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	11/19/2025

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 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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to make prompt efforts to resolve grievances and keep the residents' RP appropriately apprised of progress toward resolution for 1 of 6 residents (Resident #1) reviewed for grievances. The facility failed to notify Resident #1's RP the resolution of her filed grievances on [DATE]. This failure could place the residents at risk of unresolved grievances and decreased quality of life. Findings included:Record review of Resident #1's admission record, initially admitted on [DATE], reflected the resident was an [AGE] year old female with diagnoses that included vascular dementia (decreased blood flow to the brain), hypertension (the pressure in the blood vessels are consistently too high), irritable bowel syndrome (condition that affects stomach and intestines),. Record review of Resident #1's admission MDS assessment, dated [DATE], reflected Resident #1 had a BIMS score of 2 out of 15, which indicated severe cognitive impairment. Record review of Resident #1's progress note, dated [DATE] at 2:16 PM, Resident #1 had expired. Record review of the Grievance/Concern Report, submitted in SW box on [DATE], reflected three grievances written by Resident #1's RP. The Grievances were as follows:*1. [DATE] Saturday-[Resident #1's neighbor/friend] visited around 4:00pm and [Saturday] found two pils on the floor. [Resident #1's neighbor/friend] went and got LVN B. LVN B said [the] yellow oval pill was for her stomach and the round white pill was for BP. LVN B said she would write a report. In Resident #1's present stated the dispenser of the medication should make sure Resident #1 swallows all medication. 2. [DATE] Sunday-Resident #1's RP visited around 1:15pm, resident had a large bruise on the side (left) of her head and bruises on the chins of her legs. RP ask the nurse as they were changing shift night nurse [wound nurse] if resident had fallen and she said no it was from her banging her head on the bed railing. I don't believe resident is on anticoagulants. Bruise there on [DATE]. *not sure of the name of the morning nurse. *3. Sunday-Need a podiatrist appointment to take care of cracked/flaky skin on heels. * Findings of Investigation dated [DATE] documented by the DON indicated. Resident was noted to being to have skin changes on [DATE] due to terminal state. Wound Dr. [NAME] coded her wounds as terminal. Her skin was fragile and easily bruise with normal care activities. Recommendation for corrective action:The pills found on the floor to be BP meds or pills for her stomach would be Labetalol and Protonix. The record reflects the BP meds were held several days for [low] BP. Results of action taken:It is suspected that the held medications fell to the floor instead of the trash can when held due to BP outside parameter. Protonix however is not document as held on MAR. Further record review of Resolution in grievance on [DATE], revealed the section blank. There was no response regarding the investigation reported to Resident #1's RP. In an interview on [DATE] at 8:08 AM, Resident #1's RP stated the facility had not returned her call regarding the grievances she submitted on [DATE]. She stated she filed a grievance report regarding medication administration and bruises and need of an appointment on the morning of [DATE] when Resident #1 passed away. She stated she was in route to the facility to visit Resident #1 and submit the grievance when she go the call she had passed away. She stated as of [DATE] she had still not received a call from the facility about her filed grievances. In an interview with the DON on [DATE] at 2:11 PM, she stated the SW received all grievances. She revealed the SW received the grievance form from Resident #1's RP on [DATE]. She also revealed she received Resident #1's RP, filed grievances and started investigating. The DON stated shortly after she started her investigation, she had to go out for surgery and handed it off the ADON. She stated she did not know how far the ADON had gotten into the grievance process. The DON stated as of [DATE] she had not followed up with a resolution call to Resident #1's RP. She stated she had completed the investigations into the filed concerns in the grievance. The DON stated it was the responsibility of the DON or ADON to investigate any concern that dealt with the nursing side. She stated she, ADON or SW were responsible for providing an update of progress to a resident, a resident's RP or family member. She stated she thought the call to Resident #1's RP was completed by ADON or SW while she was on leave. In an interview on [DATE] at 2:45 PM, the SW stated she attempted to contact Resident #1's RP to discuss the grievance. SW stated she did not document the attempt to contact. The SW also stated she did not remember if she left a message on the Resident #1's RP voicemail. She stated she did not know what days she attempted to contact the resident's RP, but she felt it was the same day she saw the grievance. She stated as of [DATE] she had not updated Resident #1's RP about resolution of the grievances she filed. In an interview on [DATE] at 4:06 PM, the ADON stated she had not investigated the concerns in the grievance submitted by Resident #1's RP. She stated she knew the

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed, in accordance with State and Federal laws, to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 1 of 6 residents (Resident #1) reviewed for medication storage. The facility failed to secure all medications in a locked storage area when Resident #1's Labetalol HCl and Pantoprazole Sodium medications were found on the floor approximately 2-3 inches from resident's bed on [DATE]. This failure could place residents at risk of access to medications not approved for administration by their physician. Findings included: Record review of Resident #1's admission record, initially admitted on [DATE], reflected the resident was an [AGE] year old female with diagnoses that included hypertension and irritable bowel syndrome. Record review of Resident #1's admission MDS assessment, dated [DATE], reflected the resident had a BIMS score of 2 out of 15, which indicated severe cognitive impairment. In the MDS assessment Section GG-Functional Abilities, it revealed Resident #1 needed partial and maximum assistance with ADLs. Resident #1 required partial assistance with mobility. In the MDS assessment Section J Health Condition, it revealed no for scheduled pain medication regimen, PRN pain medications or offered and declined, and received non-medication intervention for pain. There was no information about medication types. Record review of Resident #1's care plan, dated [DATE], reflected to administer medications per orders. Record review of Resident #1's order summary report, reflected may crush meds or open capsules as needed unless contraindicated. Record review of Resident #1's medication administration on [DATE], reflected LVN A administered the following medications:*Bactrium DS Tablet 800-160 MG, *Pantoprazole Sodium Oral Tablet Delayed Release 40 MG, *Prostat 30ml, *MiraLax Oral Pack 17 GM (Polyethylene Glycol 3350) 17 GM,Labetalol HCl Oral Tablet 200 MG,Juven andIpratropium-Albuterol Solution 0.5-2.5 (3) MG/3M In an interview with Resident #1's RP on [DATE] at 11:42 AM, she stated on [DATE] Resident #1's friend visited and upon arrival, she found two pills on Resident #1's floor. She stated their friend told her there was a white and yellow pill on the floor next to the resident's bed. She stated the nurse informed Resident #1's neighbor/friend that one pill was for the resident's stomach and the other pill found was identified as blood pressure. RP stated she was concerned as she did not know if Resident #1 received her medications on the morning of [DATE]. Resident #1's RP revealed she had attempted to contact management at the facility over that weekend but to no avail. She stated she submitted her concerns in a grievance. She stated she wanted the facility to investigate her concerns and inform her of the findings. In an interview on [DATE] at 4:06 PM, the ADON revealed she was not in the facility on [DATE]. She stated she received information from one of the nurses that Resident #1's friend had seen medications at resident's bedside. She stated she spoke with the nurse and had her told her to document the incident. She also stated she told the nurse to assess the resident. On [DATE] at 2:55 PM and (second time) attempts were made to contact staff LVN but phone was disconnected. In an interview with Resident #1's friend on [DATE] at 3:12 PM, she stated on [DATE] she visited Resident #1. She stated when she walked in the resident's room, she noticed two pills on the resident's floor. She stated it was a white and yellow pill approximately 2-3 inches on the right side of resident's bed on the floor. She also stated she picked the medications off the floor and sat them on the resident's tray table. She stated afterwards, she walked to the nurse's station and informed LVN B. She stated LVN B told her that she had just come onto her shift for the day, so she was not aware of the medications. She stated LVN B told her she would come to get the medications. Resident #1's friend stated shortly after LVN B went into Resident #1's room and retrieved the medications. Resident #1's friend also stated that LVN B told her she would check the computer to find out which pills it was. Resident #1's friend stated LVN B came back into the room and informed her it was Resident #1's Protonix (treat conditions that cause too much stomach acid) and Labetalol HCl (lower high blood pressure). She stated the LVN told her one was for Resident #1's stomach and the other for the resident's blood pressure. She stated the LVN stated the resident record showed she had taken two medications in the morning and did not want to give it to her if she had already taken them. Resident #1's friend stated LVN B stated she would document the medications on the floor in the system. Resident #1's friend stated she did not know how long it had been on the floor and was concerned. Interview with LVN B, she stated she had worked for agency. She stated she worked with Resident #1 on [DATE] on 2nd shift. She stated she worked from 2:00pm-10:00pm. LVN B stated Resident #1's friend came out and got her from the nurse's station. She stated it was shortly after she