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	12/21/2025

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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were provided with 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 one (Resident #1) of five residents reviewed for pharmacy services. The facility failed to have policies and processes in place to ensure the accurate dispensing and administering of medications. The admitting nurse for Resident #1 entered medications into Resident #1's medical record without verifying them against an accurate and current medication list, and the facility's physician subsequently signed the medication orders as entered. This resulted in Resident #1 being administered multiple doses of medications that were not prescribed to him. Resident #1 was found unresponsive and was subsequently sent to the hospital. On 12/20/25 at 6:10 p.m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 12/21/25, the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk of health decline, allergic reactions, hospitalization, and death.Findings included: Record review of Resident #1's MDS Assessment, dated 12/20/25, reflected he was an [AGE] year-old male, admitted [DATE] with a BIMS score of 9, which indicated moderate cognitive impairment characterized by impaired short-term memory and inconsistent orientation, requiring cueing or assistance to understand, retain, and follow instructions. The resident's diagnoses included Parkinson's disease (a brain disorder that causes tremors, stiffness, and slow movement), dysphagia (difficulty speaking or understanding language, usually due to brain injury or stroke), vascular dementia (brain damage from reduced blood flow that affects memory, judgment, and understanding), hypothyroidism (underactive thyroid gland that did not make enough hormone), bradycardia (the heart is beating slower than normal, can cause fatigue, dizziness, confusion, or fainting, the brain and body may not get enough blood and oxygen), hyperlipidemia (too much fat like cholesterol or triglycerides in the blood, which can raise the risk of heart disease and stroke), presence of cardiac pacemaker (a small device implanted in the chest to help the heart beat at a regular pace), anemia (the body has too few red blood cells or not enough hemoglobin), cognitive communication deficit (trouble understanding, processing, or expressing information) and encounter for surgical aftercare following surgery. Record Review of Residents #1 Medication Administration Review (MAR), dated 12/01/2025 through 12/06/2025, reflected the resident was administered the following incorrect medications: Metformin HCl oral tablet, 500 mg, 2 tablets administered by mouth 2 times a day for diabetes. The medication was administered to Resident #1 at 6:00 p.m. on 12/01/2025, 8:00 a.m. and 6:00 p.m. on 12/02/2025, 8:00 a.m. and 6:00 p.m. on 12/03/2025, 8:00 a.m. and 6:00 p.m. on 12/04/2025, 8:00 a.m. and 6:00 p.m. on 12/05/2025, and at 8:00 a.m. on 12/06/2025. Insulin Glargine subcutaneous solution 100 UNIT/mL (Insulin Glargine) inject 15 units subcutaneously in the evening for diabetes. The medication was administered to Resident #1 at 8:00 p.m. on 12/03/2025 and at 8:00 p.m. on 12/04/2025. Farxiga Oral Tablet 10 MG, (Dapagliflozin Propanediol) give 1 tablet by mouth one time a day for diabetes. The medication was administered to Resident #1 at 8:00 a.m on 12/02/2025, 8:00 a.m. on 12/03/2025, 8:00 a.m. on 12/04/2025, 8:00 a.m. on 12/05/2025, and 8:00 a.m. on 12/06/2025. Lasix Oral Tablet 40 MG (Furosemide) give 1 tablet by mouth two times a day for fluid overload. The medication was administered to Resident #1 at 6:00 p.m. on 12/01/2025, 8:00 a.m. and 6:00 p.m. on 12/02/2025, 8:00 a and 6:00 p.m. on 12/03/2025, 8:00 a.m. and 6:00 p.m. on 12/4/2025, 8:00 a.m. and 6:00 p.m. on 12/5/2025, and 8:00 a.m. on 12/06/2025. Insulin Lispro Injection Solution 100 UNIT/mL (Insulin Lispro) inject as per sliding scale:If 0-150 = 0; 151-200 = 2; 201-250 = 4; 251-300 = 6; 301-350 = 8; 351-400 = 10; 401 + = 12 units and notify the doctor, subcutaneously before meals for diabetes. Resident #1 was administered 8 units at 11:00 a.m. on 12/02/25 with a blood sugar reading of 312. Record review of Resident #1's Physician's Orders, dated 12/20/25, reflected the resident was currently prescribed Topiramate. The Black Box Warning (the most serious warning issued by the U.S. Food and Drug Administration (FDA) to alert patients and healthcare providers about the potential for serious or life-threatening side effects associated with certain medications) for the incorrectly administered Metformin HCl (hydrochloride) specifically identified the use of Topiramate (a carbonic anhydrase inhibitor) as a clinical risk factor. According to the manufacturer's warning, the use of these two medications at the same time was associated with an increased risk for the development of lactic acidosis (a medical condition characterized by

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for one (Resident #1) of five residents reviewed for medication accuracy. The facility failed to ensure they had processes in place to ensure accurate verification and reconciliation of physician's orders and medications upon admission. The admitting nurse for Resident #1 entered medications into Resident #1's medical record without verifying them against an accurate and current medication list, and the facility's physician subsequently signed the medication orders as entered. This resulted in Resident #1 being administered multiple doses of medications that were not prescribed to him. Resident #1 was found unresponsive and was subsequently sent to the hospital. 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