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	05/07/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure residents are offered a therapeutic diet when there is a nutritional problem, and the healthcare provider orders a therapeutic diet for 1 of 4 residents (Resident #76) reviewed for food and nutrition. The facility failed to ensure Resident #76 received his nutritional supplement beverage (magic cup) during the lunch service on 05/06/26. This failure could lead to nutritional deficits and unintended weight loss. Findings include: Review of Resident #76's Quarterly MDS Assessment, dated 04/10/26, reflected he was a [AGE] year-old male who had recently readmitted to the facility on [DATE] after originally admitting on 10/30/25. He had a BIMS of 00 indicating severe cognitive impairment. His active diagnoses included malnutrition, adult failure to thrive, and cognitive communication deficit. His MDS indicated he had recently lost weight. Review of Resident #76's Order Summary Report, dated 05/07/26, reflected an order for Magic Cups two times a day lunch and dinner, with an order start date of 03/23/26. Review of Resident #76's Nutritional Assessment, dated 04/08/26, reflected Supplements.MAGIC CUP W/L&D [sic]. Review of Resident #76's Care Plan, revised 04/07/26, reflected the following: Focus: Unexpected/unintended weigh loss r/t loss of appetite, eating 50% of meals.Interventions: Offer high calorie/nutrient dense supplements as ordered by physician/dietitian.record meal/snack intake in clinical record.Review of Resident #76's Lunch Meal Ticket, dated 05/06/26, revealed it did not include his magic cup.Observation on 05/06/26 at 12:21 PM revealed Resident #76 sitting in the dining room in his wheelchair. Resident #76 had a family member next to him. Resident #76 was waiting for his meal because he did not like what was being served and had requested a grilled cheese sandwich and chips instead. Observation on 05/06/26 at 12:25 PM of Resident #76's lunch tray revealed it included 1 and 1/2 grilled cheese sandwiches, chips, ice cream, and tea. Interview on 05/06/26 at 12:30 PM, Resident #76's Family Member said the resident had previously lost weight because he had some infections recently that caused him to have a decrease in his appetite. Resident #76's Family Member said since the resident was readmitted to the facility he had been eating better but he was supposed to get a milkshake or something like that with his meal and it was missing today. Resident #76's Family Member said she was not sure why it was left off his meal tray today Interview on 05/06/26 at 12:35 PM, [NAME] G said the DM did not show up to the facility today so she was handling the lunch service today. [NAME] G said normally Resident #76 was supposed to get a magic cup with his meal for lunch but he was not served one today. [NAME] G said the magic cup was not listed on his meal ticket for some reason so it was not included on his meal tray. [NAME] G said the kitchen staff and nursing staff look at the meal tickets to make sure that all items were on the tray before it went to the resident. [NAME] G said since the magic cup was not listed on Resident #76's meal ticket for the lunch service today, no one noticed it was missing. [NAME] G said the previous DM was supposed to make sure that all the Dietitian's recommendations were reflected on the meal ticket for residents, including an order for a magic cup. [NAME] G said the magic cup would have only come from the kitchen. Interview on 05/07/26 on the phone at 11:23 AM with the Dietitian, she said the facility was supposed to make sure Resident #76 received his ordered magic cup for lunch and dinner because he recently had problems with his appetite and had lost weight. The Dietitian said the (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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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's meal ticket was supposed to show any supplements they were to receive for that meal and she was not sure why Resident #76's magic cup was not on his meal ticket yesterday. The Dietitian said the magic cup for Resident #76 would have only come from the kitchen and if it was not on his meal ticket, the nursing department might not have known it was missing just like the kitchen. Interview on 05/07/26 at 11:32 AM with the ADON, she said Resident #76's magic cup came from the kitchen. The ADON said the Dietitian put orders in for nutrition for weight loss and those showed up on the resident's meal tickets so the kitchen staff knew what to include on the resident's tray. The ADON said the kitchen staff were responsible for making sure all items were included on the resident's tray. The ADON said she was not sure why Resident #76's magic cup was not on his meal ticket and therefore, not on his meal tray for yesterday. The ADON said Resident #76 had recently had a decrease in his appetite after having an infection which was why the Dietitian recommended the magic cup for lunch and dinner meals. Interview on 05/07/26 at 12:22 PM with the previous DM, he said he left the facility last Thursday (04/30/26) but was called yesterday (05/06/26) to return today as the DM. The Previous DM said the Dietitian made recommendations and sent them to him to upload in the meal ticket system and then the order would show up on the resident's meal ticket. The Previous DM said he was not sure how or why Resident #76's order for magic cups at lunch and dinner was missed and not uploaded to be included on his meal ticket. The Previous DM said he was responsible for inputting the Dietitian's orders into the system, and would have been at the time the order was placed. The Previous DM said the purpose of ensuring the Dietitian's orders for nutritional supplements were included on the resident's meal tickets was so they could get the proper nutrition. The Previous DM said if the resident did not receive their ordered nutritional supplement, they could have weight loss and be too weak to perform therapy or daily functions. The Previous DM said due to staffing levels, he has not had the opportunity to complete an audit and ensure all nutritional supplements were included on the residents' meal tickets and that they were receiving them as ordered. The Previous DM said the kitchen was responsible for Resident #76 receiving his magic cup on his meal tray for lunch and dinner meals. The Previous DM said he was not here yesterday (05/06/26) and was not sure why Resident #76's meal ticket did not include his order for a magic cup. Interview on 05/07/26 at 1:44 PM with the DON, she said she had only been at the facility since 04/22/26. The DON said the kitchen was responsible for ensuring Resident #76 received his magic cup from the kitchen during the lunch meal yesterday (05/06/26). Review of the facility's undated policy, titled Nutritional and Dietary Supplements, reflected: 2. The facility will provide nutritional and dietary supplements to each resident, consistent with the resident's assessed needs.

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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** Based on observation, interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 2 residents (Resident #85) reviewed for dialysis. 1. The facility failed to ensure dialysis communication forms were completed for Resident #85 after returning from dialysis treatment. 2. The facility failed to ensure Resident #85 had an order to complete dialysis treatment. These failures could place residents at risk of inadequate monitoring after returning to facility. Findings included: Review of Resident #85's None of the Above MDS Assessment, dated 04/26/26, reflected she was a [AGE] year-old who was admitted to the facility on [DATE]. Her MDS indicated she had a BIMS of 06, which meant she had severe cognitive impairment. Her active diagnoses included renal insufficiency, renal failure, or end-stage renal disease (the final stage of chronic kidney disease, where the kidneys can no longer function adequately to sustain life without treatment) and diabetes mellitus (a chronic condition that occurs when the body cannot properly use blood sugar). Her MDS indicated she received hemodialysis and dialysis services. Review of Resident #85's order summary report, dated 05/05/26, did not reflect any orders for dialysis services. Review of Resident #85's care plan, revised 04/28/26, reflected the following: Focus: [Resident #85] has Potential for complications r/t Renal Failure with dialysis. Review of Resident #85's Progress Notes reflected the following:RN H wrote on 04/25/26 at 7:23 PM Resident admitted to the facility from [the hospital].According to Hospital report, Resident was admitted to hospital due to acute encephalopathy, hx of hepatic and renal; dysfunction. Dialysis Tu/Th & Sa at 1130. Permacath Right chest- dressing CDI- no s/s of infection. Review of Resident #85's Dialysis Pre & Post Assessment, dated 04/30/26, reflected only the Dialysis Pre-Evaluation was filled out; there was no information for the sections labeled To be Completed by Dialysis Provider or the Dialysis Post-Evaluation. Review of Resident #85's Dialysis Pre & Post Assessment, dated 05/02/26, reflected only the Pre-Dialysis section was filled out; for the Post-Dialysis section, there were only vitals listed for her blood pressure, pulse, and temperature as the rest of the section was empty/blank. Review of Resident #85's Dialysis Pre & Post Assessment, dated 05/05/26, reflected only the Dialysis Pre-Evaluation was filled out; there was no information for the sections labeled To be Completed by Dialysis Provider or the Dialysis Post-Evaluation. Observation and interview on 05/05/26 at 11:53 AM with Resident #85, she was sitting in her wheelchair in her room eating her lunch tray. Resident #85 said she went to dialysis three days a week. Observation and interview on 05/06/26 at 12:31 PM with Resident #85, she was sitting in her wheelchair in her room. Resident #85 said she did not go to dialysis today and she was not sure when she was supposed to go to dialysis. Interview on 05/06/26 at 1:46 PM with CNA B, she said Resident #85 went to dialysis on Tuesdays, Thursdays, and Saturdays. CNA B said she helped to get Resident #85 ready to go and made sure she had a warm lunch when she came back from dialysis. Observation and interview on 05/06/26 at 1:50 PM with RN A, she said Resident #85 left the facility to go to dialysis on Tuesdays, Thursdays, and Saturdays. RN A said Resident #85 went to dialysis yesterday but was confused and not aware of her days for dialysis services. RN A said she sent Resident #85 with her pre and post dialysis assessment paperwork to be filled out and put in the electronic record. RN A said Resident #85 was supposed to have dialysis orders that included the information for dialysis, the pre and post assessment, and her port site care. RN A looked at Resident #85's orders in her electronic health record and did not see any orders for dialysis. Phone interview on 05/07/26 at 10:16 AM with RN H was unsuccessful as she did not answer or call back prior to exit. A message was left for her to call back. RN H admitted Resident #85 on 04/25/26. Interview on 05/07/26 at 10:30 AM with RN A, she said Resident #85 left to go to dialysis during her shift and she was responsible for filling out the first portion of the pre and post dialysis assessment. RN A said Resident #85 came back from dialysis on (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the next shift so the next shift's nurse would complete the next portion of the pre and post dialysis assessment. Interview on 05/07/26 at 11:32 AM with the ADON, she said Resident #85 went to dialysis on Tuesdays/Thursdays, and Saturdays. The ADON said the nurse who sends the resident to dialysis during their shift should open up the pre and post assessment in the resident's electronic health record, input the information, and print the document out to be sent with the resident to dialysis. The ADON said when the resident came back from dialysis, the next nurse should input the information from the sheet and any new vitals taken into the resident's electronic health record. The ADON said Resident #85 should have dialysis orders that included the days of dialysis for the resident, the timing of the dialysis, the pick up information, where the resident's port was located, any fluid or dietary restrictions, and the name/address/phone number of the dialysis center. The ADON said this was so that the information was accessible in case someone from the facility needed to call the dialysis center. The ADON said the nurse who admitted Resident #85 should have included the order for dialysis services and after a resident admitted , the ADON would have completed an audit to check and make sure all orders were included. The ADON said anything could happen if the resident did not have dialysis orders such as missing their chair time, could become hospitalized or have a change in condition that was not noticed quickly. The ADON said all nurses were trained and expected to include orders for any care the resident received. The ADON said she noticed that Resident #85's pre and post dialysis assessments were not being completed as expected. The ADON said if staff were not completing the pre and post dialysis assessments then they may not know what the resident's vitals were or what happened at the dialysis center. The ADON said that then can affect other care because the doctor may not have a full understanding of the resident's current condition when adding orders for them. The ADON said the pre and post dialysis assessment was a form of communication between the facility and the dialysis center. The ADON said usually the morning shift would complete the pre part of the assessment and the afternoon shift would complete the post part of the assessment and input the information from the dialysis center. The ADON said the facility recently had staff/personnel changes and had newer staff working so they might not have known to collect that information. The ADON said there was not a monitoring or auditing system in place to make sure the pre and post dialysis assessments were completed by staff. Interview on 05/07/26 at 1:44 PM with the DON, she said she had only been at the facility since 04/22/26. The DON said Resident #85 did not have an order for dialysis. The DON said after reviewing the situation, she could see how the dialysis order would be beneficial because it would make sure there was communication in place for all parties that are involved in that care pathway. The DON said the nurse who admitted the resident should make sure all necessary orders were included, then the next shift would double check all orders were included, then lastly the DON or ADON would check to ensure all orders were included. The DON said ultimately, as the DON everything was her responsibility. The DON said if a resident did not have dialysis orders they could miss their dialysis appointment. The DON said she expected staff to implement all orders into the resident's electronic health record. The DON said the purpose of the pre and post dialysis assessment was to monitor the resident after dialysis to make sure there was not a change in condition from the time they left dialysis to their return to the facility. The DON said a resident on dialysis services was at higher risk of having a change in condition and staff need to ensure they were stable and to monitor them. The DON said the nurse who sent the resident to dialysis and the nurse who received them back from dialysis were responsible for ensuring he pre and post dialysis assessment forms were completed. The DON said the ADON should be auditing the pre and post dialysis assessments to ensure they were being completed. Review of the facility's policy, revised 05/01/25, and titled Hemodialysis reflected: Purpose: Ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring, of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices.13. The facility will ensure that the physician's instructions for dialysis include: a. The type of access for dialysis (e.g. graft, (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	arteriovenous shunt, external dialysis catheter) and location; b. The dialysis schedule; c. The dialysis facility name and phone number; d. Transportation arrangements to and from the dialysis facility; e. Any medication administration or withholding of specific medications prior to dialysis treatments; f. Any fluid restriction if requested by the physician.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide 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 1 of 3 medication carts (Hall 300 nurse cart) reviewed for pharmacy services. The facility failed to ensure that one bottle of OTC Simethicone 125 mg, with an expiration date of February 2026, and Benzonatate 100 mg capsule prescribed to Resident #29, with an expiration date of 03/26/26, had been removed from the 300-hall nurse cart. This failure could place residents at risk of receiving medications that were ineffective. Findings included: Record review of Resident #29's Face Sheet, dated 05/07/26, revealed she was an [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #29's Quarterly MDS, dated [DATE], revealed she had the following diagnoses: COPD (progressive lung disease caused by damage to the lungs), Chronic respiratory failure without hypoxia (long-term condition where the lungs cannot efficiently remove carbon dioxide from the blood), and Dementia (decline in brain function that interferes with daily life). The MDS also revealed Resident #29 has a BIMS score of 8, indicating moderate cognitive impairment. Record review of Resident #29's Care Plan, revised 05/05/26, revealed that she had impaired cognitive function related to Dementia with an intervention to administer medications as ordered. The care plan also revealed that Resident #29 was at risk for impaired gas exchange (condition where the lungs cannot adequately transfer oxygen into the blood) related to COPD with an intervention to administer medications as ordered. Record review of Resident #29's order summary, dated 05/07/26, revealed the following with a start date of 04/02/25: Tessalon Perles Capsule 100 mg (Benzonatate) [prescription used to relieve coughs] Give 2 capsules by mouth every 8 hours as needed for cough related to chronic obstructive pulmonary disease Record review of Resident #29's MAR from 03/26/26-05/07/26 revealed that she did not receive any as needed doses of Benzonatate 100 mg. Observation on 05/06/26 at 11:19 AM of the 300-hall nurse cart with LVN E revealed a bottle of Simethicone 125 mg (medication used for gas relief) that had an expiration date of 02/26. Observation also revealed a bubble pack of Benzonatate 100 mg prescribed to resident #29 with an expiration date of 03/26/26. Interview on 05/06/26 at 11:24 with LVN E revealed that she had been working at the facility for 4 weeks. LVN E stated the Benzonatate 100 mg expired on 03/26/26. She stated that it was an as needed medication for Resident #29 and that she had not given her any doses. LVN E stated the Simethicone expired on 02/26. LVN E stated the nurses were responsible for ensuring there was no expired mediation in the carts. LVN E stated that pharmacy also came to audit the carts, but she was unsure how often. She stated she checked the expiration date before administering any medications and was trained on reviewing expiration dates. LVN E stated the risk of having expired medications in the cart was they could be administered and cause a medication error. Interview on 05/07/26 at 12:03 PM with the ADON revealed she had worked at the facility since January 2026. The ADON stated she checked the medication carts and did an audit in April 2026. She stated the pharmacist also checked the carts at least once a month. The ADON stated the nurses were responsible for checking the expiration dates in their carts, and that she was overall responsible. She stated when she did her cart audits, they missed one medication cart, so the expired medications must have been missed. The ADON stated she was going to add an audit system for the staff to complete and educate all the nurses and medication aides. She stated the risk of having expired medications was administering medications with lower efficacy. The ADON stated it was important not to keep any expired medications to ensure medications were effective. Interview on 05/07/26 at 1:57 PM with the DON revealed she started working at the facility on 04/22/26. She stated that any staff member responsible for the cart was responsible for ensuring there were no expired (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications. The DON stated she expected the staff to be checking each medication for the expiration date when they were administering any medications. The DON stated nursing management was responsible for performing audits on the medication carts. The DON stated she knew the ADON was performing regular audits but missed one of the medication carts during the last audit. The DON stated the risk of having expired medication in the cart was the medication could be administered and be less effective. She stated there have not been any training/in-services on expired medication since she started, but that she would start to educate and train staff to prevent further issues with expired medications. Record review of the facility's Medication Storage policy, undated, revealed the following: Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the clinical records were maintained in accordance with accepted professional standards and practices and were complete and accurately documented for 1 of 5 residents (Resident #76) records reviewed for accurate documentation. RN D failed to accurately document in Resident #76's clinical record when he documented on 05/06/26 that Resident #76 received his magic cup during the lunch meal when he had not received it. This failure could affect the residents medical record not being an accurate representation of the resident's medical condition or medical needs. Findings included: Review of Resident #76's Quarterly MDS Assessment, dated 04/10/26, reflected he was a [AGE] year-old male who had recently readmitted to the facility on [DATE] after originally admitting on 10/30/25. He had a BIMS of 00 indicating severe cognitive impairment. His active diagnoses included malnutrition, adult failure to thrive, and cognitive communication deficit. His MDS indicated he had recently lost weight. Review of Resident #76's Order Summary Report, dated 05/07/26, reflected an order for Magic Cups two times a day lunch and dinner, with an order start date of 03/23/26. Review of Resident #76's Nutritional Assessment, dated 04/08/26, reflected Supplements.MAGIC CUP W/L&D [sic]. Review of Resident #76's Medication Administration Record for May 2026 reflected RN D signed off that he received his magic cup on 05/06/26. Review of Resident #76's Care Plan, revised 04/07/26, reflected the following: Focus: Unexpected/unintended weigh loss r/t loss of appetite, eating 50% of meals.Interventions: Offer high calorie/nutrient dense supplements as ordered by physician/dietitian.record meal/snack intake in clinical record. Observation on 05/06/26 at 12:21 PM of Resident #76 sitting in the dining room in his wheelchair. Resident #76 had a family member next to him. Resident #76 was waiting for his meal because he did not like what was being served and had requested a grilled cheese sandwich and chips instead. Observation on 05/06/26 at 12:25 PM of Resident #76's lunch tray revealed it included 1 and 1/2 grilled cheese sandwiches, chips, ice cream, and tea. Interview on 05/06/26 at 12:30 PM, Resident #76's Family Member said the resident had previously lost weight because he had some infections recently that caused him to have a decrease in his appetite. Resident #76's Family Member said since the resident was readmitted to the facility he had been eating better but he was supposed to get a milkshake or something like that with his meal and it was missing today. Resident #76's Family Member said she was not sure why it was left off his meal tray today Interview on 05/06/26 at 12:35 PM, [NAME] G said the DM did not show up to the facility today so she was handling the lunch service today. [NAME] G said normally Resident #76 was supposed to get a magic cup with his meal for lunch but he was not served one today. [NAME] G said the magic cup was not listed on his meal ticket for some reason so it was not included on his meal tray. [NAME] G said the kitchen staff and nursing staff look at the meal tickets to make sure that all items were on the tray before it went to the resident. [NAME] G said since the magic cup was not listed on Resident #76's meal ticket for the lunch service today, no one noticed it was missing. [NAME] G said the previous DM was supposed to make sure that all the Dietitian's recommendations were reflected on the meal ticket for residents, including an order for a magic cup. [NAME] G said the magic cup would have only come from the kitchen. Interview on 05/06/26 at 1:20 PM, RN D said Resident #76's magic cup was normally included on his meal tray during lunch. RN D said he did not check Resident #76's meal tray for lunch service today because he was busy providing care to other residents. RN D said another nurse must have checked his tray and so he assumed Resident #76 received his magic cup with his meal. RN D said Resident #76 received the magic cup because the facility was following up on his weight loss. RN D said the magic cup would have come from the kitchen. RN D said Resident #76 had an infection recently which caused him to have a decrease in appetite which caused him to lose weight. RN D said normally, the nurse checks each resident's meal (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tray and looked at the meal ticket to make sure that each item was included on the tray. RN D said he knew he was not supposed to document on the resident's MAR that the resident received the magic cup if he did not confirm the resident actually received it. RN D said he did document on Resident #76's MAR that he received it today when he had not. RN D said he just checked it off since he assumed Resident #76 had received it. Interview on 05/07/26 at 11:32 AM with the ADON, she said Resident #76's magic cup came from the kitchen. The ADON said the Dietitian put orders in for nutrition or weight loss and those showed up on the resident's meal tickets so the kitchen staff knew what to include on the resident's tray. The ADON said the kitchen staff were responsible for making sure all items were included on the resident's tray. The ADON said she was not sure why Resident #76's magic cup was not on his meal ticket and therefore, not on his meal tray for yesterday. The ADON said Resident #76 had recently had a decrease in his appetite after having an infection which was why the Dietitian recommended the magic cup for lunch and dinner meals. The ADON said she was not aware the magic cup showed up on the nurse's MAR to sign off the resident had received the nutritional supplement. The ADON said she saw on Resident #76's MAR where RN D signed off that the resident had received his supplement for the lunch meal on 05/06/26 when he had not received it. The ADON said RN D should have made sure Resident #76 received the magic cup before signing off that he did. The ADON said the purpose of accurate documentation was to represent the medications and treatments the resident received. The ADON said the importance of accurate documentation was to ensure clear communication between every department. The ADON said staff were trained and expected to accurately document in the resident's chart. The ADON said if staff were not accurately documenting in the resident's chart there could be instances where the resident does not get the care they needed. The ADON said she only monitored to ensure the resident's MAR was completed, not that it was accurate. Interview on 05/07/26 at 1:44 PM with the DON, she said she had only been at the facility since 04/22/26. The DON said the kitchen was responsible for ensuring Resident #76 received his magic cup from the kitchen during the lunch meal yesterday (05/06/26). The DON said she was informed the magic cup showed up on the nurse's MAR to sign off the resident received it. The DON said if RN D was signing off on the resident's MAR that the resident received something they should ensure they actually received it first. The DON said the purpose of accurate documentation was because the medical record should always reflect accurate care. The DON said if Resident #76's record was not accurate in regards to him receiving his magic cup and for example, was still losing weight the facility might not be able to brainstorm other weight loss interventions in this case. The DON said RN D was responsible for ensuring he accurately documented on Resident #76's MAR. The DON said she was still too new to be able to put something in place to monitor accurate documentation by staff. Review of the facility's undated policy, titled Documentation in Medical Record, reflected: .4. Principles of documentation include, but are not limited to: a. Documentation shall be factual, objective, and resident centered.b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care.

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	05/07/2026

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and observation, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 3 residents (Resident #13) reviewed for hospice services. The facility failed to ensure Resident #13, who was receiving hospice services, had a physician order for hospice care. This failure could place residents who receive hospice services at risk of receiving inadequate end-of-life care, coordination of care and communication of resident needs. Findings included: Record review of Resident #13's Face Sheet, dated 05/07/26, revealed she was an [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE].Record review of Resident #13's Quarterly MDS, dated [DATE], revealed she had the following diagnoses: Alzheimer's Disease (progressive brain disease that causes a slow decline in memory, thinking, and reasoning skills) and Parkinson's Disease (progressive brain disorder that occurs when nerve cells die). The MDS further revealed Resident #13 was on Hospice care and had a BIMS score of 00, indicating severe cognitive impairment. Record review of Resident #13's Care Plan, last reviewed 04/13/26, revealed she was receiving Hospice care with a diagnosis of Alzheimer's Disease with an intervention to obtain physician order and appropriate referral. Record review of a progress note from 07/11/25 at 9:26 PM revealed the following from LVN C, Patient admitted to [Hospice Company]. Orders updated on the MAR.Record review of Resident #13's order summary, dated 05/07/26, revealed no physician order for hospice care services. Observation on 05/05/26 at 11:29 AM revealed Resident #13 was sitting in her wheelchair in the dining room. An interview was attempted with Resident #13; however, she did not respond. Interview on 05/07/26 at 1:15 PM with LVN C revealed that she had not worked at the facility since December 2025 and was a PRN nurse. She stated she did recall Resident #13 and was the one working when she was admitted to hospice services. LVN C stated she would normally put in a physician order but must had forgotten that day. LVN C stated all residents on hospice should have a physician order so that all staff were aware she was on hospice services. LVN C stated the risk of not having a physician order was miscommunication between staff. Interview on 05/07/26 at 1:30 PM with RN D revealed that he was Resident #13's nurse. He stated she was on hospice services and had been for several months. RN D stated Resident #13 should have a hospice physician order in her EHR. RN D stated he could see she was on hospice in their special instructions but stated there was no physician order for hospice. He stated because it was in the special instructions, he never reviewed the physician orders. RN D stated the nurse who got the order would be responsible for putting it into physician orders, but all the nurses were responsible for reviewing the orders. RN D stated the hospice order was important for continuity of care and so all staff were aware she was on hospice. He stated the risk of not having a physician order was that not all staff were familiar with Resident #13 and may not be aware she was receiving hospice services. Interview on 05/07/26 at 1:49 PM with the DON revealed she was new to the facility and started 04/22/26. The DON stated the other building she worked at; a hospice order was required. The DON stated their policy at this facility did not state that an order was needed, just to obtain orders from Hospice. The DON stated when they get orders from hospice, they were added into the MAR. She stated she would be educating staff to ensure there was a hospice order for any hospice resident. She stated the admitting nurse would be responsible for putting in the hospice order. The DON stated the hospice order was important for communication between facility staff and hospice. Interview on 05/07/26 at 3:34 PM with the ADON revealed she had worked at the facility since January 2026. She stated there should be a hospice order since it was a service provided to Resident #13. The ADON stated any nurse was responsible for putting in orders, but the nurse that (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	received the order was the one who put it in their system. The ADON stated it was important to have the hospice order to communicate through different departments and allow transparency between all staff. The ADON stated there was a risk for confusion and miscommunication without a hospice order. Interview on 05/07/26 at 4:05 PM with Hospice Nurse F revealed that Resident #13 was her patient. Hospice Nurse F stated that Resident #13 had been on hospice since 07/11/25.Record review of the facility's policy titled, Hospice Program, revised July 2017, revealed the following: .C. Ensuring that the LTC facility communicates with the hospice medical director, the resident's attending physician, and other practitioners participating in the provision of care to the resident as needed to coordinate the hospice care with the medical care provided by other physicians.D. Obtaining the following information from the hospice: .7. Hospice physician and attending physician (if any) orders specific to each resident.