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	06/27/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents receive adequate supervision and assistance devices to prevent accidents for two of three residents (Resident #2 and Resident #3) reviewed for accident hazards/supervision/devices 1. The Facility failed to ensure CNA A and CNA B used a gait belt when transferring Resident #2 from her wheelchair to the bed and instead lifted the resident under her arms and by her pants on 06/27/26. 2. The Facility failed to ensure CNA A and CNA B used a gait belt when transferring Resident #3 from her wheelchair to the bed and instead lifted the resident under her arms on 06/27/26. These failures could affect the residents by placing the residents at risk for discomfort, pain, falls, injuries, and skin tears.Findings included: 1. Record Review of Resident #2's Quarterly MDS assessment, dated 04/21/26, reflected an [AGE] year-old female admitted to the facility on [DATE]. She had a BIMS score of 0 which indicated she was severely cognitively impaired. She required maximum assistance with transfers, toileting, and personal hygiene. She was always incontinent of urine and bowels. Diagnoses included Alzheimer's disease (progressive brain disorder) and heart failure. Review of Resident #2's care plan initiated on 08/07/22 reflected, [Resident #2] has an ADL Self Care performance deficit related to dementia, impaired balance, limited mobility.Interventions.Transfer: Extensive assistance of one staff. During an observation and interview attempt on 06/27/26 at 10:25 a.m. Resident #2 was observed sitting in her wheelchair in the dining room. Resident #2 was anxious and repeating words over and over. The Staffing Coordinator stated she spoke Spanish only but stated the Housekeeping Supervisor could interpret. The Housekeeping Supervisor asked resident what she needed and stated she kept repeating her husband's name but was not saying anything else. She stated this was her typical behavior. During an observation on 06/27/2026 at 1:30 p.m. CNA A and CNA B entered Resident #2's room to transfer her to bed. Both staff positioned the wheelchair next to the bed with the resident facing toward the head of the bed. Both staff then placed one arm under the resident's arm pit, and the other hand grabbed the back of her pants and lift the resident from the chair onto the bed. Resident was not bearing her full weight on her legs. No gait belt was used during the transfer. A gait belt was observed hanging on the door in the resident's room. 2. Record Review of Resident #3's Quarterly MDS assessment, dated 05/29/26, reflected a [AGE] year-old female admitted to the facility on [DATE]. She had a BIMS score of 3 which indicated she was severely cognitively impaired. She required substantial to maximum assistance with transfers, toileting, and personal hygiene. She was always incontinent of urine and bowels. She had sustained two falls without injury since the prior assessment. Diagnoses included dementia (decline in cognitive function) and diabetes (metabolic disorder). Review of Resident #3's care plan initiated on 08/19/25 reflected, Impaired Physical functioning related to cognitive impairment, debility/ weakness.Interventions.2 staff for transfer. During an observation with Resident #3 on 06/27/26 at 12:30 p.m. resident was observed sitting in her wheelchair in the dining room. Attempts to interview were unsuccessful. During an observation on 06/27/2026 at 1:45 p.m. CNA A pushed Resident #3 from the dining room to her room to transfer her to bed and perform incontinent care. CNA A stated Resident #3 was a two-person transfer. CNA B (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	entered Resident #3's room to assist with the transfer. Both staff positioned the wheelchair next to the bed with the resident facing toward the head of the bed. Both staff then placed their arm under the resident's arm pits and lifted the resident from the chair onto the bed. Resident was not bearing her full weight on her legs. No gait belt was used during the transfer. During an interview with CNA A and CNA B on 06/27/26/26 at 10:10 a.m. they both stated they were not supposed to lift residents under their arms because it could cause injury to their shoulders. They stated they did not know they were not supposed to grab the back of the residents' pants. They stated they were supposed to use a gait belt but stated they did not see one in the resident's room. They stated they had been trained on gait belt transfers. During an interview with the Director of Rehab on 06/27/26 at 02:15 p.m. she stated the facility was doing gait belt training during orientation but stated she was not sure when the last one was done. She stated they recently placed gait belts in all of the residents' rooms who required gait belt transfers. She stated it was not acceptable to lift someone under their arm pits due to the potential for injury not only to the resident but also to the caregiver. She stated it increased the risk of falls, fractures and nerve damage. During an interview with the DON on 06/27/26 at 03:00 p.m. she stated she would expect staff to use a gait belt when transferring a resident. She stated the risk of staff not following the correct procedure for transfers were injury to a resident's shoulders and arm and or the risk of the resident falling. She stated she would be doing one on one training with the CNA and also begin In-services with all of the staff to ensure staff were providing correct transfer techniques. Record review of the facility's undated policy, Safe Resident Handling/Transfers, reflected, It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines.Handling aids may include gait belts, transfer boards and other devices.Staff members are expected to maintain compliance with safe handling/transfer practices.Resident lifting and transferring will be performed according to the resident's individual plan of care.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for two of four residents (Resident #1 and Resident #2) reviewed for incontinence care. 1. The facility failed to ensure staff provided Resident #1 timely perineal care after an incontinent episode when they failed to check and change the resident from 07:30 a.m. to 1:15 p.m. on 06/27/26. 2. The facility failed to ensure staff provided Resident #2 timely perineal care after an incontinent episode when they failed to check and change the resident from 07:45 a.m. to 1:30 p.m. on 06/27/26. This failure could place residents at risk for not receiving appropriate care to address their incontinence and could increase the risk of urinary tract infections.Findings included:1. Record Review of Resident #1's Quarterly MDS assessment, dated 03/29/26, reflected an [AGE] year-old female admitted to the facility on [DATE]. She had a BIMS score of 0 which indicated she was severely cognitively impaired. She required maximum assistance with transfers, toileting, and personal hygiene. She was frequently incontinent of urine and always incontinent of bowels. Diagnoses included Alzheimer's disease (progress brain disorder) and diabetes (metabolic disorder). Record review of Resident #1's care plan initiated 05/15/23 reflected, Risk of Urinary Incontinence Always Incontinent .Interventions.Assist me with peri care very shift and as needed. During an observation on 06/27/26 at 9:07 a.m. Resident #1 was observed sitting up in her wheelchair in the dining room. Resident #1 was leaned over the arm of the wheelchair sleeping. During an interview with CNA A on 06/27/26 at 9:35 a.m. she stated Resident #1 was gotten up around 7:30 a.m. before breakfast. She stated they always get her up for her meals because she needed feeding assistance. During an observation on 06/27/26 at 10:25 a.m. Resident #1 was observed still sitting in the dining room sitting up in her wheelchair with eyes closed. Attempts to interview were unsuccessful. During an observation on 06/27/26 at 11:45 a.m. Resident #1 was pushed to her room by LVN C so she could perform her finger stick blood sugar check. LVN C completed the blood sugar monitoring and then returned the resident to the dining room. Resident #1 was not checked to see if she needed incontinence care. During an observation on 06/27/26 at 12:30 p.m. Resident #1 was observed in the dining room being provided with feeding assistance by the Staffing Coordinator. During an observation with Resident #1 on 06/27/2026 at 01:15 p.m. CNA A pushed Resident #1 from the dining room to her room while CNA B retrieved the mechanical lift. Both staff entered the room washed their hand and put on gloves. Both staff positioned the mechanical lift and attached it to the sling and lifted Resident #1 from her wheelchair onto the bed. CNA A the unfastened Resident #1's brief revealing it to be saturated in urine. A strong smell of urine was noted. CNA A wiped from front to back and then down the middle. Both staff assisted the resident onto her side, removed the soiled brief and wiped the resident's buttocks area from front to back. There was no skin breakdown noted but there was some slight redness and indentions from the brief. CNA A then placed the clean brief and a clean bed pad under the resident and both staff rolled the resident back onto her back, fastened the brief and repositioned the resident. 2. Record Review of Resident #2's Quarterly MDS assessment, dated 04/21/26, reflected an [AGE] year-old female admitted to the facility on [DATE]. She had a BIMS score of 0 which indicated she was severely cognitively impaired. She required maximum assistance with transfers, toileting, and personal hygiene. She was always incontinent of urine and bowels. Diagnoses included Alzheimer's disease and heart failure. Review of Resident #2's care plan revised on 08/07/22 reflected, [Resident #2] is at risk of Urinary incontinence.has functional bladder incontinence related to confusion, impaired mobility, loss of peritoneal tone.Interventions. ACTIVITIES: notify nursing if incontinent during activities.Assist me with peri care (cleansing of the genital and anal area) every shift and as needed. During an observation on 06/27/26 at 9:07 a.m. Resident #2 was observed sitting up in her wheelchair in the (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dining room. Her empty breakfast tray was sitting in front of her. During an interview with CNA A on 06/27/26 at 9:35 a.m. she stated Resident #2 was gotten up around 7:45 a.m. before breakfast. She stated they always get her up for her meals. During an observation and interview attempt on 06/27/26 at 10:25 a.m. Resident #2 was observed sitting in her wheelchair in the dining room. Resident #2 was anxious and repeating words over and over. The Staffing Coordinator stated she spoke Spanish only but stated the Housekeeping Supervisor could interpret. The Housekeeping Supervisor asked resident what she needed and stated she kept repeating her husband's name but was not saying anything else. She stated this was her typical behavior. Resident #1 was observed with food particles in her lap and a spilled liquid on her pants. During observation on 06/27/26 at 11:00 a.m. Resident #2 was observed still sitting in her wheelchair in the dining room. Clothing had not been changed and was observed to still have food particles on her pants. During an observation on 06/27/26 at 12:30 p.m. Resident #2 was observed in the dining room being assisted with meal by a family friend. During an observation on 06/27/26 at 1:10 p.m. CNA D was observed removing Resident #2 from the dining room and taking her to her room. CNA D stated CNA A would be in later to put her to bed. During an observation on 06/27/2026 at 1:30 p.m. CNA A and CNA B entered Resident #2's room to transfer her to bed and provide incontinent care. Both staff washed their hands and put on gloves. Both staff positioned the wheelchair next to the bed with the resident facing toward the head of the bed. Both staff then placed one arm under the resident's arm pit, and the other hand grabbed the back of her pants and lifted the resident from the chair onto the bed. The resident's pants were soaked from her waist down to her knees. CNA A stated Resident #2 was a heavy wetter, and she drank a lot of fluid. Both staff removed the resident's pants and CNA A unfastened the saturated brief and wiped down each groin and then down the middle. Both staff rolled the resident onto her side, revealing the resident was having a small bowel movement. CNA A wiped from front to back and removed the soiled brief. She placed a clean brief under the resident, and with the assistance of CNA B rolled the resident back onto her back and fastened the brief. During an interview with CNA A and CNA B on 06/27/26 at 2:00 p.m. they both stated they had only checked and changed Resident's #1 and Resident #2 once this shift. CNA A stated the hall the two residents were on was a very heavy hall and had several residents who were a two-person transfer. CNA A stated between the showers they had to give and waiting for the other CNA to be able to help they did not get the residents checked like they should. She stated the medication aides, nor the nurses were able to help. She stated they did the best they could do. They both stated they knew residents who were incontinent needed to be checked and changed every 2 hours. They stated the risk of not changing them timely was urinary infections and skin irritation. During an interview with the DON on 06/27/26 at 02:50 p.m. she stated any resident who was incontinent of bowel and bladder needed to be checked for incontinence every 2 hours and changed as needed. She stated by not providing timely incontinent care placed residents at risk for urinary tract infections, skin breakdown and overall poor hygiene. She stated they were going to have to increase their monitoring to ensure residents were getting changed timely. She stated she had already started servicing the staff on the expectation. Record review of the facility's policy titled, Perineal Care, revised May 2025, reflected, It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 4 Residents (Resident #1, Resident #2 and Resident #3) observed for infection control. The facility failed to ensure CNA A performed hand hygiene during incontinent care on Resident #1, Resident #2, and Resident #3 on 06/27/26. These failures could place the residents at risk of cross-contamination and development of infection.Findings included: 1. Record Review of Resident #1's Quarterly MDS assessment, dated 03/29/26, reflected an [AGE] year-old female admitted to the facility on [DATE]. She had a BIMS score of 0 which indicated she was severely cognitively impaired. She required maximum assistance with transfers, toileting, and personal hygiene. She was frequently incontinent of urine and always incontinent of bowels. Diagnoses included Alzheimer's disease (progressive brain disorder) and diabetes (metabolic disorder). During an observation with Resident #1 on 06/27/2026 at 01:15 p.m. CNA A pushed Resident #1 from the dining room to her room while CNA B retrieved the mechanical lift. Both staff entered the room washed their hands and put on gloves. Both staff positioned the mechanical lift and attached it to the sling and lifted Resident #1 from her wheelchair onto the bed. CNA A unfastened Resident #1's brief revealing it to be saturated in urine. A strong smell of urine was noted. CNA A wiped down both groins and then down the middle towards the resident's buttocks. Both staff assisted the resident onto her side, removed the soiled brief and wiped the resident's buttocks area from front to back. CNA A then placed the clean brief and a clean bed pad under the resident, changed her gloves but did not perform hand hygiene and both staff rolled the resident back onto her back, fastened the brief and repositioned the resident. Both staff then removed their gloves and washed their hands. 2. Record Review of Resident #2's Quarterly MDS assessment, dated 04/21/26, reflected an [AGE] year-old female admitted to the facility on [DATE]. She had a BIMS score of 0 which indicated she was severely cognitively impaired. She required maximum assistance with transfers, toileting, and personal hygiene. She was always incontinent of urine and bowels. Diagnoses included Alzheimer's disease and heart failure. During an observation on 06/27/2026 at 1:30 p.m. CNA A and CNA B entered Resident #2's room to transfer her to bed and provide incontinent care. Both staff washed their hands and put on gloves. Both staff positioned the wheelchair next to the bed with the resident facing toward the head of the bed and transferred the resident to the bed. Both staff removed the resident's wet pants and CNA A unfastened the saturated brief and wiped down each groin and then down the middle. Both staff rolled the resident onto her side, revealing the resident was having a small bowel movement. CNA A wiped from front to back and removed the soiled brief. CNA A then removed her gloves and put on clean gloves without performing hand hygiene and placed a clean brief under the resident, and with the assistance of CNA B rolled the resident back onto her back and fastened the brief. Both staff then removed their gloves and washed their hands. 3. Record Review of Resident #3's Quarterly MDS assessment, dated 05/29/26, reflected a [AGE] year-old female admitted to the facility on [DATE]. She had a BIMS score of 3 which indicated she was severely cognitively impaired. She required substantial to maximum assistance with transfers, toileting, and personal hygiene. She was always incontinent of urine and bowels. She had sustained two falls without injury since the prior assessment. Diagnoses included dementia (decline in cognitive function) and diabetes. During an observation on 06/27/2026 at 1:45 p.m. CNA A pushed Resident #3 from the dining room to her room to transfer her to bed and perform incontinent care. CNA B entered Resident #3's room to assist with the transfer. Both staff washed their hands and put on gloves. Both staff positioned the wheelchair next to the bed with the resident facing toward the head of the bed and transferred the resident to the bed. CNA A unfastened the resident's brief and wiped down each groin and then down the middle. Both staff assisted the resident onto her (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	right side and CNA A wiped from front to back. CNA A changed her gloves but did not perform hand hygiene and placed a clean brief under the resident. Both staff assisted the resident onto her back, fastened the brief and lowered the bed. Both staff then removed their gloves and washed their hands. During an interview with CNA A on 06/27/26 at 2:00 p.m. she stated she was supposed to do hand hygiene before and after incontinent care but then stated she should have done it after she finished cleaning the resident and changed her gloves. She stated the risk of not doing hand hygiene when going from dirty to clean was the spread of germs and infection. During an interview with the DON on 06/27/26 at 02:50 p.m. she stated staff were to change their gloves and perform hand hygiene before going from dirty to clean, before entering a resident's room and before leaving a resident's room. She stated they train and do in-services constantly on infection control. She stated she would be doing skills checks and re-education with the staff on overall infection control. Record review of the facility's undated policy titled, Hand Washing, reflected, All staff will perform proper hand hygiene procedures to prevent the spread of infections to other personnel, residents and visitors.The use of gloves does not replaced hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.