above MDS Assessment, dated 11/12/24, reflected she had a BIMS of 15 indicating no cognitive impairment. Resident #1's had a diagnosis of dependence on renal dialysis. Resident #1's MDS did not address her use of peritoneal dialysis. Record review of Resident #1's Order Summary Report, dated 02/04/25, reflected the following: Check access site daily Peritoneal dialysis port- signs of infection (redness, hardness, swelling, pain, drainage, elevated temperature, body chills) every shift [sic]. Record review of Resident #1's care plan, initiated 11/06/24, reflected the following: Focus: Cancelled: Alteration in Kidney Function .Interventions: Cancelled: Check access site daily fistula/graft/catheter - signs of infection (redness, hardness, swelling, pain, drainage, elevated temperature, body chills). Record review of Resident #1's November 2024 progress notes reflected the following: - 11/06/24 at 4:00 PM written by LVN F: 69y/o [sic] female resident admitted from [facility name] into facility under care of MD [Physician L]. MD made aware of resident's arrival into facility. Resident with diagnosis of Peritoneal dialysis .dialysis port present on left side of abdomen . - 11/06/24 at 5:30 PM written by LVN F: Resident is on peritoneal dialysis every day in evening. Family members bring all the supplies for dialysis. Resident is alert and oriented x 4, resident and family members knowns [sic] how to use peritoneal dialysis machine. This nurse just helps the patients [sic] to setup [sic] the supply. Resident setup [sic] everything needed for dialysis and start [sic] machine, connect the machine to her dialysis port and start the dialysis by herself using the sterile technique. Monitor resident for 15min [sic] after dialysis started, vitals stable,WNL, [sic] no distress noted at this time. Call light within reach. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on the phone on 02/03/25 at 9:44 AM with Resident #1's Family Member C revealed he was upset because the facility admitted Resident #1 knowing she utilized peritoneal dialysis which had to be managed inside the facility. Family Member C said the facility told the resident and her family that she would need to bring her supplies and machine with her after being admitted . Resident #1's Family Member C said the staff at the facility would not help Resident #1 with her peritoneal dialysis, so Family Member B had to go to the facility to assist Resident #1 instead. Family Member C said when he met with the staff at the facility they acknowledged that the facility was not prepared to assist Resident #1 with her peritoneal dialysis. Family Member C said the facility declined to help Resident #1 with her peritoneal dialysis because they did not know what they were doing and were not trained. Interview via phone on 02/04/25 at 11:19 AM with Resident #1 revealed she was doing good today and was at a different facility now. Resident #1 said she had a nice time at the facility, but they did not follow through with what they said they would regarding assisting her with her peritoneal dialysis in the evenings. Resident #1 said the staff were afraid to help her and wanted to be trained before assisting her with her peritoneal dialysis. Resident #1 said the staff were never trained on how to assist her with her peritoneal dialysis. Resident #1 said she was told she had to leave the facility because the staff were not trained and were not going to be trained regarding peritoneal dialysis. Resident #1 said she did need some assistance with her peritoneal dialysis, so when staff could or would not help, she called Family Member B to come to the facility to help her. Resident #1 said this happened a few nights while she was at the facility, and Family Member B had to come to the facility to assist her to complete her peritoneal dialysis. Interview via phone on 02/04/25 at 10:52 AM with Resident #1's Family Member B revealed he understood the facility was going to be able to assist Resident #1 with her peritoneal dialysis daily. Family Member B said he brought Resident #1's supplies to the facility for her peritoneal dialysis and started talking to the nurse on duty about the machine, supplies, and procedures for Resident #1's peritoneal dialysis, and he did not realize that was going to be necessary. Family Member B said a few hours after Resident #1 admitted , he was called because the facility could not get her peritoneal dialysis machine to work, so he drove to the facility and fixed the issue. Family Member B said after that, the facility was never able to get the peritoneal dialysis machine to work themselves because they were not trained and relied on the resident and family to assist her with it instead. Family Member B said shortly after that the facility made the decision that they could no longer facilitate her care regarding the peritoneal dialysis and admitted that their staff were not educated or trained to operate the machine and never should have admitted her. Interview via phone on 02/04/25 at 11:43 AM with CNA G revealed she remembered Resident #1, but since she was only a CNA she did not assist with any care related to her dialysis. CNA G said she was not trained on how to provide peritoneal dialysis for the resident. Interview via phone on 02/04/25 at 11:49 AM with CNA H revealed she could not remember Resident #1 and was never trained on how to provide peritoneal dialysis for any resident. Interview via phone on 02/04/25 at 11:51 AM with CNA I revealed she remembered Resident #1 because she had dialysis in her room. CNA I said she never helped Resident #1 with her dialysis because she was just a CNA, but she saw the nurse trying to help the resident in the room. CNA I said she never had any training on how to provide peritoneal dialysis for the resident. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview via phone on 02/04/25 at 11:57 AM with CNA J revealed she could not remember Resident #1 and was never trained on how to provide peritoneal dialysis for any resident. Interview on 02/04/25 at 12:33 PM with LVN D revealed she cared for Resident #1 while she was at the facility. She stated since her peritoneal dialysis was scheduled for the evening time, she did not need to assist with that service. LVN D said she was never trained on how to assist Resident #1 with her peritoneal dialysis. LVN D said she never knew how to work the dialysis machine or how to use any of the supplies. Interview on 02/04/25 at 1:12 PM with the ADON revealed she remembered Resident #1 was admitted to the facility and was able to manage her peritoneal dialysis on her own and with the family's assistance. The ADON said Resident #1's family was very involved in her peritoneal dialysis and throughout her stay it was clear that she was becoming incapable of handling it without their help and they were no longer at the facility during the time she used the peritoneal dialysis machine. The ADON said that was when Resident #1 began asking facility staff to assist her with her peritoneal dialysis in her room but the facility staff were not trained to do so. The ADON said the facility reached out to a few dialysis centers who refused to assist in training the facility's staff regarding peritoneal dialysis. The ADON said after that, the discussion about Resident #1 discharging was had since the facility was not going to be able to meet her needs since they could nor and had not received any training regarding her peritoneal dialysis. Interview on the phone on 02/04/25 at 1:42 PM with the previous ADON revealed when Resident #1's referral came through the facility was told that Resident #1 could handle her peritoneal dialysis on her own. The previous ADON said when Resident #1 was admitted to the facility she was able to handle the peritoneal dialysis machine on her own but later on during the weekend there was an issue with the machine. The previous ADON said since the staff were not trained on how to assist Resident #1 with her peritoneal dialysis, the facility called the family for assistance and that frustrated them. Interview on the phone on 02/04/25 at 1:47 PM with the previous DON revealed Resident #1 was admitted to the facility already on peritoneal dialysis services. The previous DON said she was told Resident #1 was totally independent and only needed help to carry the bags to put them on the table, but that the resident could do everything else related to her peritoneal dialysis. The previous DON said over the weekend, the dialysis machine began messing up so the staff had to call the family to come and help the staff and the family was upset about this. The previous DON said she told the family the facility staff were not trained on peritoneal dialysis and would not touch the machine since they were not trained. The previous DON said she contacted a nephrologist who suggested the staff get training for peritoneal dialysis to assist Resident #1. The previous DON said she did not think to get staff trained before Resident #1 was admitted to the facility and the facility had never admitted a resident who used peritoneal dialysis prior to this. Interview on 02/04/25 at 2:52 PM with LVN E revealed she cared for Resident #1 during the evening shift when her peritoneal dialysis was supposed to start. LVN E said Resident #1 was able to handle her own peritoneal dialysis and only needed minimal assistance like moving her bags closer to her. LVN E said she was never trained on how to assist Resident #1 with her peritoneal dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/04/25 at 3:05 PM with the Administrator revealed the facility knew Resident #1 used peritoneal dialysis services but was admitted to the facility because they were told she could manage it herself. The Administrator said the facility staff were not trained regarding peritoneal dialysis. The Administrator said the previous DON at the time started to realize that the facility staff might need training in case something went wrong with Resident #1's peritoneal dialysis so they attempted to get the staff trained but were unsuccessful in obtaining that. The Administrator said after that they decided that the facility could not meet the resident's needs any longer. Interview on 02/04/25 at 4:03 PM with the DON revealed she was only hired four days ago and was not here when Resident #1 was admitted to the facility. The DON said she expected all staff to be trained on any service a resident could receive while in the facility. The DON said she would be responsible for ensuring all staff were trained on the services provided to residents while in the facility. The DON said if staff were not trained on services provided to the residents they might not be able to receive proper care. Record review of the facility's End-Stage Renal Disease, Care of a Resident policy, revised September 2010: 1. Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents