

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675822	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2025
NAME OF PROVIDER OR SUPPLIER  Beltline Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  106 N Beltline Rd 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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51181</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of X residents (Resident #1's) reviewed for drug diversion.</p> <p>The facility failed to prevent an employee with access to controlled medications from diverting 44 Tablets of Hydrocodone-Acetaminophen ,d+[DATE] MG tablets (a schedule II-controlled substance opiate used to treat pain) belonging to Resident #1 from a medication cart.</p> <p>The noncompliance was identified as PNC. The noncompliance began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk for unrelieved pain due to his medication not being readily available.</p> <p>Findings included:</p> <p>Record review of Resident #1's Face Sheet, dated [DATE], reflected an [AGE] year-old female, who most recently admitted to the facility on [DATE]. Resident #1 had a diagnosis which included senile degeneration of brain (a decline in cognitive functioning), malignant neoplasm of colon (cancer of large intestine), and intra-abdominal and pelvic swelling (growth or swelling in abdomen).</p> <p>Record review of Resident #1's Physician orders dated [DATE], reflect she was prescribed Hydrocodone-Acetaminophen ,d+[DATE] MG tablets, 1 tablet by mouth every 6 hours for pain, on [DATE].</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's Provider Investigation Report, dated [DATE], reflected on [DATE] between 7:00PM and 10:00PM 44 Hydrocodone-Acetaminophen ,d+[DATE] MG tablets prescribed to Resident #1 were reported missing from a nurse's medication cart. Medication Aide A, who had access to the cart between 7 PM and 10 PM claimed she was unaware of the Hydrocodone in the cart and only administered narcotics to two other residents. Charge Nurse B confirmed the Hydrocodone was missing during her 10 PM count with Medication Aide A, while Charge Nurse B verified it was present during her 7 PM count with Medication Aide A. The discrepancy indicates the Hydrocodone disappeared between 7 PM and 10 PM, with Medication Aide A as the sole individual with access during that time. The missing count sheet further obscured the discrepancy until Charge Nurse B discovered the loss the next day. Each personnel with access to the medication cart was drug tested at the facility. Medication Aide A failed a drug test in which she tested positive for Benzodiazepine and marijuana for which she was prescribed neither. Medication A's employment with the facility was terminated. The police department was notified, and a report was filed for the missing Hydrocodone-Acetaminophen.</p> <p>Record review of Facility staff in-service was completed on the facility's-controlled substance policy which included receiving, storing, and handling narcotic medications. A card count for all controlled substances was enforced every shift.</p> <p>Record review of a pharmacy packing slip addressed to Resident #1 reflected 45 Hydrocodone-Acetaminophen tablets were delivered to the facility on [DATE].</p> <p>Record review of Resident #1's Medication Administration Record show she was administered one Hydrocodone-Acetaminophen tablet on [DATE] at 1PM by Charge Nurse B.</p> <p>Observation of the medication cart on [DATE] at 11:40 a.m., which included a review of narcotic logs and count sheets, reflected no evidence of a current drug diversion. The facility staff were following the facility's policies and procedures to prevent a drug diversion. The observation was completed with Charge Nurse B.</p> <p>During a phone interview with Medication Aide A on [DATE] at 12:47 p.m., she stated the medication count was correct when she left her shift at 10 p.m. but admitted she was not paying full attention when counting with the nurse. She insisted the numbers matched in the book and pill count but could not recall details clearly. Medication Aide A stated she believed she was being set up but could not name anyone with a specific grudge against her.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Administrator on [DATE] at 2:00 p.m., she stated the Hydrocodone-Acetaminophen arrived at the facility on [DATE] and Charge Nurse B administered one tablet to Resident #1 on [DATE] at 1 p.m. She stated that on [DATE] Charge Nurse B worked from 7 a.m. to 7 p.m. She stated the standard protocol was a nurse completed the medication counts with the medication aides. The Administrator stated that on [DATE], Charge Nurse B counted medications with Medication Aide A at 7 p.m. and all medications, including the Hydrocodone-Acetaminophen were accounted for. She stated Medication Aide A passed medications on [DATE] between 7 p.m. and 10 p.m. She stated at 10 p.m. Medication Aide A counted the medications with Nurse C. The Administrator stated that Nurse C did not count any Hydrocodone-Acetaminophen tablets because the tablets were not in the cart. She stated that Nurse C had no knowledge of the Hydrocodone-Acetaminophen being prescribed to Resident #1 prior to her shift. She stated if the Hydrocodone-Acetaminophen and count sheet were in the cart as they should have been, Nurse C would have counted them. She stated everything else Nurse C counted was accurate. The administrator stated Medication Aide A's drug test was positive and she was terminated due to her results, and she reported Medication Aide A to the state survey agency. She stated the facility never recovered the missing Hydrocodone-Acetaminophen tablets.</p> <p>The Administrator stated Resident #1's hospice was notified about the missing Hydrocodone-Acetaminophen. She stated hospice directed the facility to administer Morphine for pain management.</p> <p>Resident #1 was deceased at time of the survey, therefore surveyor was unable to interview Resident #1.</p> <p>Review of the facility's Controlled Substances Policy, dated ,d+[DATE], reflected, .All controlled medications will be stored under double lock and checked for accountability at each change of shift by the nurse going off duty and the nurse coming on duty. Documentation of the audit will be completed on the appropriate form Entries are to be made in pen each time a controlled substance is used. The nurse administering the medication will record the following information: Date and time drug is administered, amount of drug administered, remaining balance of drug, and signature of nurse administering drug. If the pharmacy does not provide a controlled substance audit sheet, the nursing staff will utilize the facilities-controlled drug audit sheet and fill in all of the required information from the Rx label of the medication being audited.</p>		