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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview, the facility failed to post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility and failed to ensure residents were informed of how to access most recent survey results reviewed for resident rights. The facility failed to post, in a place readily accessible to residents, family members and legal representatives of residents, the results of the most recent survey of the facility. The facility failed to ensure residents were informed of the right to review the results of the recent survey results for the facility. These failures could affect residents not being informed of their rights and informed of recent survey results of the facility. Findings included: In a confidential group interview on 12/17/25 at 11:00 AM with six residents, all the residents were not aware of the right to review recent survey results and it had not been discussed with them as a resident right. They stated they would like to know where they were located, because they did not know and so they can have access to review them. Interview on 12/18/2025 at 3:26 PM with the Activity Director revealed she had not informed the residents in resident council about their right to review recent survey results, and was unsure where they were located at the facility. She stated she was designated to review resident rights at the resident council meetings. Interview on 12/18/2025 at 3:58 PM with the Administrator revealed the survey results were accessible to residents at the front lobby. She stated residents should be aware of being able to review the recent survey results without having to ask for it. Observation and Interview on 12/1/25 at 4:10 PM with the Administrator revealed she had to look for the recent state survey result binder and found it in a closed cabinet in the front lobby. The Administrator stated the results of the most recent survey result should be accessible without having to ask for them. Observation revealed there was no notice to inform residents or others how to access the most recent survey results. The facility failed to provide resident rights' policy prior to exit on 12/18/25.

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: 675503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Beacon Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 3515 S Park Ave Denison, TX 75020	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview, and record review, the facility failed to ensure residents were informed on how to file a grievance or complaint available to the resident reviewed for resident rights. The facility failed to ensure residents were informed on how to file a grievance and the grievance policy. These failures could place residents at risk of resident rights' violations, a decline in quality of life, and delay in resolving grievances.Findings included: In a confidential group interview on 12/17/25 at 11:00 AM with 6 residents revealed all residents did not know how to file a grievance and were unaware of who to discuss their individual grievances with. All six residents stated they would like access to be able to write down their grievances on their own and turn it in to the facility. They stated the facility had not informed them of their grievance policy. Three of the six residents stated there was a binder in the resident activity room that stated grievance on it, but there were no grievance forms in there. Observation on 12/17/25 at 11:15 AM of grievance binder in resident activity room on a table revealed blank coloring pages. There were no grievances or information on grievances. Interview on 12/18/25 at 3:15 PM with the DON revealed residents were able to come to any staff member and the staff member would input their grievance into the computerized system. She stated the facility did not have a specific form that residents had access to where they could write down their grievance on their own. She stated the Administrator was responsible for overseeing the grievances and ensuring grievances were looked into. Interview on 12/18/2025 at 3:26 PM with the Activity Director revealed she did attend the resident council meetings with residents in agreement. She stated she had not discussed, with the residents, about the grievances or the grievance policy. She stated she was newer to the facility and been working at the facility for a couple of months. She was unaware of the specific grievance policy for the facility. She stated the Administrator was responsible for grievances. Interview on 12/18/2025 at 3:58 PM with the Administrator revealed she was responsible for overseeing the grievances and grievance policy. She stated residents were able to come to a facility staff member and the staff member could write down a grievance on behalf of the resident. She stated the facility did not have a form available to the residents to complete grievances on their own, but the residents did have the right to submit grievances in writing or orally on their own. She was unaware of the resident council not knowing how to file a grievance. She stated she would ensure residents were informed and had access to filing a grievance moving forward. Review of the facility's policy Grievances dated November 2017 reflected the patient or patient representative has a right to voice grievances to the facility.Grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other patients, and other concerns regarding their.facility stay.2. The facility must make information on how to file a grievance or complaint available to the Patient.7. The Executive Director is the designated grievance official for the facility with the Director of Nursing as the designee who is responsible for overseeing: a. The grievance process.

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(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. **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 (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 exit.

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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 #51) of 6 residents reviewed for ADLs. The facility failed to ensure Resident #51's fingernails were clean. This failure could place residents who were dependent on staff for ADL care at a loss of dignity and a decreased quality of life.A record review of Resident #51's Quarterly MDS assessment dated [DATE] reflected Resident #51 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included cerebrovascular accident (a loss of blood flow to part of the brain, which damages brain tissue), type 2 diabetes (elevated blood sugar), and Post Traumatic Stress Disorder (a mental health condition that can develop after experiencing or witnessing a traumatic event, characterized by intrusive memories (flashbacks, nightmares), avoidance of reminders, negative mood changes (hopelessness, detachment), and heightened arousal [hypervigilance, irritability]). No BIMS score was recorded for Resident#51. Section C1000: cognitive skills for daily decision making for Resident #51 was coded (3) indicating severely cognitive impairment. He required extensive assistance of two-person physical assistance with personal hygiene. Record review of Resident #51's care plan with an initiation date of 11/12/25 reflected, Focus: The resident has an ADL self-care performance deficit r/t Disease Process (Cerebral Infarction). Goals . The resident will demonstrate the appropriate use of adaptive device(s) to increase mobility through the review date. The resident will improve current level of function in through the review date. Interventions . personal hygiene/oral care: The resident is totally dependent on (X1-2) staff for personal hygiene and oral care. Bathing/showering: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. An observation on 12/16/25 at 10:18 AM revealed Resident #51 laying in his bed. Resident's fingernails on the left hand had a brown substance under all his nails. Resident #51's right hands fingernails were clean. Resident #51 was non-verbal and was unable to answer questions. In an interview with CNA C on 12/16/25 at 1:17 PM, she looked at Resident #51's fingernails on the left hand and stated they needed to be cleaned. She stated she had not noticed his nails needed cleaning. She stated it was the responsibility of nurses and CNAs to check residents' fingernails daily, and make sure they were clean and trim. She stated they were also required to do nail care and personal hygiene on their shower days or whenever the residents needed it. She stated the risk to residents was the development of infections. In an interview with LVN F on 12/18/25 at 09:11 AM, she stated the CNAs were responsible for nail care on the residents, unless they were diabetic, and the LVNs were responsible for the diabetics. She stated CNAs and nurses were supposed to do rounds on the residents daily and checked their nails to make sure they were cleaned and trimmed to the residents' liking. She stated long dirty nails could pose a risk for infections, or skin tears. An interview with the DON on 12/18/25 at 12:45 PM revealed her expectation was that nail care should be provided on shower day or as needed. She stated that CNAs were responsible for doing nail care for non-diabetic residents, and nurses were responsible to do diabetic residents. She stated that as the DON, either herself or her designee were responsible to do routine rounds for monitoring. The DON stated residents having long and dirty fingernails could be an infection control issue. Record Review of the facility's policy titled Care of Fingernails/Toenails revised October 2010 reflected, The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections 1. Nail care included daily cleaning and regular trimming. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 one of two medication rooms (Medication Room for Hall 600-700-800) reviewed for pharmaceutical procedures. The facility failed to ensure a vial of TB PPD that was opened and dated [DATE] was discarded and not been used beyond the 30-day expiration time after the open date. This failure may result in residents receiving medications with diminished effectiveness.n observation and interview on [DATE] at 08:46 a.m. of the Medication Room (for Hall 600-700-800) refrigerator with LVN B revealed an open vial of Tuberculin Purified protein derivative dated [DATE]. LVN B stated LVN F, who was the infection prevention nurse did all the TB test (skin test used to detect the presence of tuberculosis). Review of a sample of 6 residents immunization records revealed the 6 residents received TB test with the same lot# 79181:1-Resident#138 received the TB test on [DATE].2-Resident#136 received the TB test on [DATE]-Resident#133 received the TB test on [DATE]-Resident#134 received the TB test on [DATE]-Resident#135 received the TB test on [DATE]-Resident#137 received the TB test on [DATE] In an interview with LVN F on [DATE] at 9:11 a.m., she stated she was the infection preventionist in the facility and she was responsible for doing the TB skin test on residents. She stated she was the one that opened and dated the bottle of Tuberculin PPD (purified protein derivate). She stated they were required to date the vial after they opened it and discard it 30 days after the open date. She stated she forgot to discard the medication and was using it beyond the 30 days. She stated the risk to the residents were false readings for the TB test, and the expired solution could be a source of infection. In an interview with the DON on [DATE] at 12:45 p.m., she stated once a multi-use vial/bottle of medication was opened, the staff were required to date it and discard it 30 days after the open date unless there were other instructions from the manufacturer. She stated all medications had to be labeled, and any TB PPD vial opened, had to be dated once opened and discarded 30 days after, to prevent the risk of using an expired medication which would render it ineffective and give the incorrect reading of the PPD. She stated the use of medications solution beyond its expiration date after opening could be a source of infection to the residents. The DON stated all nurses were responsible for checking the medication carts and the medication rooms for expiration and labelling of medication. Record review of the facility's policy titled Storage of Medications, dated [DATE], reflected, .The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed The nursing staff shall be responsible for maintaining medication storage

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for two of four medication carts (Cart for Hall 600, and cart for Hall 100) reviewed for pharmacy services. 1.The facility failed to ensure the bottle for the eye drop Latanoprost solution 0.005% (a prescription eye drop used to lower high pressure within the eye) for Resident #105 was labeled with the open date.2-The facility failed to ensure the bottle for the eye drop Latanoprost solution 0.005% (a prescription eye drop used to lower high pressure within the eye) for Resident #117 was labeled with the open date.3-The facility failed to ensure the bottle for the Pataday (topically applied antihistamine solutions containing olopatadine that provide fast, long-lasting relief from itchy, red eyes caused by pollen, pet dander, and grass for up to 24 hours) allergy eye drops for Resident #23 was labeled with the open date.4-The facility failed to ensure the bottle for the Thera-Tears (dry eye therapy/lubricant eye drop) eye drops for Resident #31 was labeled with the open date.These failures could affect residents and staff resulting in diminished effectiveness and not receiving the therapeutic benefits of the medications. Observation on [DATE] at 9:04 a.m. revealed CMA D administered Thera Tears eye drops to Resident #31. The bottle of the Thera Tears eye drop had an expiration of 01-2027. The bottle was not labeled with open date and per manufacture label: discard 45 days after opening. Review of the active Doctor order summary dated [DATE] on [DATE] for Resident #31 revealed Refresh Liquigel Ophthalmic Gel 1% instill 1 drop in both eyes tow times a day related to dry eye syndrome of bilateral lacrimal glands (an almond-shaped exocrine gland located in the upper outer orbit of the eye, primarily responsible for producing the aqueous layer of tears). An observation on [DATE] at 9:18 a.m. of the medication cart for Hall 600 with CMA D revealed open and undated bottles of:1-Eye drop Latanoprost solution 0.005% for Resident#105.2- Pataday allergy eye drop for Resident#23. Review of the active Doctor order summary dated [DATE] on [DATE] for Resident #105 revealed Latanoprost solution 0.005% instill 1 drop in both eyes at bedtime for Ocular Hypertension. Review of the active Doctor order summary dated [DATE] on [DATE] for Resident #23 revealed Refresh Liquigel Ophthalmic Gel 1% instill 1 drop in both eyes one time a day related to dry eye syndrome of bilateral lacrimal glands. In an interview on [DATE] at 09:25 a.m., CMA D stated all the eye drops solution should be labeled with the open date, and discarded 30 days after, or per manufacturer instructions. CMA D stated giving expired medication to residents may not be effective anymore and could be a source of infection. An observation on [DATE] at 9:30 a.m. of the medication cart for Hall 100 with LVN G revealed an open and undated bottle of eye drop Latanoprost solution 0.005% for Resident #117. Review of the active Doctor order summary dated [DATE] on [DATE] for Resident #117 revealed Latanoprost solution 0.005% instill 1 drop in both eyes at bedtime for Glaucoma (a group of eye diseases damaging the optic nerve, often due to increased eye pressure, leading to irreversible vision loss, including blindness). In interview on [DATE] at 09:35 a.m., LVN G stated the eye drops were given by the evening shift nurses, and she was not the one who opened the eye drop bottle. LVN G stated the eye drop solution should be labeled with the open date and discarded 30 days after or according to the manufacturer label. She stated the risk to resident was ineffective medication or the development of infection. In an interview with the DON on [DATE] at 12:45 p.m., she stated once a multi-use vial/bottle of medication was opened, the staff were required to date it and discard it 30 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	days after the open date unless there were other instructions from the manufacturer. She stated all medications had to be labeled, and any TB PPD vial opened, had to be dated once opened and discarded 30 days after, to prevent the risk of using an expired medication which would render it ineffective and give the incorrect reading of the PPD. She stated the use of medications solution beyond its expiration date after opening could be a source of infection to the residents. The DON stated all nurses were responsible for checking the medication carts and the medication rooms for expiration and labelling of medication. Record review of the facility's policy titled Storage of Medications, dated [DATE], reflected, .The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed The nursing staff shall be responsible for maintaining medication storage

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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 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 6 residents (Resident #46) reviewed for infection control. The facility failed to ensure CNA A changed gloves and performed hand hygiene while providing incontinent care to Resident #46. This failure could place residents at risk of infection and cross contamination. A record review of Resident #46's Quarterly MDS assessment, dated 10/30/25, reflected Resident #46 was a [AGE] year-old female admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses included Alzheimer's disease (a progressive brain disorder, the most common cause of dementia, that slowly destroys memory, thinking skills, and eventually the ability to carry out daily activities, characterized by plaques and tangles in the brain, causing symptoms like memory loss, confusion, and personality changes, with no cure but managed treatments), cerebrovascular accident (a medical emergency where blood flow to the brain is suddenly cut off by a blockage [ischemic stroke] or bleeding [hemorrhagic stroke], causing brain cells to die from lack of oxygen and nutrients, leading to potential disability or death), and anxiety disorder (mental health conditions marked by excessive and persistent feelings of fear, dread, and worry that are disproportionate to the situation, interfering with daily life and causing physical symptoms like rapid heartbeat, fatigue, or shaking) and need for assistance with personal care. Resident #46 had a BIMS score of 12 which indicated moderate cognition impairment. Resident #46 was frequently incontinent of bladder. An observation on 12/17/25 at 2:04 PM revealed CNA A entered Resident #46's room to provide urinary incontinence care. CNA A washed her hands and put on gloves. She unfastened the resident's brief and cleaned the front pubic area using several peri wipes. CNA A did not change her gloves or perform hand hygiene and assisted Resident #46 onto her right side, removed and discarded the soiled brief with urine, and cleaned the resident's buttocks area with peri wipes. CNA A did not change her gloves or perform hand hygiene and then placed a clean brief under resident, repositioned the resident back on her back, fastened the brief, covered the resident and put the bed in the low position. CNA A gathered dirty clothes and trash, and she removed her gloves and washed her hands. In an interview on 12/17/25 at 2:20 PM, CNA A stated she was to wash hands before and after care. CNA A also stated she was supposed to change gloves and complete hand hygiene each time she moved from dirty to clean area during residents' care. CNA A stated she did not change gloves during the incontinent care because she forgot. CNA A stated she was supposed to change gloves and complete hand hygiene to prevent the spread of infection. In an interview on 12/18/25 at 12:45 PM with the DON, she stated during incontinent care, the staff were to complete hand hygiene before and after care. The DON also stated, in between care, CNA A was to complete hand hygiene and change gloves because her hands were considered dirty after cleaning the resident. The DON stated the staff were to complete hand hygiene during care to prevent the spread of infection. Review of the facility's policy, Handwashing/Hand Hygiene, dated August 2019, reflected, All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .for the following situations .Before preparing or handling medications .Before performing any non-surgical invasive procedure .Before moving from a contaminated body site to a clean body site during resident care . After contact with blood or bodily fluids .after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident .After removing gloves .Hand hygiene is the final step after removing and dispose of personal protective equipment .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Beacon Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident bedside and toilet and bathing facilities were adequately equipped to allow all residents to call for staff assistance through a communication system that would relay the call directly to a staff member or a centralized staff work area for 1 of 6 residents (Resident #20) reviewed for residents' call system. The facility failed to provide a working communication system that was easily at reach, that would allow Resident #20 the ability to safely call for staff for assistance. This failure could place residents at risk of not having a means of directly contacting caregivers in an emergency or when they needed support for daily living.Record review of Resident #20's quarterly MDS assessment dated [DATE] reflected Resident #20 was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Non-Alzheimer's Dementia (brain disorders causing cognitive decline), hypertension (elevated blood pressure), and anxiety (a normal feeling of worry or fear, but when excessive and persistent, it becomes an anxiety disorder, impacting daily life with symptoms like restlessness, rapid heart rate, trouble concentrating, and sleep issues, stemming from a mix of genetics and environment). Resident #20 had a BIMS score of 03 of 15, indicating severe cognitive impairment. Review of Resident #20's Comprehensive Care Plan date 11/26/25, reflected the following: Focus: The resident is risk for falls r/t impaired mobility. Goal: The resident will not experience falls or injuries from falls through the review date. Intervention/Tasks: Follow facility fall protocol. See care plans on Mobility, ADLs, Cognitive Deficit, Communication: Ensure/provide a safe environment: Call light in reach, Adequate low glare light, Bed in lowest position and wheels locked, Avoid isolation. An observation on 12/16/25 at 1:20 PM revealed Resident #20 was sleeping in bed, and the call light button was on the floor to the right side of the bed. During an observation and interview on 12/16/25 at 1:25 PM, CNA B entered Resident #20 located the call light cord and button in the floor. CNA B picked the call light button up and put it within Resident #20's reach. She stated the call light was on the floor, and not next to Resident #20. She stated the problem was she would not be able to call for help, and anything could happen to her. CNA B stated if she was incontinent, she could not call if she was having an emergency. In an interview with the DON on 12/18/25 at 12:45 PM revealed the expectation for call light placement was residents should always have the call light within reach, and the call light should be placed on the resident's dominant side. The DON stated it was the responsibility of all the staff members to make sure the call light was within residents' reach at all times. She stated the risk of residents not having had their call lights within reach was delayed care, and possible of fall and injury. In an interview on 12/18/25 at 1:13 PM, the Administrator stated her expectation was the call light button should always be within residents' reach clipped to residents' clothes or linen where they could reach it. She stated the risk was the resident could not call for help if he/she sustained a fall, and not having their needs met. Review of the facility's policy titled Resident Call light System revised September 2022 revealed Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Policy interpretation and implementation: 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.