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	08/22/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50445 Based on observation, interview, and record review, the facility failed to ensure personal privacy during incontinent care for 4 (Residents#78,#71,#38, and #3) of 15 residents reviewed for privacy. The facility failed to ensure Residents#78,#71,#38, and #3 were not put at risk of being exposed to view from the outside of the facility and to other windows of the facility during incontinent care or getting dressed. This failure could place other residents at risk for embarrassment and loss of self-esteem and dignity. Findings included: Review of the Admission Record indicated Resident #78 was [AGE] years old female admitted on [DATE]. Review of the MDS assessment dated [DATE] indicated Resident #78 had diagnoses of cerebral vascular accident (stroke) and generalized muscle weakness and was dependent on staff for toileting, and hygiene. During an observation on 08/20/24 at 1:16 p.m., revealed Resident #78 was observed receiving incontinence care by LVN C. Resident #78's bed was located beside a window that had vertical blinds with slats. The blinds were missing multiple slats, leaving large areas where the resident could be visible to anyone outside the building, or anyone looking out the windows of the part of the building facing directly across from Resident #78's room. The window itself did not have a curtain. The privacy curtain had been pulled in the middle of the room to provide privacy between roommates and to block the view of anyone entering the room. The privacy curtain did not block the view of the window. Resident #78 was observed being turned on her left side with the complete back part of her body unclothed and facing the window. In an interview on 08/20/24 at 01:20 p.m., with LVN C, when asked about the gapping blinds in Resident #78's room, the incontinence care that he had just provided, and the lack of resident privacy, LVN C stated, Of course, privacy was going to be a concern and that it could have negatively affected the resident. He reported all staff were responsible for ensuring the privacy of residents during personal care. (continued on next page)

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	08/22/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/20/24 at 01:22 p.m., Resident #78 stated she had difficulty with her vision and had not been able to tell that the blinds did not cover the window. She reported that made her feel uncomfortable. In an interview on 08/20/24 at 01:25 p.m., CNA B reported that she had worked at the facility for 1 year. She reported that staff had knocked on residents' doors and utilized the privacy curtains in the rooms to protect residents' privacy. She stated that window blinds were broken throughout the facility. She stated that if someone had walked by the window while a resident had been changed, it was very concerning for privacy. She stated staff had tried to use the curtains. She reported she had reported the broken blinds to maintenance a month or two ago. She stated that some residents had received better blinds (the horizontal blinds), but that many of them had not. In an interview and observation on 08/20/24 at 01:13 p.m., Resident #3 stated that her blinds had been broken since her admission two years ago. She stated she had submitted a request to the DON that they be fixed but did not know the exact date. The lateral blinds were observed to have approximately 13 slats which were not enough to fully cover the window. The window did not have a curtain. Resident #3 stated anyone could see in the window. She reported the window showed into the dining room across the way. She was noted with a privacy curtain in her room but stated she did not use it. She stated she turned off the lights when she needed to change clothes. She was noted with a roommate. She stated, you don't like to have people looking in on you and you can't tell. In an interview and observation on 08/20/24 at 01:25 p.m., Resident #38 stated he had lived at the facility for 7 years. The lateral blinds in his room (approximately20 individual slats) did not cover the entire window at their widest. The window did not have a curtain. The window directly faced the parking lot. He reported he was legally blind and was not aware of that. He stated he always wore a hospital gown. He stated he was not aware of the privacy issue. He laughed and stated, I hope I gave them a good show! The privacy curtain that was in use was providing privacy between him and his roommate. In an interview on 08/20/24 at 05:20 p.m., MA A stated he had worked at the facility for 8 years. He reported that when providing personal care, the curtain should be drawn, and the blinds should be closed to protect residents' privacy. In an interview on 08/20/24 at 05:25 p.m, CNA D reported she had worked at the facility for 3 weeks. She stated that to protect the privacy of residents the blinds needed to be closed and a curtain could also be used to block the resident from any roommates and anyone coming in the room during personal care. She reported that providing privacy was a dignity issue. In an interview on 08/20/24 at 05:40 p.m., LVN E reported that the windows needed to be covered to provide residents with privacy for personal care. She reported that not providing privacy could result in resident embarrassment. In an interview on 08/20/24 at 05:50 p.m., CNA F stated she had worked at the facility for ten months. She reported that to protect the privacy of residents, staff closed the blinds, pulled the curtain, and shut the door prior to providing any personal care. (continued on next page)

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	08/22/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/21/24 at 12:00 p.m., DON reported he expected staff to have closed the blinds or used the privacy curtain hanging from the ceiling when they provided residents with personal or incontinence care. He reported that failure to do that could affect the residents' privacy and dignity but that it would depend on the situation, noting that some residents' windows faced a brick wall. He reported that all staff were responsible for maintaining the privacy of residents. He stated the facility was currently under construction and that there was a plan to replace the blinds in resident rooms. In an interview on 08/22/24 at 12:56 p.m., RN G reported that regarding privacy and providing personal care to residents, she expected that staff would provide privacy, making sure that the blinds were closed to ensure the privacy and dignity of residents. She reported that if this had not occurred, what the resident could experience would depend on what care had been provided to the resident. In an interview and observation on 08/22/24 at 01:02 p.m., Resident #71 stated, I've been asking for blinds since I got here in October (2023). I have been mostly asking DON. He said they are ordering them and going to put them all in at one time. They are those long vertical blinds. They don't work. You can't close them. I have just been getting dressed without them closed. My window faces the gazebo and courtyard. We close the door. We don't use the curtain because it blocks the air conditioner. Observation during the interview revealed there were no blinds on Resident #71's window. Resident #71 had hung personal decorative curtains which were tied back to the sides of the window away from the air conditioner. In an interview on 08/22/24 at 01:22 p.m., LVN H reported when providing residents with personal care, the staff, usually the first thing is, they have to close the curtain. Close the door. Close the blinds. To keep the resident's privacy. No one wants to show their privacy. To respect the resident. If this is not done, some residents would not notice, but some would be angry, feel embarrassed, or unsafe because we are not keeping their dignity. Review of facility policy titled, Policy/Procedure-Nursing Clinical, Section: Routine Procedures, Subject: Incontinence Care with revision date of 5/2007, reflected that #1 for providing incontinence care stated, Assemble equipment. Explain procedure. Provide privacy by closing door and securing privacy curtain.

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	08/22/2024

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070 Based on observations, record reviews and interviews, the facility failed to ensure the resident environment remains as free of accident hazards as is possible and that residents received adequate supervision to prevent accidents for one (Resident #139) resident of three residents reviewed for assisted transfer. The facility failed to ensure on 02/01/2024 PT K used the Hoyer lift (mechanical/patient lift designed to assist caregivers move patients from one place to another) correctly, attach the Hoyer lift sling pad and condcuted with assistance of a second person as care planned, when he transferred Resident #139 from his wheelchair to the bed. On 02/01/2024 Resident #139 fell from the Hoyer lift sling pad while in use fracturing the right clavicle (right shoulder), right femoral neck (hip), right proximal tibia fracture (long bone in the right lower leg) and sustained an intraventricular hemorrhage (bleeding into the brain). The noncompliance was identified as PNC (past non-compliance). The Immediate Jeopardy(IJ) began on 02/01/2024 and ended on 02/03/2024. The facility had corrected the noncompliance before the survey began. The failures placed residents at risk for harm and/or serious injury, hospitalization , a decline in health, and death. Findings included : Record review of Resident #139's quarterly MDS assessment, dated 04/25/2024 reflected the Resident was a [AGE] year-old-male who admitted to the facility on [DATE] and discharged on [DATE]. The resident had diagnoses which included: Diabetes (increased blood sugar), dialysis (kidneys do not function have to have machine to cleanse blood), osteoporosis (brittle bones), left above knee amputation (leg missing from above the knee downward) and Protein malnutrition (poor nutrition). The MDS reflected he had a BIMs score of 12, which indicated moderate cognitive impairment and the resident was dependent on two or more staff members to transfer him from bed to wheelchair. Record review of Resident #139's care plan, dated with a review/revise date of 06/13/2022, addressed the resident's activities of daily living needs, requiring mechanical aide for transfers for chair/bed transfers (requiring two staff), and risk for falls and assistance required for activities of daily living. Further review of the clinical record reflected, the care plan was updated quarterly, addressing the transfer bed/chair needs requiring mechanical assistance and two staff members, until discharge on [DATE]. Record review of Resident #139's Fall Risk Assessment completed 06/09/2022 and quarterly thereafter scored Resident #139 as high risk. Further review of the clinical record reflected on 02/06/2024 a follow-up fall risk assessment was completed after hospitalization ; Resident #139 was still a high risk for falls. (continued on next page)

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	08/22/2024

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the Provider Investigation Report, dated 02/02/2024 and completed on 02/07/2024, revealed Resident #139 was total assist for activities of daily living and had fallen during a Hoyer lift transfer with the Physical Therapist K on 02/01/2024 at approximately 4:00 p.m. Resident #139 had been transferred by PT K without any assistance from other staff and the PT knowingly attached the Hoyer lift sling/pad incorrectly. The transfer resulted in Resident #139's injuries: 1) right distal clavicle fracture, 2) the right proximal tibia fracture, 3) right intertrochanteric femoral neck fracture, and 4) intravascular hemorrhage of the brain. Resident #139 had to be transferred from the local ER to a larger hospital for further evaluations of his injuries. The Provider Investigation Report reflected a finding of confirmed (incident). The facility suspended the physical therapist and then later terminated,due to the PT admited he did not follow the policy for mechanical transfer (Hoyer lift). The facility started an in-service on fall prevention, transfer, and abuse/neglect policy and procedure with all staff and conducted competencies for mechanical lift training, Hoyer lift competency check off, and transfer training with a gait belt, was performed on all staff who transfer residents prior to returning to care with all staff. Review of the Provider Investigation Report dated 02/01/2024 and completed on 02/07/2024, reflected a finding of substantiated for an incident based on the Physical Therapist's interview. The physical therapist in the interview admitted the Hoyer lift transfer of Resident #139 was conducted without following policy of the facility, including two staff members for the transfer, and attaching the Hoyer lift pad/slip correctly. Review of the External/Internal/Systemic Approach Investigation Summary dated 02/02/2024 completed on 02/07/2024 reflected: There was an emergency QAPI meeting was held on 02/02/2024 with Medical Director in attendance. The meeting concluded all residents had a safe survey interview completed with BIMs score greater than 10 (no concerns about transfers noted), staff interview initiated, facility inspected lift sling and equipment to check for failure. (No failures of equipment or sling were identified), in-services began on all staff that care directly for residents, concerning Hoyer lift transfer, gait belt transfers, falls, abuse, and neglect. Who was responsible for in-servicing: Nurse Management. Who will monitor: Regional Director of Clinical Services/Director of Nursing. In additional meeting the QAPI decided, The Nursing Administration, including the ADON and DON will randomly select five staff for Hoyer lift transfers demonstration each week to continue since February 2024. The DON will monitor for compliance for 8 weeks and then on 04/02/2024 QAPI decided to continue the five employee's observation of transfer training a week ongoing basis. This training is including new hires, CNAs, Nurses, MAs, and therapists. Who will monitor: The Administrator will continue to monitor and oversee the training by reviewing with the DON the weekly trainings in the morning meeting. Resident care plans will be reviewed and updated about the transfer needs. Audits will be ongoing basis and compiled into a binder that the DON maintains. The binder was reviewed with the DON and the Surveyor. Further review of the Provider Investigation Report reflected monitoring and audits by the designated staff (the DON and Nurse Managers) had occurred. (continued on next page)

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	08/22/2024

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the nursing progress notes reflected on 02/01/2024, the PT reported to and doucmeneted by RN L at approximately 4:30 p.m. that Resident #139 had slipped from the Hoyer lift during a transfer. RN L observed Resident #139 in the room lying on the floor, next to the bed with a pillow under his head. The RN assessed the resident due to complaint of pain to his bilateral (both) hips, right toe, right temporal mandibular joint (right cheek), and right shoulder. The RN called the family and the physician ordered x-rays. Further review of the progress note reflected Resident #139's x-rays results at 5:46 p.m. were questionable for a right distal fracture and proximal tibia fracture, positive for right intertrochanteric femoral neck fracture, and right clavicle fracture. The physician was notified of the results of the x-rays, orders were given to transfer the resident to the local hospital. The family was notified of the results and the transfer to the hospital. Record review of the nursing progress notes dated 02/06/2024, at aporximalty 2:20 p.m. documented by RN L reflected Resident #139 on 02/06/2024 returned from the hospital with a right hip fracture and right shoulder fracture. Orders noted for Physical Therapy, Occupation therapy, and Speech therapy. Resident #139 remained a total assist for transfer with two staff members using a Hoyer lift. In an interview on 08/20/2024 with PT K at 9:30 a.m. revealed PT K knowingly with no assistance from another staff member, transferred Resident #139 using the Hoyer lift. PT K stated no other staff was asked to assist with the Hoyer lift transfer. PT K stated there was plenty of staff and a CNA assigned to Resident #139. PT K stated the Hoyer lift sling pad was not hooked appropriately, the sling pad was not fully clipped to the sling loop onto the lift hook, causing the loop to slip off. The sling pad became undone, and the resident slipped out and was eased to the floor. PT K could not explain if the resident was eased to the floor how so many injuries had occurred. PT K stated that Resident #139 hit the floor hard. The PT stated a pillow was placed under the resident's head and the nurse was informed. PT K admitted to knowing and understanding that the facility policy and the training specified that lift transfers required at least two staff, but he did not offer any reason as to why he did not follow policy for a safe transfer. PT K stated he could not come back until the investigation was completed. PT K stated he made a very poor decision, but it was an accident. PT K stated the facility terminated his position in the facility. The PT stated he was a four-year degreed PT with a doctorate degree and he knew the importance of a safe Hoyer lift transfer. The PT stated in-services were given concerning Hoyer lift transfer and how to appropriately perform them, by PT K, at this facility. An observation on 08/20/2024 at 11:00 a.m. revealed Resident #140 was transferred by Hoyer lift. CNA M and CNA N transferred Resident #140 appropriately to the wheelchair with no pain or anxiety related to the resident. CNA M and CNA N both stated there had been multiple in-services on Hoyer lift transfers, including appropriately securing the lift sling/pad. Both CNAs stated they had been tested after the training and one of the CNAs stated there was random competency testing. (continued on next page)

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	08/22/2024

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 08/20/2024 with RN L at 1:45 p.m. revealed the PT came and reported Resident #139 had slipped out of the Hoyer lift , while being transferred. The RN stated there was no other staff in the room when Resident #139 was being assessed for injuries. The family and the physician were notified, x-rays were ordered, and the result of the x-rays indicated there were fractures to the shoulder and possible tibia and possible hip, all on the right side. Resident #139 was sent to the hospital when the results of the x-ray came back. RN L stated PT K stated Resident #139 was transferred in the Hoyer lift by the PT with only one person and the sling/pad had come undone and the resident had slid out of the Hoyer lift onto the floor. Resident #139 was hurting all over and denied hitting his head. RN L stated when a resident had a fall the resident was assessed, and the physician and responsible party were informed. They followed physician's orders and then reassessed according to the physician's orders and the injures. The RN stated the ADON, and the DON would be notified when a resident had a fall and had to go to the hospital. The RN sated the entire staff had to have the transfer in-service concerning gait belts and Hoyer lifts before working on the floor after Resident #139 fell from the Hoyer lift. The RN stated the facility had in-serviced the entire care staff and the therapists, and the facility had continued to randomly select staff and have them Hoyer lift transfer a resident or another staff member. In an interview on 08/22/24 at 10:00 a.m. with the DOR revealed the PT had been trained on all transfer methods including the use of the Hoyer lift. The PT had even given in-services concerning the Hoyer lift and how to transfer a resident safely and appropriately. The DOR could not recall how long ago. The DOR stated the PT had worked at the facility for 7 years as a Physical Therapy Assistant, then got accepted into therapy school completed and gotten his doctorate and passed the board. The DOR stated it was shocking to hear how the PT had transferred Resident #139. In an interview on 08/22/2024 with the DON at 4:00 p.m. revealed the RN had contacted the physician and the responsible party when Resident #139 had fallen. The x-rays were positive for injuries and the investigation was started by the Administrator and DON. The DON stated the PT admitted to inappropriately transferring the resident and not following the company policy for Hoyer lift transfer. The resident's family was contacted, and the family had decided to bring the resident back to the facility as they were satisfied with how the facility had conducted the investigation and the outcome. The DON stated the PT had been trained on the policy and procedure for Hoyer lift transfers and had even given some of the in-services at the facility. In an interview on 08/22/2024 with the Administrator at 4:15 p.m. revealed the staff had all been in-serviced on Hoyer lift transfers, gait belt transfer, and abuse and neglect starting on 02/02/2024 and the in-services continued for the nursing and therapy departments given by the DON and ADON with competency testing. The DON and ADON choose five different staff off different shifts during the week to perform Hoyer lift testing. He stated the Quality Assurance team decided in April 2024 to continue with that part of the plan. The Administrator stated the PT had been suspended on 02/01/24 and had immediately been dismissed, as soon as the injuries were verified. The PT admitted completing the Hoyer lift transfer and not following the company policy of always having two staff and using appropriate safety concerning the Hoyer lift sling pad. The Administrator stated the staff had been in-serviced on safe transfers and the expectations of the Administrator. (continued on next page)

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	08/22/2024

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 08/23/2024 at 1:00 p.m. with LVN O revealed Resident #139 had been on the rehab hallway. LVN O stated Resident #139 was a very pleasant man, who had originally admitted to the facility to get stronger and learn to use a sliding board since his left leg was an above the knee amputation. Resident #139 did not accomplish the sliding board safely and then had to be transitioned to a Hoyer lift transfer and remained a Hoyer lift transfer the entire stay at the facility. The resident was not on the rehab hallway the entire time. LVN O stated after the fall occurred the entire direct care staff had been in-serviced with competency testing on different types of transfers to include Hoyer lifts. The Hoyer lift required two staff members, it always had. The LVN stated the testing continued by the DON and ADON even now for Hoyer lift transfers, to make sure the staff understood the safety measures and always had two staff members, as well appropriate use of the lift sling pads. The LVN stated it was shocking that the PT had not gotten assistance to transfer Resident #139. In an interview on 08/22/2024 at 3:30 p.m. with the Medical Director revealed the facility had been contacted when Resident #139 had fallen and had serious injuries. The Medical Director stated there was a QAPI meeting the next day and was plan was put into place to educate and prevent a similar incident from happing again. The PT was terminated, and it was suggested that the PT be referred, which is in agreement. The Medical Director stated the facility was very good about communicating to him concerning changes of conditions with the residents. Review of the incident and accident logs dated 01/01/2024 through 08/20/2024 reflected no other incident /accidents related to the Hoyer lift transfers. Resident #139 had no other incidents or accidents related to transfer with a Hoyer lift. Review of an in-service dated 02/02/2024 reflected all staff attended and the subject matter was regarding the facility policy on falls, Hoyer lift transfers, and gait belt transfers with the competency testing for each transfer by each individual staff member. Further review reflected additional continued random testing one time a week for random selected staff for Hoyer lift transfers and education. Review of the Facility's Policy titled Hoyer Lift revised and dated May 2024 reflected: It is the policy of this facility that the Hoyer lift will be utilized for resident transfers only. It will not be used to transport resident to another location. Assistance of two personnel will be used with Hoyer Lift Equipment . Hoyer lift , Hoyer Lift sling 6. Position seat sling .8. Attach S/hooks of the lift to the holes in the Hoyer sling. Insert hooks away from the resident to outside of sling .9. Count links to be sure there are the same number on each side. Check to see that S/hooks are hooked all the way into the loops and that the sling is closed to the knees for safety .11. Check S/hooks to makes are properly positioned

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	08/22/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46525 Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen, reviewed for food safety. 1. The facility failed to ensure food items in the refrigerators, freezer and dry storage room were labeled with the item description, the received by date, the opened date, the discard by and or expiration dates; stored in accordance with the professional standards for food service. 2. The facility failed to discard opened items stored in refrigerator, freezers and dry storage that were not properly labeled with the opened or prepped by date and or past the 'best buy', consume by or the manufacturer's expiration dates. 3. The facility failed to ensure multiple food items stored in a bin/container were each clearly identifiable. 4. The facility failed to ensure the handwashing sink #1's garbage receptacle was used for only paper towels. 5. The facility failed to ensure the eyewash station bowl was clean and fully functional. These failures could place residents at risk for food-borne illness and cross contamination. Findings included: Observation of the Kitchen on [DATE] at 09:24 AM revealed the following: - The long prep table next to the ice machine, where the juice machine also sat. Next to the juice machine were two square clear containers with lids, one labeled coffee, dated [DATE] the other labeled tea, dated [DATE] with 3 extra-large tea bags inside. There was no discard by or expiration date. -The kitchen floor was slippery even with non-skid shoes on, but it was dry to the appearance. -Handwashing sink #1's garbage receptacle has trash other than paper towels. There was a large sized cardboard carton that was sticking up from the garbage receptacle. -On the steam table, on top were four foam to-go containers with lids, which contained leftover breakfast (scrambled eggs, small pancakes, sausage links). The containers were unlabeled with an item description, no prep date, no discard by or expiration date. -On the steam table, there were two small bowls with lids, containing oatmeal. There were no item descriptions, no prep dates and no discard by or expiration dates. (continued on next page)

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	08/22/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On the steam table, there was a small stack of bread slices wrapped in foil. There was no item description, no prep date and no discard by or expiration date. -The prep table across from the stove, on the bottom shelf was a tray with ten bowls with lids containing various cereals. The bowls were labeled: RC (rice cereal), CH (whole grain cereal o's) and CF (cornflakes). There were various prep dates ranging from ,d+[DATE] and ,d+[DATE] (out dated) ,d+[DATE] and , d+[DATE]. There was no discard by or expiration dates. -1 Extra-large bin with a lid labeled cornmeal dated [DATE], no discard by date. -,d+[DATE] lbs. 5 oz container with lid of mashed potatoes granules, previously opened, dated [DATE]. There was no open date, the manufacturer's expiration date was [DATE]. -1-Extra-large bin with a lid labeled sugar dated [DATE], no discard by date. -1-Extra-large bin with lid labeled thickener dated [DATE], no discard by date. -The eyewash station bowl had dust and debris inside and there was a substantial crack in the bowl nearest the side where the wall was. The crack was wide enough to see through it toward the floor (wide enough a dime or penny could fit through). Observations of the Walk-in refrigerator on [DATE] at 09:52 AM revealed the following: -Left side: 1 small square bin labeled dressing, dated [DATE]. There were 5 small individual containers of ranch dressing, 2 small individual containers of balsamic vinegar dressing and 2 yogurts (manufacturer expirations [DATE] & [DATE]). No labels for the yogurts were noted. -Right side: 1 extra-large zip top bag with shredded cheese dated [DATE], no discard by date. -1 medium metal pan labeled mix veggies dated [DATE], expiration date [DATE]. -2 plates with garden salads wrapped in plastic wrap dated [DATE], no discard by date. -1 medium zip top bag with chips, a sandwich, a pastry and bottled water, dated [DATE]. There was no patient name on the bag, no item description, no discard by date. -1 large zip top bag containing previously opened turkey deli meat, dated [DATE], no discard by date. -1 large zip top bag containing previously opened ham deli meat date [DATE], no discard by date. Observation of the Walk-in freezer on [DATE] at 10:19 AM revealed the following: -1 Extra-large zip top bag labeled chicken dated [DATE] and had a moderate amount of ice crystals in the bag. The meat was darkened and had a dried appearance in some areas. Observations of the Dry Storage Room on [DATE] at 10:27 AM revealed the following: (continued on next page)

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	08/22/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Left back corner of room: -1 extra-large bin with lid, labeled flour, dated [DATE], expiration date [DATE]. It was left open to air. - 1 extra zip top bag of crispy rice cereal date [DATE], opened [DATE], no discard by date. -1 extra large bag of cornflakes cereal dated [DATE], opened [DATE] had plastic wrap draped over it (not securely wrapped); product left open to air. -,d+[DATE].7 oz bottle of previously opened caramel sauce, no received by date, opened [DATE], no discard by date. -1 plastic bag of 3 hamburger buns, previously opened, no received by date, no opened date, no discard by date. Observation of Dining room on [DATE] at 09:50 AM, revealed the following: -Near Kitchen entry door: -1 large drink dispenser containing dark colored liquid, no label of item description, no prep. date, not discard by date. In an interview on [DATE] at 09:39 AM with the DM, she stated leftovers were kept for 3 days in refrigerator unless it was something they generally kept longer. The DM stated the dry goods were kept ,d+[DATE] days once opened. She stated items like cereal were kept 3 months, when opened then they were kept 1 month but then once they transferred to the cereal containers, they only kept for 10 days. The DM stated she did a walkthrough of the kitchen after the surveyors left the kitchen on the first day and noted some of the things that had been brought to her attention. She stated when items in the big bins run low or are out, they wash the bin, dry it, then put new product inside and label it. The DM stated when written the labels should be legible not hard to read, smeared or not visible as noted during our walk through. She stated that not putting the end dates (expiration/discard dates) could cause something that is outdated to be served or not having the dates legible could cause the staff to not know when something had expired, these things could lead to food born-illness. She stated she would do an in-service with staff on the labeling of food items and the discard by dates. Review of the facility's Dietary Services Food Storage Policy, Date Revised [DATE], reflected Policy: It is the policy of this facility to prevent contamination of food products and therefore prevent foodborne illness. Procedures: 1. Director of food Service Responsibilities .E. Provide for the proper receipt and storage of all food supplies. 5. Food Storage. C. All non-food items must be properly labeled and stored away from labeled food products. G. Old stock is rotated and used first. 6. Proper Handling. K. Leftovers must be dated, labeled, covered, cooled and stored (within ,d+[DATE] hour) in a refrigerator, not at room temperature. P. Foods that have stood for several hours at room temperature cannot be considered safe and free from contamination and cannot be made so by refrigeration, especially during the summer season. They must be discarded. (continued on next page)

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	08/22/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the U.S. FDA Food Code 2022 reflected: Chapter 3 . section ,d+[DATE].11 Compliance and Food Law: . C. Packaged Food shall be labeled as specified in Law, including 21 CFR 101 Food Labeling [* .(b) A food which is subject to the requirements of section 403(k) of the act shall bear labeling, even though such food is not in package form. (c) A statement of artificial flavoring, artificial coloring, or chemical preservative shall be placed on the food or on its container or wrapper, or on any two or all three of these, as may be necessary to render such statement likely to be read by the ordinary person under customary conditions of purchase and use of such food. The specific artificial color used in a food shall be identified on the labeling when so required by regulation in part 74 of this chapter to assure safe conditions of use for the color additive.], 9 CFR 317 Labeling, [*(a) When, in an official establishment, any inspected and passed product is placed in any receptacle or covering constituting an immediate container, there shall be affixed to such container a label .Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S ,d+[DATE].18. Section ,d+[DATE].12 Food Storage Containers, Identified with Common Name of Food: Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food. Section ,d+[DATE].17 . Commercial processed food: Open and hold cold . B. 1. The day the original container is opened in the food establishment shall be counted as Day 1. 2. The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. C. 2. Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section. 3. Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section. Definitions 3. Food Receiving and Storage - When food, food products or beverages are delivered to the nursing home, facility staff must inspect these items for safe transport and quality upon receipt and ensure their proper storage, keeping track of when to discard perishable foods and covering, labeling, and dating all PHF/TCS foods stored in the refrigerator or freezer as indicated. Chapter 6 . Section ,d+[DATE].20 Disposable Towels, Waste Receptacle. Waste receptacles at handwashing sinks are required for the collection of disposable towels so that the paper waste will be contained, will not contact food directly or indirectly, and will not become an attractant for insects or rodents www.fda.gov