

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676408	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER Bear Creek Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interviews, and record review, the facility failed to provide an environment that remained as free of accident hazards as possible for 1 of 3 (100/200 hall) nurse's cart sharps container that was observed full with syringes overflowing. The facility failed to ensure nursing staff replaced the full sharps container on the 100/200 hall nurses' cart with a new one at 09:21AM on 7/28/26[KA4.1]. This failure could place residents at risk of harm or injury and contribute to avoidable accidents and spread of infection. The findings included: Observation on 07/28/26 at 9:21AM revealed nurses' cart for halls 100/200 sharp container was observed full and overflowing with sharps. Observation revealed insulin syringes were near spilling on the floor. No resident was observed in the area. Interview on 07/28/25 at 9:35 AM with RN D revealed she was the charge nurse for 100/200 hall. She said she was responsible for checking and changing the sharps container when she arrived on shift. She said she was aware the sharps container was full on 7/27/26 and on 7/28/26 when she reported for duty and she was to replace the filled sharps container with an empty one, but she got busy and forgot. She said the risk of leaving the sharps container full and overflowing was sharps would spill over and could cause hazards like needle sticks. She said this could cause the spread of infection. Interview on 07/28/26 at 4:50 PM with the DON revealed her expectation was all nurses to be checking on sharp containers every shift and replaced them when they were half full. She said they should not wait until they were full. She said the sharps containers have a line marked where nurses should ensure sharps did not pass. She said all nurses were responsible for replacing the sharps container when they were half full. She said she was responsible for checking behind the nurses performing spot checks to ensure sharps containers were replaced when half full, but she could not recall when she last checked the sharps containers. The DON stated failing to change the full sharps container could risk accidental needle sticks which could lead to the spread of infection. Record review of facility policy titled, Regulated (Biohazard) Medical Waste, undated, revealed the following: 11. Sharps containers must be maintained upright throughout use and replaced routinely. Do not overfill the container.		

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free of any significant medication errors for 1 (Resident #2) of 4 residents reviewed for pharmacy services. The facility failed to ensure Resident #2 was not given an antibiotic that was identified as an allergy when he was administered doxycycline on 07/13/25. This failure could place the residents at risk of harm and/or serious injury. Findings included: Review of Resident #2's quarterly MDS assessment dated [DATE], reflected the resident was an [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included high blood pressure (condition where blood pushes too hard against the artery walls), end stage renal disease (permanent kidney failure), obstructive uropathy (blockage in the urinary tract that stops urine from flowing normally), non-Alzheimer's dementia, and cognitive communication deficit (breakdown in communication caused by impaired mental processes). The resident had a BIMS score of 6 which indicated his cognition was severely impaired. Review of Resident #2's face sheet, dated 07/28/26 reflected the resident had the following allergies: Fexofenadine, Tetracycline (doxycycline and tetracycline belong to the same family of antibiotics), and Sulfa Antibiotics. Review of Resident #2's progress notes, dated 07/12/26 documented by LVN C reflected the following, Resident noted with productive cough, lung sounds are diminished, temp elevated, on call NP notified, received the following orders. Doxycycline. Review of Resident #2's progress notes dated 07/12/26 documented by LVN C further reflected the following: Reason for alert charting: The system has identified a possible drug allergy for the following order: Doxycycline Hyclate Tablet 100 mg Give 1 tablet by mouth two times a day for URI for 7 days. Review of Resident #2's Order Audit Report dated 07/12/26 created by LVN C, reflected the following: Doxycycline Hyclate Tablet 100mg Give 1 tablet by mouth two times a day for URI for 7 days Review of Resident #2's MAR for July 2026 reflected he was administered doxycycline on 07/12/26 at 5:00 PM by MA D. Observation on 07/28/26 at 10:44 AM of Resident #2 revealed he was in his room, sitting in the wheelchair who was accompanied by a private sitter. Resident #2 did not respond when he was spoken to but only smiled and made some hand gestures. The resident did not appear to be in any distress at the time of the observation and per the private sitter, Resident #2 was at his baseline. The Private Sitter said sat with the resident most days and she had not noticed the resident have any type of change in condition the past weeks. Interview on 07/28/26 at 2:22 PM with RN E revealed she worked on 07/13/26 and noticed the drug allergy in Resident #2's clinical record. RN E said she did not administer the doxycycline but had called the doctor to notify him of the possible allergy and it was changed to a different antibiotic. RN E said she did not notice Resident #2 have any negative side effects from taking doxycycline and had remained at his baseline. Interview on 07/28/26 at 2:41 PM with MA D revealed Resident #2 had been on so many different antibiotics in the past and did not recall the time she gave Resident #2 doxycycline or any of the details around the time she gave it. Attempts to contact LVN C on 07/28/26 at 3:17 PM were unsuccessful. Interview on 07/28/26 at 3:56 PM with the NP revealed he was called and made aware Resident #2 was given doxycycline and of the possible drug allergy. He said he was not the provider that prescribed it, but he changed the order to a different antibiotic. The NP said he saw Resident #2 the following day (07/14/26) and did not notice any negative reactions from taking doxycycline. The NP further stated risk of an allergy to the medication could vary depending on the type of allergy the resident had to tetracycline in the past. Interview on 07/28/26 at 4:18 PM with the ADON revealed she was not aware Resident #2 was given doxycycline after the computer system gave a possible drug allergy alert. The ADON said the facility (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had an after-hours call system, they used if a resident experienced any type of change in health. The ADON said she believed that might have been who prescribed the doxycycline for Resident #2 so if the nurse used the on-call system, they should have given the on-call NP Resident #2's allergies so they would have known what to prescribe. The ADON further stated risk of a resident being given a medication with a drug allergy included a rash to something severe like anaphylactic shock (a severe life-threatening allergic reaction causing a sudden drop in blood pressure and narrowed airways). Interview on 07/28/26 at 4:47 PM with the DON revealed she was not aware Resident #2 was given doxycycline despite the possible allergy and did not know the details around the time it was ordered. The DON said a resident could experience different negative signs/symptoms if they were given a medication, they were allergic to. Review of the facility's policy titled Medication Errors revised 05/2025 reflected the following: PolicyIt is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. Significant medication error means on which causes the resident discomfort or jeopardizes his/her health and safety.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and 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 1 of 2 residents (Resident #1) reviewed for infection control. The facility failed to ensure:- there was a sign outside of Resident #1's room indicating that the resident was on enhanced barrier precautions, which was due to the resident having an open chronic ulcer (non-pressure related) on his right heel;- LVN A, who was the Wound Care Nurse, performed hand hygiene prior to putting on gloves and between glove changes; and- LVN A wore as gown as required due to the resident being on enhanced barrier precautions; This failure could place residents at risk of cross-contamination and infection. Findings included: Record review of Resident #1's comprehensive assessment MDS, dated [DATE], reflected a [AGE] year-old female admitted to the facility on [DATE]. His diagnoses included non-pressure chronic ulcer of right heel and midfoot with unspecified severity (result from poor blood circulation, often caused by conditions like diabetes or vascular disease). Resident #1 had a BIMS score of 15 which indicated his cognition was intact. The MDS reflected that the resident had diabetic foot ulcer(s) (an open sore caused by nerve damage, poor blood flow, or high blood sugar). The MDS further reflected Resident #1 had treatment for application of dressings to feet (with or without topical medications). The MDS further reflected Resident #1 was at risk of developing pressure ulcers/injuries. Record review of Resident #1's care plan, dated 07/14/26, reflected the resident had impaired skin integrity rule out diabetic foot ulcer (right heel). Goal: - Skin will heal without sign and symptoms of infections as evidenced by a decrease in size and depth through next review date. No date. Interventions included treatments and dressing changes as ordered by physician [SIC]. Record review of Resident #1's physicians order summary report, dated 07/24/26, reflected the following: Right heel Cleanse Wound with Dakins 0.125%, apply lightly moistened Dakins 0.125%(percentage) sterile gauze to wound bed, cover with abdominal pad, secure with tape daily and as needed in the morning. No order on enhanced barrier Observation on 07/28/26 at 10:58 AM revealed LVN A, who was the Wound Care Nurse, providing Resident #1 with wound care, revealed there was no signage on the door for enhanced barrier and no PPE by the door. Observation indicated LVN A disinfected the table and left it to dry. She removed gloves, sanitized hands, and put the supplies together. She wheeled the table to Resident #1's bedside. She then put on gloves without washing hands and she failed to wear a gown. She removed the old dressing on Resident #1's right heel. She changed gloves and did not perform hand hygiene. She cleansed the wound with gauze soaked with Dakin's solution, removed her gloves, did not wash hands, put on new gloves, and applied lightly moistened Dakins 0.125% sterile gauze to wound bed, covered with abdominal pad and tape, dated 7/28/26. Interview with LVN A on 07/28/26 at 11:37 AM revealed she was supposed to remove the old dressing, remove gloves and wash hands. She said she knew she was supposed to wash hands before contact, during care and with each change of gloves and if the gloves were contaminated, but she forgot. She said she did not wear a gown because she was not aware she was supposed, and there was no indication, no signage for enhanced barrier precautions and no PPE at the door. She said she had not been wearing gowns while performing wound care on Resident #1. She said she was instructed by the DON to wear PPE only on chronic wounds, but she could not tell whether Residnet#1's wound was chronic. She said the DON was the one that decided which resident needed PPE, and she did not know what was included in the facility policy. She stated failure to wear gowns and perform hand hygiene with (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	change of gloves would cause cross contamination and spread of infection. She stated she was trained on infection control and handwashing. Interview on 07/28/26 at 5:50 PM with the DON revealed her expectation was that those residents with chronic wounds should have enhanced barrier precautions signage and have PPE outside the resident's door. She said they had not put PPE because they discussed it during morning meetings, and Resident #1 was not one of the residents on PPE, but she could not state why. She said for residents with chronic wounds, staff were required to wear gowns and gloves when having direct contact with the residents and while providing wound care. She could not tell whether Resident #1 wound was chronic or not although the diagnosis stated non-pressure chronic ulcer of right heel. The DON stated that EBP protects residents from exposure to infectious agents. She said her expectation was for the staff to wash hands before contact, between care and when they removed or changed gloves. She stated failure to perform hand hygiene risk contamination and spread of infection. She said she trained staff on EBP and handwashing. EBP training requested, but no record was provided by the time we exited. Employee files were not reviewed for training offered by the facility. Record review of the facility's Enhanced Barrier Precautions policy, dated 4/10/2025, reflected: Enhanced Barrier Precautions refer to an infection control intervention designed to reduce transmission of multi-drug-resistant organisms that employs targeted gowns and gloves use during high contact residents care activities. 2 b. An order for enhanced barrier precautions will be obtained for residents with any of the following: 1. Wounds (e.g., chronic wounds such as pressure ulcer, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis and or indwelling medical devices. 4 h. Wound care: any skin opening requiring dressing Record review of the facility's Hand Hygiene policy, undated, reflected: Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub. 6. Additional considerations: The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.		