

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675579	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/04/2024
NAME OF PROVIDER OR SUPPLIER  Beacon Harbor Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268</b></p> <p>Based on observation, interview, and record review the facility failed to the resident had a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely for one (Resident#1) of four reviewed for environment.</p> <p>The facility failed to ensure Resident #1's sheets were clean and free of any stains.</p> <p>This failure could place residents at risk for a reduced quality of life and unsanitary and hazardous living conditions.</p> <p>Findings included:</p> <p>Record review of Resident #1's Face Sheet printed 12/04/2024, reflected a [AGE] year-old female who was admitted to the facility initially 06/02/2022 and readmitted on [DATE] and 12/11/2022 with diagnoses to include but not limited to Dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance (term used to describe a group of symptoms affecting memory, thinking and social abilities), high blood pressure and heart failure.</p> <p>Record review of Resident #1's quarterly I MDS, dated [DATE], reflected a BIMS score of 10 which indicated moderate cognitive impairment.</p> <p>Record review of Resident #1s care plan revised 06/15/2024reflected, Resident #1 at risk for impaired cognitive function/dementia or impaired thought processes regarding UNSPECIFIED DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE. Intervention included: COMMUNICATION: Identify yourself at each interaction. Face when speaking and make eye contact. Reduce any distractions- turn off TV, radio, close door etc. Use simple, directive sentences. Provide with necessary cues- stop and return if agitated. Engage in simple, structured activities that avoid overly demanding tasks.</p> <p>Observation and interview on 12/04/2024 at 1:30PM with Resident #1 revealed the sheets on the bed were largely stained with a light brown substance that appeared to be food. Resident #1 stated she may have spilled something a few days ago and the sheets were not changed. Resident #1 stated she would have liked to have the sheets changed on the bed however staff had not done it yet. Resident #1 stated maintenance was supposed to change out her mattress today(12/04/2024) and had come in the room to look at the mattress but had not returned with the mattress yet.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 12/04/2024 at 2:40PM with CNA A revealed she worked the hall for Resident #1's room however she did not change the sheets. CNA A stated she did not notice that the sheets needed to be changed. CNA A stated the sheets were typically changed on shower days or as needed.</p> <p>Interview on 12/04/2024 at 4:16PM with the Director of Nursing revealed CNA's or any staff who noticed that bed linens needed to be changed were able to do so. The Director of Nursing stated there had not been issues with bed linens being changed in the facility. The Director of Nursing stated Resident #1 did have dementia and may not have been aware of timeframes however he was not disregarding her concerns. The Director of Nursing stated Resident#1 received a new mattress today (12/04/2024) and the sheets were changed after she got the new mattress.</p> <p>Review of the facility policy Resident Rights dated amended July 13, 2017, revealed You have a right to a safe, clean, comfortable and homelike environment, and use of your personal belongings to the extent possible, including but not limited to receiving treatment and supports for daily living safely.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268</b></p> <p>Based on interview and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive assessment and quarterly review assessments for one (Resident #1) of four residents were reviewed for comprehensive care plans.</p> <p>The facility failed to ensure the interdisciplinary team revised and reviewed Resident #1's care plan quarterly.</p> <p>This failure could affect residents by placing them at risk for not having their individual needs met.</p> <p>Findings included:</p> <p>Record review of Resident #1's Face Sheet printed 12/04/2024, reflected a [AGE] year-old female who was admitted to the facility initially 06/02/2022 and readmitted on [DATE] and 12/11/2022 with diagnoses to include but not limited to dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance ( term used to describe a group of symptoms affecting memory, thinking and social abilities), high blood pressure and heart failure.</p> <p>Record review of Resident #1's quarterly I MDS, dated [DATE], reflected a BIMS score of 10 which indicated moderate cognitive impairment.</p> <p>Record review of Resident #1s care plan revised 06/15/2024reflected, Resident #1 at risk for impaired cognitive function/dementia or impaired thought processes regarding UNSPECIFIED DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE. Intervention included: COMMUNICATION: Identify yourself at each interaction. Face when speaking and make eye contact. Reduce any distractions- turn off TV, radio, close door etc. Use simple, directive sentences. Provide with necessary cues- stop and return if agitated. Engage in simple, structured activities that avoid overly demanding tasks.</p> <p>Review of Resident #1's care plan conference revealed the last care plan was held 5/03/2024.</p> <p>Interview on 12/04/2024 at 3:05 PM with the social worker revealed care plan conferences were held quarterly. She stated she did reach out to Resident #1's family member today (12/04/2024) to schedule the care plan meeting however the family member was not available for a meeting until after Christmas. The Social worker stated she had not contacted the family member prior to today (12/04/2024) to schedule the meeting. The Social worker stated the electronic system the facility was using had not prompted her that the care plan was due. The Social Worker stated she had known the care plan meeting was due for about 3 weeks. The Social Worker stated she did could not say whether or not there was a risk to the resident due to the care plans not being completed because staff see the residents on a regular basis however, she was aware that the care plan conference has to be done quarterly.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 12/04/2024 at 4:16PM with the Administrator revealed the care plan had not been updated due to the electronic system not informing staff that the care plan was due. The Administrator stated this was the first time the system had failed and now the Social Worker was auditing resident files to ensure care plans were up to date. The Administrator stated the care plan was a formal setting in which family and residents had the opportunity to voice concerns however residents were asked daily about needs. The Administrator stated the care plan conference was a formality and resident care did not lack due to a care plan conference not being held.</p> <p>Review of the facility care plan policy Policy / Procedure - Nursing Administration, Subject -Comprehensive Person-Centered Care Planning revised 05/2021 revealed The resident's comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment as indicated.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45268</p> <p>Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 (Resident #2) of 4 residents reviewed for accuracy of medical records.</p> <p>The facility failed to ensure the nursing notes accurately reflected Resident #2's condition. The nursing notes dated 08/17/2024 indicated the resident had old bruises to the bilateral upper arms, chest area and knees that were old however those bruises were new following the fall on 08/17/2024.</p> <p>These failures could place residents at risk for medication and /or treatment errors and omissions in care.</p> <p>Findings included:</p> <p>Review of Resident #2's electronic face sheet printed 12/04/2024 revealed a [AGE] year- old female admitted to the facility initially on 03/30/2023 and re admitted on [DATE] with diagnoses that included but not limited to dementia(term used to describe a group of symptoms affecting memory, thinking and social abilities), Stroke(when the blood supply to part of the brain is blocked or reduced.), and Parkinson(a movement disorder of the nervous system that worsens over time.)</p> <p>Review of Resident #2's care plan revised 6/28/2024 Has had an actual fall with No Injury, regarding Poor Balance, Poor communication/comprehension, Unsteady gait Falls:1/6/24, 2/15/24, 04/27/24 and 06/25/24, intervention included - Neuros initiated, therapy screen. Resident educated on call light and asking for assistance when needed, Resident redirected and educated to use walker to ambulate. Resident and staff educated to ensure w/c are locked during transfers, Monitor/document /report to medical doctor for signs/symptoms: Pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation.</p> <p>Review of Resident #2's quarterly MDS dated [DATE] revealed a BIMS of 07 which indicated mild cognitive impairment.</p> <p>Review of Resident #2's incident report authored by LVN B dated 08/17/2024 revealed Resident was assisted back in bed x 2 staff members, assessment done, skin warm and dry to touch, old bruises noted to Bilateral upper arms, chest area and knees. bed in the lowest position, fall mat in place, resident brought to nurse's station for close observation, Resident educated to call for assistance, Call placed to [Hospice] and notified [family member] of the fall. [director of nursing], [doctor] and [family member].</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's incident report dated 08/12/2024 authored by LVN C revealed - Nursing description- CNA [name] told writer that resident was sitting on the floor. Went in room and resident was up from the floor and walking in. Assessment performed ROM on all extremities, scratch on right arm, vital signs 137/61, 88, 18, 97%, 98.2. NP.Description: Assessment performed ROM on all extremities, scratch on right arm, first aide given, vital signs 137/61, 88, 18, 97%, 98.2. Neuro checks initiated. Resident educated to use the call light system for help, therapy screen, resident brought to the nurse's station for close monitoring. Injury type- no injury observed at the time of the incident. No injures observed post incident.</p> <p>Review of Resident #2's incident report dated 8/11/2024 authored by LVN D Resident Nurse heard uh [sic] nurse's station, stand up to see and saw resident lying on the floor in front of nurse's station.Nurse went to see the noise and notice resident is on the floor, Head to toe assessment completed, no physical injury noted. Pull up by nurse and walk her down to her room. DON, hospice, MD notified, RP Sunny called and informed also. Neuro checks initiated. Resident is non- complaint with instruction but educated to use walker and to ask for assistance, therapy screen, medications reviewed. No injures noted at the time of the incident. No injuries observed post incident.</p> <p>Review of nursing note dated 8/12/2024 authored by LVN E revealed post fall neuro checks in progress, no injury noted, resident denied any pain, sitting at nursin station at lunch time, took all her prescribed meds without any issues.</p> <p>Review of the skin assessment dated [DATE] revealed document all ulcers, wounds, and other skin problems- Bruising BUE d/t recent fall.</p> <p>Review of the skin assessment dated [DATE] revealed document all ulcers, wounds, and other skin problems- no new skin issues noted.</p> <p>Review of the skin assessment dated [DATE] revealed document all ulcers, wounds, and other skin problems- no new skin issues noted.</p> <p>Review of the skin assessment dated ,d+[DATE]/ 2024 Review of the skin assessment dated [DATE] revealed document all ulcers, wounds, and other skin problems- bruises on face from post fall, no new skin issues noted.</p> <p>Attempted call to LNV B on 12/04/2024 at 4:00PM was unsuccessful.</p> <p>Interview on 12/04/2024 at 4:16 PM with the Director of Nursing and administrator revealed the Director of nursing stated LVN B completed the nursing notes and incident report incorrectly and the notes should have indicated that bruises to the bilateral upper arms, chest and knees were new. The Administrator stated he could not say if there was a risk to residents or not if documentation was not correct and followed up. The administrator stated there could have been an issue however documentation was not a end all be all.</p> <p>A policy regarding documentation was requested from the administrator and Director of Nursing on 12/04/2024 at 3:20PM however was not provided prior to exit.</p>		