STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675579	A. Building B. Wing	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Harbor Healthcare and Rehabilitation	6700 Heritage Parkway Rockwall, TX 75087

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 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to choose his or her attending physician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44405 Based on observation, interview, and record review, the facility failed to honor the resident right to choose his or her attending physician for 1 of 5 residents (Resident #1) reviewed for resident rights. The facility did not honor Resident #1's right to choose his primary care physician as his attending physician when readmitted to the facility on [DATE]. This deficient practice could place residents at risk of decreased quality care and treatment due to their lack of free choice for their attending physician care while in the facility. Findings included: Record review of Resident #1's Admission Record, revealed an [AGE] year-old female, who admitted to the facility on [DATE] from a short-term (acute) hospital with the following diagnoses: Anemia; unspecified Dementia; Chronic Diastolic (Congestive) HF (occurs if the left ventricle muscle becomes stiff or thickened); CKD, Stage 3 (kidneys have mild to moderate damage); Other lack of coordination; and T2DM. The Admission Record reflected MD G as Resident #1's attending physician. Record review of Resident #1's 5-Day (conducted between days one to eight after the resident enters the facility) MDS Assessment, dated 01/22/24, revealed Resident #1 had a BIMS of 10 which suggested moderately impaired cognition. Resident #1's functional status required one-person physical assist with ADLs. Resident #1 was frequently incontinent of bladder and had a colostomy appliance to collect bowel wastes. Record review of Resident #1's Hospital Medicine Discharge Summary dated 01/19/24 reflected encounter dates 1/15/24 - 01/18/24. The Hospital Medicine Discharge Summary (01/18/24) reflected discharge disposition to SNF, recommended diet, and other discharge instructions: Follow-Up: Your Appointments (scheduled at discharge by hospital): 02/19/24 at 1:30 PM with MD D at Cardiac Clinic Follow-Up Appointments to be scheduled (discharge: 01/18/24): Hepatology in 1 - 2 weeks (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Gastroenterologist in 2 weeks Cardiology in 2 weeks Discharge History by Follow-Ups reflected: Follow up with Internal Medicine with MD B Follow up with Gastroenterology with MD C Follow up with cardiovascular disease in 2 weeks (02/01/24) with MD E Follow with Internal Medicine (PCP) with MD A Follow with Endocrinology with MD E Follow up with Nephrology with MD F The discharge follow-up provider list revealed Resident #1's primary providers that included the primary care physician (MD A) and other responsible care professionals. During an observation and interview on 02/16/24 at 1:09 PM revealed Resident #1 up to wheelchair. Resident #1 appeared clean and groomed. There were no visible injuries or behavior suggestive of abuse, neglect, or sub-quality care. Resident #1 was awake, alert, and oriented to self-awareness, place, surroundings, time of day [with prompts/cues], and situation. Resident #1 received 1 LPM oxygen via nasal cannula by concentrator. Resident #1 presented with a flat affect congruent with mood. Resident #1 spoke in an appropriate volume and tone, at a moderate pace with pausing affected by breathing or word selection. Resident #1 had good recall of immediate and past events. Resident #1 said that her family member visited but had a lot going on and was unable to take care of her at home or manage her appointments. Resident #1 stated that she needed to follow up with her PCP and cardiologist and have not since she returned to the SNF. Resident #1 indicated that she was concerned because she recently had a heart attack. Resident #1 could not immediately recall her PCP's name but was able to state the name and location of the clinic her appointments were scheduled with her PCP. During an interview on 02/16/24 at 3:45 PM, the RP said that Resident #1 appointments were not scheduled and did not receive services by the facility to ensure continuity of care. The RP said that Resident #1 was assigned a doctor provided by the facility as a primary physician. The RP said that he was concerned because Resident #1 was closely followed by providers outside the facility and the facility provider was not familiar with Resident #1's care needs. The RP said that Resident #1 needed to follow up with her PCP but was told that Resident #1 would be followed by the facility physician. The RP said that he requested a care plan meeting to discuss his concerns about upcoming appointments that were not scheduled per the hospital discharge summary (01/18/24) and transportation needs. The RP stated that he was told by the LSW during the meeting that he would first need to complete release of information forms for each of Resident #1's specialty providers before appointments could be scheduled. The RP said that when asked about transportation arrangements, the LSW informed that the RP could take [Resident #1] to appointments. The RP said that Resident #1 had an appointment the day of the care plan meeting and [the RP] took her to the appointment. (continued on next page)

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F 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/16/24 at 4:28 PM, the SSA said she was not involved in the admission process with residents. The SSA said that she was not familiar with the facility responsibility to notify a resident about the right to choose a primary physician or if required to use the facility physician. During a phone interview on 02/16/24 at 4:46 PM, the LSW said that he worked remotely and was familiar with Resident #1 when attended a care plan meeting with the RP and facility management to discuss the RP's concerns. The LSW said that he was responsible for scheduling follow-up appointments if outlined in the discharge instructions when a resident was admitted to the facility. The LSW said sometimes the admitting nurse would schedule appointments if needed and communicate with the LSW. The LSW said that new admissions were discussed during morning meetings with a focus on appointment(s) scheduling and/or transportation needs. The LSW said that there was an Admission Director who would coordinate appointments when the hospital clinical records were reviewed, but the Admission Director no longer worked at the facility. The LSW said that the RP asked about AEM and Resident Rights. The LSW said that the RP was provided a copy of the AEM application and policy. The LSW said he discussed Resident Rights with the RP. The LSW said that the RP said that Resident #1 wanted to see her outside PCP and not the facility provided physician and an appointment needed to be scheduled. The LSW said that he explained that the facility had to first check with the selected PCP if they would follow the resident while resided at the SNF. The LSW indicated that the RP had to complete and return to the facility a release of information form for each provider Resident #1 wanted to see. The LSW said that the RP asked about transportation and was informed that the facility could provide transportation or arrange with a transportation service provider. The LSW stated that the concerns the RP voiced during the meeting suggested a grievance should be filed and followed up by the facility. The LSW said he had not initiated the grievance. During a phone interview on 02/16/24 at 5:18 PM, the Marketing Specialist (MS) stated that she assessed the clinical needs of potential and existing residents to assure the facility had the clinical capability to treats the resident. The MS said that she did not initially admit Resident #1 but currently filled the role of the Admissions Director. The MS said that she informed residents about certain forms that required signature at admission. The MS said that forms that required signature included consent to treat, an Admission Agreement, and Resident Rights. The MS said there were a lot of pages in the admission packet and could not say for sure which documents required signature without the packet in front of her. The MS said the resident or RP was offered the opportunity to read the admission packet in its entirety before signing and informed could receive a printed copy as an alternative to the digital copy reviewed on a computer tablet. The MS said that she has never verbalized in detail that a resident had the right to choose their own primary care physician. The MS said in [AGE] years, she did not recall a resident asking about a primary care physician specifically because a physician is provided by the facility. The MS said that she would be sure to review the packet and become familiar with important details. The MS said that when she reviews the admission packet with a potential resident, she would be sure to inquire if the resident had a PCP and to communicate the terms of the admission agreement in a way the resident or RP understood before they sign. Record Review of the facility's Resident Rights and Responsibilities, Notice of policy revised 01/2022 reflected: Policy: (continued on next page)

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F 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is the policy of this facility to inform the resident both orally and in writing of his/her rights as a resident, as well as, the rules and regulations governing the resident's conduct and responsibilities during his/her stay in the facility. Procedure: Prior to or upon admission, a representative of the admitting office will provide the resident with a written copy of resident rights and a copy of all rules and regulations governing the resident's conduct and responsibilities during his/her stay in the facility. The resident will be required to sign a statement acknowledging that he/she was informed of his/her rights and responsibilities. The facility will inform the resident of his/her rights and responsibilities in a language that is both clear and understandable to the resident. Written copies of resident rights and responsibilities are available upon request and may be obtained from the social services department during normal office hours (8:00 a.m.- 5:00 p.m., Monday-Friday (except holidays). The resident will be promptly informed, both orally and in writing, of a change in resident rights and when changes occur in facility rules that govern the resident's conduct or responsibilities.