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	05/26/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for one (Resident #1) of 1 resident reviewed for dignity. The facility failed to promote Resident #1's dignity when CNA B and CNA C talked disrespectfully to Resident #1 when she requested assistance. This failure could place residents at risk for a decrease in self-esteem, quality of life and self-worth.Record review of Resident #1's MDS assessment dated [DATE] indicated an [AGE] year-old female with initial admission date of [DATE] to the facility. Her pertinent diagnoses included: shortness of breath, muscle weakness, and cognitive communication deficit. Her BIMS score was 14, which indicated Resident #1' cognition was intact. Resident #1 needed maximal assistance with toileting and moderate assistance with personal hygiene. Review of Resident #1's comprehensive care plan dated [DATE] reflected: Resident has an ADL self-care performance deficit. The resident requires assistance to turn and reposition in bed. The resident requires one staff assist to eat. The resident requires assistance . for toileting. Record review of Resident #1' face sheet reflected Resident #1 was discharged from the facility on [DATE] Record review of the hospital record reflected Resident #1 was admitted to the hospital on [DATE] and she expired on [DATE] related to hospital acquired infection complications. Record review of camera video footage, dated [DATE] not timed, reflected CNA B entered Resident #1' s room. Resident #1 asked CNA B to assist her to get up. CNA B yelled at resident for being impatient, CNA B talked loudly to resident using body language and pointing with the finger to the resident. Resident was frustrated and asked CNA are mad at me. CNA B responded, I am not mad and she walked way and left the room without assisting resident. Record review of camera video footage, dated [DATE] not timed, reflected CNA C entered Resident #1' s room with the dinner tray. He set up the tray and threw the napkins on the resident's laps. Resident #1 asked CNA C to assist her and told him, don't go away CNA C responded, I have better things to do and he walked out. Record review of CNA B date of hire [DATE] background checks and Employee Misconduct Registry reflected it was done as required and no bars to employment. Record review of CNA C date of hire [DATE] background checks and Employee Misconduct Registry reflected it was done as required and no bars to employment. Record review of grievance reports did not reveal any grievance filed on behalf of Resident #1. Interview on [DATE] at 9:33 AM to 9:59 AM, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, and Resident #7 said they felt safe and had no concerns with CNA B and CNA C Interview on [DATE] at 12:59 PM, Resident #1's Responsible Party stated he never spoke to the DON or the Administrator about his concerns. He stated he never showed the video to anyone at the facility. Interview on [DATE] at 2:20 PM, the Regional Nurse after he watched the camera video footage, said he was not aware of the incident. He said CNA B should not yell at Resident#1 and she should not have walked away without providing assistance. The Regional Nurse said CNA C should not have talked to Resident #1 the way he did telling her, I have better things to do. He stated CNA B was loud because Resident #1 was hard of hearing. He stated he initiated an in-service with all staff in resident rights and customer services. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Regional Nurse said that was poor customer service and would affect Resident #1's dignity. Interview on [DATE] at 2:30 PM, the Administrator and the DON said they were not aware of the incident, and the responsible party never spoke to them about his concerns. Administrator said she expected CNA B and CNA C to be respectful and assist Resident #1 when she asked for assistance. She stated it was a dignity issue and resident right's issue on how CNA B and CNA C responded to Resident #1. She stated they have started a staff in-service on how to talk to residents and meet resident care needs. The DON said Resident #1 was hard of hearing; staff talked loudly with her. The DON said it was customer service issue. In an interview on [DATE] at 2:34 PM, CNA B stated she had never been disrespectful, nor yelled at a resident. After she watched the camera video footage, she stated that's me and it is not acceptable to talk to the resident that way. She stated that it was a dignity issue. CNA B stated she talked loudly because Resident #1 was hard of hearing and she said she always used hand gestures when she talks. In an interview on, the phone, on [DATE] at 3:30 PM, CNA C stated it was not acceptable to throw the napkins on the resident laps, and it was inappropriate to tell a resident I have better things to do. He stated it was a resident right to be respectful to residents and protect their dignity. CNA C did not remember Resident #1. Once the facility learned about the incident, they self-reported it to the State on [DATE]. They suspended CNA B and CNA C pending investigation. Review of the facility's policy Resident Rights dated [DATE] reflected . The facility will ensure that all direct care and indirect care staff members, including contractors and volunteers, are educated on the rights of residents and the responsibility of the facility to properly care for its residents. Respect and dignity - The resident has a right to be treated with respect and dignity.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 (Resident #2) of 3 residents reviewed for ADLs. The facility failed to ensure Resident #2 had his fingernails trimmed and cleaned on 05/26/2026. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and skin breakdown, and a decreased quality of life. Record review of Resident #2's Quarterly MDS assessment dated [DATE] indicated an [AGE] year-old male with initial admission date of 07/28/2022 to the facility. His pertinent diagnoses included: dementia (a decline in cognitive abilities, severe enough to interfere with daily life), and need for assistance with personal care. His BIMS score was 7, which indicated Resident #2' cognition was severely impaired. Resident #2 needed maximal assistance with personal hygiene. Record review of Resident #2 's Comprehensive Care Plan, revised 09/15/2025 reflected, Focus: Resident has an ADL self-care performance deficit related to impaired mobility.Interventions: . Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. In an observation on 05/26/2026 at 9:33 AM, revealed Resident #2 was sitting in his wheelchair. The nails on both hands were approximately 0.3cm in length extending from the tip of his fingers. The nails were discolored, tan and had green brownish colored residue underside and around the nail beds. Resident #2 was unable to answer questions. In an interview on 05/26/26 at 9:37 AM, CNA A stated CNAs and nurses were responsible for cleaning and cut the residents' nails. CNA A stated she did not notice Resident #2's nails. She stated she would do it right then. She stated the risk would be infection and injury. In an interview on 05/26/2026 at 1:34 PM, the DON stated that her expectation was that ADL care be provided as needed. She stated that CNAs were responsible for providing nail care, including trimming fingernails, unless the resident had a diagnosis of diabetes. She stated that charge nurses were responsible for monitoring this care. The DON stated that residents having long, dirty fingernails could result in skin breakdown and potential of infections. Record review of the facility policy Nail Care, dated 10/1/2025 reflected . Routine nail care, to include trimming and filling, will be provided on a regular schedule. Nail care will be provided between scheduled occasion as the need arises .