STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675503	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Hill	3515 S Park Ave Denison, TX 75020

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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 0628 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 reviews, the facility failed to notify the resident and resident's representative(s) of the discharge, reasons for the move, and right to appeal in writing and in a language and manner they understand and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for 1 of 7 residents (Resident #89) reviewed for discharge planning. The facility failed to notify Resident #89 and Resident #89's responsible party of Resident #89's discharge, reasons for the move, and right to appeal in writing, in a language and manner they understand, and at least 30 days before Resident #89 was discharged from the facility on 12/15/25 in a facility-initiated discharge to a memory care facility. The facility failed to send a copy of the notice to the facility's Ombudsman before Resident #89 was discharged from the facility on 12/15/25. These failures could place residents at risk of being discharged without alternative placement, discharge options, their rights to appeal and access to advocacy services. Record review of Resident #89's face sheet dated 12/18/25 reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included dementia (severe decline in mental abilities), Alzheimer's disease (progressive brain disorder), depression (mood disorder), hyperlipidemia (high cholesterol), and vitamin deficiency (insufficient necessary vitamins). The face sheet reflected Resident #89 was discharged [DATE]. Review of Resident #89's Quarterly MDS assessment, dated 08/11/25, reflected a BIMS score of 06, which indicated severe cognitive impairment.Review of Resident #89's Care Plan, closed 12/16/25, reflected there were no notes related to Resident #89's discharge goals and plans. In an interview on 12/18/25 at 12:43 PM with the Social Worker, she stated she informed Resident #89's family member the facility was not an appropriate placement since Resident #89 required one-on-one supervision. The Social Worker stated she recommended a memory care as an appropriate placement. She stated a specific time frame was not discussed nor was a 30-day notice initiated. She stated the business office was responsible for 30-day notices and notification to the Ombudsman. In an interview on 12/18/25 at 12:48 PM with the Finance Manager, she stated she was not informed to submit a 30-day notice to the party responsible for Resident #89. She stated Resident #89's family member came to the facility, 12/15/25, and stated Resident #89 was being discharged that day. She stated she was unsure if the Ombudsman was contacted and unsure who was responsible for notifying the Ombudsman of discharges. She stated there were alternate placement suggestions discussed previously with the family member who declined them. In an interview on 12/18/25 at 4:15 PM with Resident #89's family member, she stated she was constantly contacted by the facility to find alternate placement. She stated the Social Worker informed her, after she spoke with corporate office, Resident #89 could stay with 24-hour care services or sitters, if not, Resident #89 would need to go elsewhere. She stated the Social Worker faxed a list of sitters. She stated she hired sitters 7am-7pm, the hours the facility allowed. She stated she was never provided with a 30-day written notice, although the Ombudsman informed her that she should have received one. In an interview on 12/18/25 at 1:25 PM with the area Ombudsman, she stated she did not receive notification of Resident #89's discharge and did not receive monthly reports from the facility of discharges. In an interview on 12/18/25 at 2:20 PM with the DON, she stated Resident #89 had behavior problems and was exit seeking. She stated the Social Worker notified Resident #89's family member and recommended memory care for Resident #89's safety. She stated a 30-day notice was not provided because there was no physical address for Resident #89's family member; there was a PO Box. She stated the facility worked with the family member to find memory care facilities. She stated she was unsure if the ombudsman was notified. In an interview on 12/18/25 at 3:13 PM with the Administrator, she stated Resident #89's family member did not provide an address where the resident was discharging to for a safe discharge, although safe locations were recommended. She stated an address was needed before a 30-day notice was sent per policy. She stated a timeframe was not discussed with the family member during alternate placement discussions. She stated the Ombudsman would have been notified when a 30-day notice was facility initiated. She stated if a 30-day notice was issued, it was discussed with the responsible party as well as discharge options and a discharge plan. Review of Resident #89's progress notes reflected: A nursing progress note dated 12/15/25, Order received for resident may discharge with instructions and medications. RP here and aware of discharge today. Review revealed Resident # 89 was discharged to a memory care unit where her needs were being met.The Transfer or Discharge-Facility Initiated policy was requested December 18, 2025, to the Administrator. The policy was not provided prior to