| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675579 | A. Building<br>B. Wing | 12/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Beacon Harbor Healthcare and Rehabilitation | 6700 Heritage Parkway<br>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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>(continued on next page) |

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

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

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to immediately inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident's representative when there was a significant change in the resident's physical, mental, or psychosocial status in either life threatening conditions or clinical complications for 1 of 3 residents (Resident #1) reviewed for change in condition. The facility failed to ensure Resident #1's RP was notified when Resident #1 was found sitting up in bed with his midline IV (flexible catheter inserted into a vein in the arm) removed from his left arm on 12/03/25, which resulted in his arm having to be elevated and wrapped to lessen any swelling and bleeding. This failure could place residents at risk of their RP not being aware of conditions that may require them to make medical decisions. Findings include:Record review of Resident #1's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Atherosclerotic cardiovascular disease (caused by plaque buildup in arterial walls), Chronic Kidney Failure (gradual loss of kidney function over time), Dementia (loss of thinking, remembering, and reasoning skills), and Malignant Neoplasm of Brain (cancer that grows aggressively, and can spread). Record review of Resident #1's admission MDS, dated [DATE], indicated he had a BIMS score of 5, which indicated severe cognitive impairment. Record review of Resident #1's Care Plan, dated 11/20/2025, indicated At risk for impaired cognitive function/dementia or impaired thought processes. Record review of Resident #1's SBAR Communication Form, dated 12/3/2025 at 11:00 AM, and completed by RN B, reflected Resident #1 had a change in skin color that started on 12/3/25. Under section Name of Family/Health Care Agent Notified was FM [Name]. Record review of Resident #1's Skin Check, dated 12/3/25 at 19:57 (7:57 PM) and completed by LVN B, reflected Resident #1 had a new skin tear on his left outer forearm that was acquired in-house. The Skin Check further revealed Resident #1's skin was not warm and dry, his skin color was not within normal limits, and his skin turgor (skin's elasticity, its ability to snap back after being stretched) had decreased. Record review of Resident #1's Progress Notes, dated 12/03/2025 at 11:22 AM and written by RN B, revealed Midline observed out of pt's arm during this shift. Catheter tip was intact. Plan of care ongoing. Record review of Resident #1's Progress Notes, dated 12/03/2025 at 11:29 AM and written by RN B, revealed eINTERACT SBAR Summary for Providers: The Change in Condition/s [sic] reported on this CIC Evaluation are/were: Change in skin color or condition. Primary Care Provider responded with the following feedback: A. Recommendations: Wound care order. Record review of Resident #1's Progress Notes, dated 12/03/2025 at 13:20 (1:20 PM) and written by RN B, revealed Monitor PIV / PICC / Midline / Central Line For S/S Of Infection/Infiltration Every Shift **Notify Provider If Present every shift. Record review of Resident #1's Progress Notes, dated 12/04/2025 at 11:34 AM and written by RN B, revealed Pt transfered [sic] to [Hospital] ER per family - [RP]'s [Name] request. Pt is stable at time of transfer. [FM], [Name] at bedside. In an interview on 12/09/25 at 5:47 PM with the RP, she stated the facility removed Resident #1's midline IV from his left arm on 12/3/2025 without informing her. The RP stated she visited Resident #1 on 12/2/2025 and he was fine with no issues. The RP stated FM visited Resident #1 on 12/3/2025 and he was told the facility removed the midline IV. The RP stated FM said he observed Resident #1 sitting up in his chair with his arm wrapped. The RP stated on 12/4/2025, a male staff member called her and asked if they could insert another midline IV in his right arm. In an interview on 12/10/25 at 3:05 PM with LVN A, she stated if there was any type of change in condition, they contacted the NP or the doctor to get orders. She stated they also notified the DON and the RP. LVN A stated the RP must always be contacted for any change in condition. LVN A stated she should had contacted the RP. She stated she was trained on changes in conditions and proper notifications by the ADONs and the DON. In an interview on 12/11/25 at 11:00 AM with ADON C, she stated when a resident had a change in condition, they assessed the resident and contacted the doctor or the NP and shared their findings and then notified the RP. ADON C stated they processed any orders (medications, lab work, etc.). ADON C stated once they received the results, they informed the doctor and NP and implemented any new orders given. ADON C stated they updated the RP as soon as possible to get approval and if the RP was not in agreement, they notified the doctor. In an interview on 12/11/25 at 11:45 AM with ADON D, she stated when there was a change in condition, if the resident did not have a cognitive diagnosis, she discussed the lab results with the resident. ADON D stated they notified the resident, the RP, the physician, the NP and the DON. ADON D stated after a change in condition, the physician would give |