| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675822 | A. Building<br>B. Wing | 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Beltline Healthcare Center | 106 N Beltline Rd<br>Garland, TX 75040 |

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 0661<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637<br><br>Based on interviews and record review, the facility failed to complete a discharge summary that included a reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter), for 1 (Resident #1) of 1 resident reviewed for discharge planning.<br><br>The facility failed to complete a reconciliation of Resident #1's medications when she discharged home.<br><br>This failure placed residents at risk of a lack of continuity of care and adequate medication administration after they are discharged home.<br><br>Findings included:<br><br>Record review of Resident #1's Admission Record dated 9/19/24 reflected she was a [AGE] year-old female admitted to the facility on [DATE] and was discharged home on 8/20/24.<br><br>Record review of Resident #1's Admission MDS assessment dated [DATE] reflected she was cognitively intact. Her diagnoses included presence of a right artificial hip joint, osteoarthritis of hip (occurs when the tissue at the ends of a bone wears down), hypertension (high blood pressure), and lumbar region radiculopathy (injury to the nerves in the lower back causing pain).<br><br>Record review of Resident #1's Care Plan reflected the following entries: Date initiated 8/17/24. [Resident #1] is on anticoagulant therapy (prevents blood from clotting too quickly). Enoxaparin (medication used to prevent blood clots in the leg in patients on bedrest or after having surgery). Interventions included daily skin inspections; report bruising, nosebleeds, bleeding gums, prolonged bleeding from a wound, blood in urine/feces/vomit, coughing up blood . [Resident #1] teaching to include: Take/give medication at the same time each day. Use soft toothbrush. Avoid activities that could cause injuries .<br><br>Record review of Resident #1's progress notes reflected the following entries:<br><br>(continued on next page) |



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

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| F 0661<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 8/16/24: [Resident #1] is a [AGE] year-old female admitted from [hospital name]. Dx: right hip total replacement. Hx: HTN, hyperlipidemia (high levels of fat particles in the blood), cataracts (clouding of the normally clear lens of the eye), spinal fx . A&Ox4 [alert and oriented to person, place, time, and situation] . verbally makes needs known . Signed by RN A<br><br>8/20/24: May DC home on/after 8/20/24. Home Health Eval & treat as appropriate (SN, PT/OT , Home Health Aide) . Signed by the SW<br><br>Record review of Resident #1's Discharge to Home Instructions dated 8/20/24 and provided by the DON reflected the following:<br><br>A. Nursing Discharge. This section is to be completed immediately prior to discharge .Discharging Nurse before completing this, you will need to print off the resident's 'Transfer/Discharge Record.' This will be used for medication education and can be used as an inventory of medications the resident will be dc'd with. To print the Transfer/Discharge Record if not already, exit the screen click Reports. At the report screen search for and clickclick [sic] Transfer Discharge Record New, enter the resident's name, then run the report. Then return to this assessment. 1. Discharge instructions given to 'Resident'. 2. Discharging to 'Home' .7. Review the medications on the Transfer/Discharge Record, note any special instructions below: 'Yes, all medications given to resident.' . The Document was signed by Resident #1.<br><br>Record review of Resident #1's electronic clinical record revealed no transfer/discharge record or other record containing a reconciliation of Resident #1's pre-discharge medications with her post-discharge medications could be located.<br><br>During a telephone interview on 9/19/24 at 10:09 AM, Resident #1 stated she received medications when she discharged from the facility, but the staff did not give her blood thinners. She stated she did not contact the facility afterward and had addressed the issue with her physician after her discharge and got her medication reordered. Resident #1 could not recall whether they had provided her with a list of her medications when she left.<br><br>During an interview on 9/19/24 at 12:01 PM, RN A stated she had provided care for Resident #1 but was not there when she discharged home. She stated, when a resident was to be discharged , a medication list was pulled from the computer, the medications and instructions were reviewed with the residents, and all their medications were sent home with the resident. RN A stated a copy of the medication list with instructions, the Discharge Summary, and the Admission Record were also sent home with the resident. She stated a copy of the documents should also be in the resident's electronic record. RN A stated it was important the resident had a copy of everything and their medications when they leave so they do not miss any medication doses .<br><br>During an interview on 9/19/24 at 12:52 PM, the SW stated she had assisted with Resident #1's discharge by setting up home health care for her with the company she had chosen. She stated she was unaware of any complaints or concerns related to Resident #1's medications.<br><br>(continued on next page) |

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| F 0661<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview and record review on 9/19/24 at 2:35 PM, the DON reviewed a copy of the signed discharge instructions provided to Resident #1 along with a signed inventory list for Resident #1's hydrocodone (narcotic pain medication) tablets dated 8/20/24. The inventory list included a note indicating the medications were counted and released to Resident #1. The DON stated she had been unable to locate a list of the other medications sent home with Resident #1 when she was discharged , but believed all her medications were released with her. The DON stated she had checked the medication carts after Resident #1 had been discharged and none of her medications remained at the facility. She stated a medication reconciliation list was typically pulled when a resident was discharged that included their medications ordered as well as the instructions for taking the medications. She stated she was unable to pull the list from the computer after the resident was discharged from the facility. She stated she would check with the medical records for the missing documentation.<br><br>During a telephone interview on 9/19/24 at 3:09 PM, RN B stated she had discharged Resident #1 and had provided her medications along with a list of her medications, her Discharge Summary, and a copy of her face sheet. She stated the medication discharge forms were pulled from the computer whenever a resident was getting discharged and was used to reconcile their medications and orders. She stated a copy of the signed documents should have been added to her clinical record. RN B stated she believed she had provided Resident #1 with her blood thinner, enoxaparin, upon discharge. RN B stated Resident #1's discharge planning had been completed and her home health had been arranged. She stated she did not recall Resident #1 having any complaints or concerns at the time she was discharged home. RN B stated she did not know why Resident #1's medication reconciliation was not located in her electronic record .<br><br>In an interview on 9/19/24 at 4:30 PM, the DON stated she was unable to locate any medication reconciliation documentation for Resident #1 and was previously unaware the documentation had not been completed. She stated the risk to residents was they may not be aware of any dosing changes or proper instructions for taking their medications .<br><br>In an interview on 9/19/24 at 4:42 PM, the Administrator stated the discharge summary and medication reconciliation documents were important for all involved because a resident may go home and be unsure of what they need to do or what medications they needed to take .<br><br>Record review of the facility's policy titled, Discharge Planning Process Policy, dated Revised 11/28/16 reflected the following:<br><br>Nursing facility must complete discharge planning when you anticipate discharging a resident to a private residence, another Nursing Facility or Skilled Nursing Facility, or another type of residential facility . Discharge Summary must include: .B) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter) .E) The Final discharge summary will be filed in the resident's medical record. |