STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675822	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beltline Healthcare Center	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)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675822	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beltline Healthcare Center	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)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident's physician and responsible party of a significant change in condition for one (Resident #1) of three residents reviewed for notification of changes. The facility failed to notify Resident #1's physician and responsible party of a witnessed seizure on 09/15/25. Facility staff did not initiate neurological checks, perform an assessment or obtain labs following the event and the physician was not informed to direct further care. Resident #1 remained without clinical intervention until later that day, when the family requested a hospital transfer due to unaddressed changed in condition. On 09/18/25 an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 09/23/25, the facility remained out of compliance at a severity level of no actual harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure placed residents at risk for delayed medical evaluation, treatment, lack of timely involvement by the responsible party and the physician in resident care decisions and the potential for worsening of the resident's condition. Findings included:Record review of Resident #1's Face Sheet dated 09/17/25 reflected she was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of anemia (red blood cell or hemoglobin deficiency, leading to reduced oxygen transport in the blood), hyperlipidemia (abnormally high levels of fats in the blood), major depressive disorder (persistent feelings of sadness and loss of interest), insomnia (persistent difficulty falling asleep or staying asleep), hypertensive heart disease (heart problems due to high blood pressure), hemiplegia and hemiparesis-right dominant side (paralysis or weakness affecting one side of the body), acute respiratory failure (sudden inability to maintain adequate gas exchange), gastro-esophageal reflux disease (a chronic condition where stomach acid flows back into the esophagus, causing irritation), osteoarthritis (degenerative joint disease characterized by cartilage breakdown and joint pain), muscle wasting and atrophy (loss of muscle strength and muscle tissue mass). She had no listed diagnosis of a seizure disorder (a condition characterized by recurrent, unprovoked seizures due to abnormal electrical brain activity). Resident #1 had two family members listed as her emergency contacts and resident representative.Record review of Resident #1's admission MDS assessment dated [DATE] reflected she a BIMS score of 04, which indicated severe cognitive impairment. Resident #1 had no signs or symptoms of delirium, no negative mood issues and behavioral symptoms and no rejection of care concerns. Resident #1 required substantial/maximum assistance for activities of daily living and total dependance on eating. Resident #1 had no range of motion issues and did not require any mobility devices. Resident #1 was always incontinent of bowel and bladder. Seizure disorder was not indicated as an active diagnosis on the MDS assessment. Under the section High-Risk Drugs, Resident #1 was noted to take anticonvulsant medication. Record review of Resident #1's care plan dated 07/02/25 and last revised on 08/02/25 reflected, [Resident #1] has Seizure Disorder.Interventions: Give seizure medication as ordered by doctor. Monitor/document side effects and effectiveness-Date Initiated: 07/02/2025, Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated-Date Initiated: 07/02/2025, Post Seizure Treatment: Turn on side with head back, hyper-extended to prevent aspiration, keep airway open, after seizure take vital signs and neuro check, Monitor for aphasia, headache, altered LOC, paralysis, weakness, pupillary changes. Date Initiated: 07/02/2025, Seizure Documentation: location of seizure activity, type of seizure activity (jerks, convulsive movements, trembling), duration, level of consciousness, any incontinence, sleeping or dazed post-ictal state, after seizure activity-Date Initiated: 07/02/2025, Seizure Precautions: Do not leave resident alone during a seizure, Protect from injury, If resident is out of bed, help to the floor to prevent injury, Remove or loosen tight clothing, Don't attempt to restrain resident during a seizure as this could make the convulsions more severe, Protect from onlookers, draw curtain, etc.- Date Initiated: 07/02/2025.Record review of Resident #1's active physician orders dated 09/17/25 reflected, Keppra Solution 100 MG/ML (Levetiracetam) give 7.5 milliliter via g-tube two times a day for seizures (start date 07/01/25 - present).Record review of Resident #1's September 2025 MAR reflected she was administered Keppra 7.5ml twice a day from 09/01/25 twice a day with the last dose documented the morning of 09/15/25. Record review of Resident #1's nursing progress notes dated 09/15/25 reflected: -11:10 AM-[Written by RN A]-The ADON called this nurse when she noticed resident having seizures when she was doing wound dressing of her roommate. Assessed and positioned the resident and provided all necessary care during and after seizure. Vital signs checked as B.P.-142/76; P/R- 80; R/R-18; SpO2-94;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675822	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beltline Healthcare Center	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675822	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beltline Healthcare Center	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility to provide necessary care and services for three (Residents #1, #2 and #3) of three residents reviewed for quality of care. 1. The facility failed to monitor and assess Resident #1 who had a seizure disorder, after she had a seizure on 09/15/25. The facility did not complete any neurochecks, assessment or lab monitoring. The resident was sent out to the ER by family request later that day due to concerns for a change in condition.2. The facility failed to complete and document neurological checks following Resident #2's fall with a head strike and injury when she returned from the ER on [DATE].3. The facility failed to assess, intervene and develop a plan of care for Resident #3 who had dementia and bipolar disorder when she refused to take prescribed psychotropic and dementia medications since her admission in July 2025, resulting in behavioral decompensation requiring psychiatric hospitalization on 09/19/25. On 09/18/25 an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 09/23/25, the facility remained out of compliance at a severity level of no actual harm and a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. The facility failures placed residents at risk of unmanaged seizure activity, hypoxia, traumatic brain injury, delay in recognition of intracranial bleeding or neurological deterioration, uncontrolled psychiatric symptoms, aggressive behaviors, harm to self or others, unnecessary hospitalization and risk for serious injury, significant decline, life-threatening complications and death.Findings included: RESIDENT #1Record review of Resident #1's Face Sheet dated 09/17/25 reflected she was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of anemia (red blood cell or hemoglobin deficiency, leading to reduced oxygen transport in the blood), hyperlipidemia (abnormally high levels of fats in the blood), major depressive disorder (persistent feelings of sadness and loss of interest), insomnia (persistent difficulty falling asleep or staying asleep), hypertensive heart disease (heart problems due to high blood pressure), hemiplegia and hemiparesis-right dominant side (paralysis or weakness affecting one side of the body), acute respiratory failure (sudden inability to maintain adequate gas exchange), gastro-esophageal reflux disease (a chronic condition where stomach acid flows back into the esophagus, causing irritation), osteoarthritis (degenerative joint disease characterized by cartilage breakdown and joint pain), muscle wasting and atrophy (loss of muscle strength and muscle tissue mass). She had no listed diagnosis of a seizure disorder (A condition characterized by recurrent, unprovoked seizures due to abnormal electrical brain activity). Resident #1 had two family members listed as her emergency contacts and resident representative. Record review of Resident #1's admission MDS assessment dated [DATE] reflected a BIMS score of 04, which indicated severe cognitive impairment. Resident #1 had no signs or symptoms of delirium, no negative mood issues and behavioral symptoms and no rejection of care concerns. Resident #1 required substantial/maximum assistance for activities of daily living and total dependance on eating. Resident #1 had no range of motion issues and did not require any mobility devices. Resident #1 was always incontinent of bowel and bladder. Seizure disorder was not indicated as an active diagnosis on the MDS assessment. Under the section High-Risk Drugs, Resident #1 was noted to take anticonvulsant medication. Record review of Resident #1's care plan dated 07/02/25 and last revised on 08/02/25 reflected, [Resident #1] has Seizure Disorder.Interventions: Give seizure medication as ordered by doctor. Monitor/document side effects and effectiveness-Date Initiated: 07/02/2025, Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated-Date Initiated: 07/02/2025, Post Seizure Treatment: Turn on side with head back, hyper-extended to prevent aspiration, keep airway open, after seizure take vital signs and neuro check, Monitor for aphasia, headache, altered LOC, paralysis, weakness, pupillary changes. Date Initiated: 07/02/2025, Seizure Documentation: location of seizure activity, type of seizure activity (jerks, convulsive movements, trembling), duration, level of consciousness, any incontinence, sleeping or dazed post-ictal state, after seizure activity-Date Initiated: 07/02/2025, Seizure Precautions: Do not leave resident alone during a seizure, Protect from injury, If resident is out of bed, help to the floor to prevent injury, Remove or loosen tight clothing, Don't attempt to restrain resident during a seizure as this could make the convulsions more severe, Protect from onlookers, draw curtain, etc.- Date Initiated: 07/02/2025. Record review of Resident #1's active physician orders dated 09/17/25 reflected, Keppra Solution 100 MG/ML (Levetiracetam) give 7.5 milliliter via g-tube two times a day for seizures (start date 07/01/25 - present). Record review of Resident #1's September 2025 MAR reflected she was administered Keppra 7.5ml twice a day from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675822	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beltline Healthcare Center	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)
F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675822	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beltline Healthcare Center	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)
F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure required physician visits were completed at least once every 30 days during the first 90 days of admission, as required, for three (Resident #1 and Resident #3) of five residents reviewed for physician services. The facility failed to ensure Resident #1 and Resident #3 were seen by a physician at least once every 30 days during the first 90 days following their admission, as required. During this time frame, Resident #1 sustained a seizure and Resident #3 had behavioral decompensation requiring in-patient psychiatric hospitalization. The failure placed residents at risk of not receiving timely medical oversight and increased the risk that changes in condition could go unrecognized or untreated. Findings included: 1. Record review of Resident #1's Face Sheet dated 09/17/25 reflected she was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of anemia (red blood cell or hemoglobin deficiency, leading to reduced oxygen transport in the blood), hyperlipidemia (abnormally high levels of fats in the blood), major depressive disorder (persistent feelings of sadness and loss of interest), insomnia (persistent difficulty falling asleep or staying asleep), hypertensive heart disease (heart problems due to high blood pressure), hemiplegia and hemiparesis-right dominant side (paralysis or weakness affecting one side of the body), acute respiratory failure (sudden inability to maintain adequate gas exchange), gastro-esophageal reflux disease (a chronic condition where stomach acid flows back into the esophagus, causing irritation), osteoarthritis (degenerative joint disease characterized by cartilage breakdown and joint pain), muscle wasting and atrophy (loss of muscle strength and muscle tissue mass). She had no listed diagnosis of a seizure disorder (A condition characterized by recurrent, unprovoked seizures due to abnormal electrical brain activity). She had no listed diagnosis of a seizure disorder. MD J was listed as the primary medical doctor for Resident #1. Record review of Resident #1's admission MDS assessment dated [DATE] reflected she a BIMS score of 04, which indicated severe cognitive impairment. Resident #1 had no signs or symptoms of delirium, no negative mood issues and behavioral symptoms and no rejection of care concerns. Resident #1 required substantial/maximum assistance for activities of daily living and total dependance on eating. Resident #1 had no range of motion issues and did not require any mobility devices. Resident #1 was always incontinent of bowel and bladder. Seizure disorder was not indicated as an active diagnosis on the MDS assessment. Under the section High-Risk Drugs, Resident #1 was noted to take anticonvulsant medication. Record review of Resident #1's care plan dated 07/02/25 and last revised on 08/02/25 reflected, [Resident #1] has Seizure Disorder.Interventions: Give seizure medication as ordered by doctor. The care plan dated 07/02/25 revealed no discussion related to physician visits, follow-up or coordination of care for the resident post-admission. Record review of Resident #1's September 2025 physician's orders from MD J reflected she was prescribed: Ascorbic Acid Tablet 500 MG Give 1 tablet by mouth two times a day (supplement), Cholecalciferol Tablet 1000 UNIT Give 1 tablet by mouth one time a day (supplement), Eliquis Oral Tablet 2.5 MG Give 1 tablet by mouth two times a day (for atrial fibrillation), Entresto Oral Tablet 49-51 MG Give 1 tablet by mouth two times a day (for heart failure), Esomeprazole Magnesium Capsule Delayed Release 20 MG Give 1 capsule by mouth one time a day (for GERD), Farxiga Oral Tablet 10 MG Give 1 tablet by mouth one time a day (for diabetes), Ferrous Sulfate Oral Tablet 325 Give 1 tablet by mouth one time a day (supplement), Humalog Kwik Pen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Lispro) Inject 10 unit subcutaneously two times a day (for diabetes), Isosorbide Dinitrate Oral Tablet 10 MG Give 1 tablet by mouth three times a day (for hypertension), Lantus Solostar Subcutaneous Solution Pen-injector 100 unit/ml Inject 19 units subcutaneously one time a day (for diabetes), Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 MG Give 1 tablet by mouth one time a day (for hypertension), Miralax Powder 17 gm/scoop Give 17 gram by mouth one time a day (for constipation), Multivitamin Adult Oral Tablet Give 1 tablet by mouth one time (supplement), Oxybutynin Chloride Oral Tablet 5 MG Give 1 tablet by mouth two times a day (for overactive bladder), Pantoprazole Sodium Oral Tablet Delayed Release 40 mg Give 1 tablet by mouth one time a day (for GERD), Sertraline HCl Oral Tablet 25 MG Give 1 tablet by mouth one time a day (for depression), Tylenol Tablet 325 MG Give 2 tablets by mouth every 4 hours as needed for Fever/Pain. Record review of Resident #1's clinical chart on 09/17/25 reflected one visit was completed by MD J on her date of admission on [DATE]. There were no face-to-face physician visits completed for the 30-day and 60-day time frame after Resident #1's admission. MD J's extenders (NP K and PA E) completed visits on 07/02/25, 07/04/25 and 08/07/25. There was no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675822	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beltline Healthcare Center	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)
F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675822	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beltline Healthcare Center	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)
F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident received and was provided the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care to include but not limited to, the prevention and treatment of mental and substance use disorders for one (Resident #3) of three residents reviewed for behavioral health care. The facility failed to assess, monitor and implement appropriate behavioral health interventions for Resident #3, who lived with bipolar disorder and dementia and repeatedly refused prescribed psychotropic medications.The facility failed to ensure Resident #3's care plan was revised or initiated timely psychological or psychiatric services in response to the refusals. As a result, Resident #3's behaviors escalated, leading to physical aggression towards another resident on 09/19/25 and subsequent transfer to an inpatient hospital for stabilization. An Immediate Jeopardy (IJ) situation was identified on 09/21/25. While the IJ was removed on 09/23/25, the facility remained out of compliance at a scope of pattern with the potential for more than minimal harm, due to the facility needing to evaluate the effectiveness of their corrective systems. Findings include: Record review of Resident #3's face sheet, dated 09/21/24, reflected a [AGE] year-old female who admitted to the facility on [DATE]. Her active diagnoses included cognitive communication deficit (Impairment in communication abilities due to deficits in attention, memory or other cognitive processes), dementia with behavior disturbance (progressive cognitive decline accompanied by agitation, aggression or other behavioral symptoms), bipolar disorder (a mental health condition marked by alternating periods of depression and elevated mood/mania or hypomania), major depressive disorder (mood disorder involving persistent sadness, loss of interest and impaired daily functioning) and insomnia (persistent difficulty staying asleep). Resident #1 had two family members listed as her emergency contacts. Record review of Resident #3's admission MDS Assessment, dated 08/06/25, reflected she had a BIMS score of 01, which indicated severe cognitive impairment. Resident #3 sometimes understood others and sometimes made herself understood. She had no signs/symptoms of delirium and no negative mood problems. Resident #3 had no potential indicators of psychosis (a mental health condition characterized by a loss of contact with reality, leading to distorted perceptions, beliefs, and behaviors), which included hallucinations and delusions. Resident #3 had no behavioral symptoms indicated on her MDS assessment and no wandering or rejection of care. Resident #3's activity preferences that were very important and included, having books/newspapers/magazines, being around people and pets, doing favorite activities, going outside to get fresh air when the weather is good and participate in religious services or practices. Record review of Resident #3's care plan, initiated 08/02/25, reflected the following focus areas were added after the resident-to resident behavioral aggression incident on 09/18/25: 1) [Resident #3] has Bipolar Disorder [Date Initiated: 09/18/25]; 2) The resident has a history of trauma that may have a negative impact. The trauma is r/t: Resident to resident encounter [Date initiated 09/18/25];3) [Resident #3] is at risk for wandering- disoriented to place [Date Initiated: 09/19/2025]; 4) [Resident #3] has potential to demonstrate physical behaviors-Poor impulse control [Date Initiated: 09/19/2025]; 5) [Resident #3] has potential to demonstrate physical behavior- Poor impulse control [Date Initiated: 09/19/2025]; 6) [Resident #3] has potential to demonstrate verbally abusive behaviors-Dementia, Mental / Emotional illness [Date Initiated: 09/18/2025]; Resident #3's care plan did not discuss a focus area related to Resident #3's medication refusals. Record review of Resident #3's Physician Order Summary for September 2025 reflected she was prescribed, Buspirone 10mg once a day related to bipolar disorder, current mixed episode (start date 07/26/25, discontinued 09/11/25), Lamictal 25 mg twice a day related to bipolar disorder (start date 07/26/25), Trazadone 100 mg at bedtime related to insomnia (start date 07/26/25), Memantine 10 mg once a day for unspecified dementia with behavioral disturbance (start date 07/26/25 and Aricept 5 mg at bedtime for dementia (start date 07/26/25). Additionally, there was an order dated 07/30/25 to refer Resident #3 for in-house psychiatric and counseling services. On 09/19/25, there was a physician's order which stated, Send to ER for Psyche Evaluation. Record review of Resident #3's August 2025 MAR reflected documented refusals of the following medications: -Buspirone was refused 18 times: (August 2nd ,3rd ,7th ,9th ,10th-13th, 15th-17th, 20th, 21st, 25th, 26th, 29th-31st).-Lamictal was refused 18 times (August 1st, 3rd, 4th, 6th, 8th, 9th, 11th-13th, 15th-23rd) on the AM dose and 16 times (August 2nd, 3rd, 7th, 11th-13th,15th-17th, 20th , 21st, 25th, 26th, 29th-31st) on the PM dose -Trazadone was refused 16 times (August 2nd, 3rd, 7th, 11th

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675822	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beltline Healthcare Center	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)
F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675822	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beltline Healthcare Center	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)
F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident who displayed or was diagnosed with dementia, received the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental and psychosocial well-being for one of three residents (Resident #3) reviewed for dementia care. The facility failed to ensure Resident #3 received the appropriate treatment and services for her dementia diagnoses. Resident #3's behavior escalation resulted in a physical aggression incident on 09/19/25 towards another resident and subsequent transfer to an inpatient psychiatric hospital for further evaluation. An Immediate Jeopardy (IJ) situation was identified on 09/21/25. While the IJ was removed on 09/23/25, the facility remained out of compliance at a scope of a pattern with the potential for more than minimal harm, due to the facility's need evaluate the effectiveness of the corrective systems. This failure could place residents at risk for untreated dementia symptoms and behavior escalation, aggression towards residents and staff, physical altercations, injuries, worsening cognitive decline, psychiatric destabilization and the need for emergency interventions such as hospitalization. Findings include: Record review of Resident #3's Face Sheet dated 09/21/24 reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. Her active diagnoses included cognitive communication deficit (Impairment in communication abilities due to deficits in attention, memory or other cognitive processes), dementia with behavior disturbance (progressive cognitive decline accompanied by agitation, aggression or other behavioral symptoms), bipolar disorder (a mental health condition marked by alternating periods of depression and elevated mood/mania or hypomania), major depressive disorder (mood disorder involving persistent sadness, loss of interest and impaired daily functioning) and insomnia (persistent difficulty staying asleep). Resident #1 had two family members listed as her emergency contacts. Record review of Resident #3's admission MDS assessment dated [DATE] reflected she had a BIMS score of 01, which indicated severe cognitive impairment. Resident #3 sometimes understood others and sometimes made herself understood. She had no signs/symptoms of delirium and no negative mood problems. Resident #3 had no potential indicators of psychosis, which included hallucinations and delusions. Resident #3 had no behavioral symptoms indicated on her MDS assessment and no wandering or rejection of care. Resident #3's activity preferences that were very important and included, having books/newspapers/magazines, being around people and pets, doing favorite activities, going outside to get fresh air when the weather is good and participate in religious services or practices. Record review of Resident #3's care plan, initiated 08/02/25, reflected the following focus areas were added after the resident-to resident behavioral aggression incident on 09/18/25: -[Resident #3] is at risk for wandering- disoriented to place [Date Initiated: 09/19/2025]; -[Resident #3] has potential to demonstrate physical behaviors-Poor impulse control [Date Initiated: 09/19/2025]; -[Resident #3] has potential to demonstrate physical behavior- Poor impulse control [Date Initiated: 09/19/2025]; -[Resident #3] has potential to demonstrate verbally abusive behaviors-Dementia, Mental / Emotional illness [Date Initiated: 09/18/2025]; Resident #3's care plan did not discuss Resident #3's medication refusals and did not address her dementia and related behavioral interventions. Record review of Resident #3's Physician Order Summary for September 2025 reflected she was prescribed, Memantine 10 mg once a day for unspecified dementia with behavioral disturbance (start date 07/26/25) and Aricept 5 mg at bedtime for dementia (start date 07/26/25). Additionally, there was an order dated 07/30/25 to refer Resident #3 for in-house psychiatric and counseling services. On 09/19/25, there was a physician's order which stated, Send to ER for Psyche Evaluation. Record review of Resident #3's August 2025 MAR reflected documented refusals of the following medications: -Aricept was refused 18 times (August 2nd, 3rd, 7th, 9th-13th, 15th-17th, 20th, 21st, 25th, 26th, 29th-31st)-Memantine was refused 23 times (August 1st, 3rd, 4th, 6th, 8th, 9th, 11th-13th,15th-23rd, 25th-27th, 29th-31st). Record review of Resident #3's September 2025 MAR reflected documented refusals of the following medications:-Aricept was refused five times (September 3rd, 4th, 7th, 8thand 9th) -Memantine was refused 15 times (September 1st, 3rd, 5th, 6th, 8th-13th, 15th-19th). Record review of Resident #3's e-administration medication notes, starting 08/22/25 through 09/19/25, reflected the main reasons for refusals of medications were because the resident did not think she needed them. Record review of NP K's progress notes (extender for MD J) reflected she saw Resident #3 twice when she first admitted to the facility on [DATE] and 07/30/25. On 07/28/25, NP K documented, Plan:. Monitor for changes in mood or behaviors, refer to psyche for support, monitor for changes in neuro or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675822	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beltline Healthcare Center	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675822	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beltline Healthcare Center	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide pharmaceutical services including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for two of five residents (Resident #1 and Resident #4) reviewed for medication administration.1. The facility failed to ensure Resident #1's blood pressure was obtained and documented prior to the administration of physician-ordered antihypertensive medications with parameters in July 2025 on 12 occasions. 2. The facility failed to ensure Resident #4's blood pressure was obtained and documented prior to the administration of physician-ordered antihypertensive medications with parameters 12 times in August 2025 and seven times in September 2025. These failures could place residents at risk for receiving antihypertensive medications without confirmation of safe blood pressure parameters, which could result in sudden hypertension leading to fainting, falls or dizziness. It also placed residents at risk for missed or delayed treatment, potentially leading to uncontrolled hypertension, stroke or other adverse cardiovascular events. 1. Record review of Resident #1's face sheet, dated 09/17/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had active diagnoses which included anemia (red blood cell or hemoglobin deficiency, leading to reduced oxygen transport in the blood), hyperlipidemia (abnormally high levels of fats in the blood), major depressive disorder (persistent feelings of sadness and loss of interest), insomnia (persistent difficulty falling asleep or staying asleep), hypertensive heart disease (heart problems due to high blood pressure), hemiplegia and hemiparesis-right dominant side (paralysis or weakness affecting one side of the body), acute respiratory failure (sudden inability to maintain adequate gas exchange), gastro-esophageal reflux disease (a chronic condition where stomach acid flows back into the esophagus, causing irritation), osteoarthritis (degenerative joint disease characterized by cartilage breakdown and joint pain), muscle wasting and atrophy (loss of muscle strength and muscle tissue mass). Record review of Resident #1's admission MDS Assessment, dated 07/02/25, reflected a BIMS score of 04, which indicated severe cognitive impairment. Resident #1 had no signs or symptoms of delirium, no negative mood issues and behavioral symptoms and no rejection of care concerns. Resident #1 required substantial/maximum assistance for activities of daily living and total dependance on eating. Resident #1 had no range of motion issues and did not require any mobility devices. Resident #1 was always incontinent of bowel and bladder. Seizure disorder was not indicated as an active diagnosis on the MDS assessment. Under the section High-Risk Drugs, Resident #1 was noted to take anticonvulsant medication. Record review of Resident #1's care plan, dated 07/02/25 and last revised on 08/02/25, reflected no discussion of her need for hypertensive medications or an issue with high or low blood pressure. Record review of Resident #1's active physician orders, dated 09/17/25, reflected she was prescribed Carvedilol Oral Tablet 25 mg via g-tube twice a day-Hold for SBP < 100, DBP < 55 or HR < 60 bpm for hypertension (start date 07/01/25).Record review of Resident #1's July 2025 MAR reflected her AM dose of Carvedilol was not administered and was documented as X on 07/07/25 and 07/30/25. It was documented as NA on 07/04/25, 07/05/25, 07/10/25, 07/14/25, 07/15/25, 07/20/25, 07/24/25, 07/27/25, 07/28/25 and 07/29/25. No blood pressure readings or vitals were recorded on the MAR for those administration times. Record review of Resident #1's July 2025 nursing progress notes reflected no blood pressure readings when the Carvedilol was held in July 2025. 2. Record review of Resident #4's face sheet, dated 09/17/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included essential hypertension (persistently high blood pressure without a known secondary cause), cardiomyopathy (disease of the heart muscle that makes it hard for the heart to pump blood effectively), chronic obstructive pulmonary disease (progressive lung disease that cause airflow blockage and breathing problems), atrial fibrillation (irregular, often rapid heart rhythm that can lead to poor blood flow), dementia (group of symptoms affecting memory, thinking and social abilities severely enough to interfere with daily functioning) and diabetes (chronic high glucose levels fur to problems with insulin production).Record review of Resident #4's care plan dated 07/02/25 reflected she was on anticoagulant therapy, had congestive heart failure, diabetes and hypertension. She was also care planned for adverse medication risks and care planning, was on diuretic therapy related to edema and had a stage 3 pressure ulcer related to immobility. Record review of Resident #4's Physician's Order Summary, dated 09/17/25, reflected she was prescribed the following blood pressure medications, Isosorbide Dinitrate Oral Tablet 10 mg Give 1 tablet by mouth three times a day for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675822	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beltline Healthcare Center	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)
F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675822	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beltline Healthcare Center	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)
F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility's governing body failed to provide effective oversight and ensure systems were in place and operational to protect resident health and safety for three (Residents #1, #2 and #3) of three residents reviewed for administration.The facility's governing body failed to ensure that administrative oversight and monitoring systems were maintained during a period in which the facility operated without and assigned administrator (09/12/25-09/17/25). During this time, three Immediate Jeopardy situations occurred, including failure to notify the physician/responsible party following a seizure for Resident #1, failure to complete neurological checks after a fall with a head strike and injury for Resident #2, and failure to address repeated psychotropic medication refusals for Resident #3 who had dementia and bipolar disorder.This failure could place residents at risk of systemic breakdowns in care oversight, lack of leadership and accountability necessary to ensure timely interventions, regulatory compliance and the protection of resident health and safety.Findings Include: 1. Record review of Resident #1's face sheet, dated 09/17/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had active diagnoses which included anemia (decreased red blood cell count causing fatigue and weakness), hyperlipidemia (elevated cholesterol levels), major depressive disorder (chronic mood disorder with persistent depression), insomnia (difficulty initiating or maintaining sleep), hypertensive heart disease (cardiac complications resulting from long term high blood pressure), hemiplegia and hemiparesis-right dominant side (paralysis affecting right side of the body), acute respiratory failure (sudden inability of the lings to provide adequate oxygenation or ventilation), gastro-esophageal reflux disease (chronic and acid reflux causing heartburn and potential esophageal irritation), osteoarthritis (degenerative joint disease causing pain and stiffness), muscle wasting and atrophy (loss of muscle mass and strength). She had no listed diagnosis of a seizure disorder. Resident #1 had two family members listed as her emergency contacts and resident representative. Record review of Resident #1's admission MDS Assessment, dated 07/02/25, reflected a BIMS score of 04, which indicated severe cognitive impairment. Resident #1 had no signs or symptoms of delirium, no negative mood issues and behavioral symptoms and no rejection of care concerns. Resident #1 required substantial/maximum assistance for activities of daily living and total dependance on eating. Resident #1 had no range of motion issues and did not require any mobility devices. Resident #1 was always incontinent of bowel and bladder. Seizure disorder was not indicated as an active diagnosis on the MDS assessment. Under the section High-Risk Drugs, Resident #1 was noted to take anticonvulsant medication. Record review of Resident #1's care plan, dated 07/02/25 and last revised on 08/02/25, reflected [Resident #1] has Seizure Disorder.Interventions: Give seizure medication as ordered by doctor. Monitor/document side effects and effectiveness-Date Initiated: 07/02/2025, Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follows up as indicated-Date Initiated: 07/02/2025, Post Seizure Treatment: Turn on side with head back, hyper-extended to prevent aspiration, keep airway open, after seizure take vital signs and neuro check, Monitor for aphasia, headache, altered LOC, paralysis, weakness, pupillary changes. Date Initiated: 07/02/2025, Seizure Documentation: location of seizure activity, type of seizure activity (jerks, convulsive movements, trembling), duration, level of consciousness, any incontinence, sleeping or dazed post-ictal state, after seizure activity-Date Initiated: 07/02/2025, Seizure Precautions: Do not leave resident alone during a seizure, Protect from injury, If resident is out of bed, help to the floor to prevent injury, Remove or loosen tight clothing, Don't attempt to restrain resident during a seizure as this could make the convulsions more severe, Protect from onlookers, draw curtain, etc.- Date Initiated: 07/02/2025. Record review of Resident #1's e-chart, to include progress notes, assessments, clinical documents and monitoring forms reflected the facility failed to promptly notify the MD of Resident #1's change in condition when she sustained a seizure on 09/15/25 during the morning shift around 7-9am. Resident #1 admitted with a known seizure disorder and was administered daily seizure medication but had not had a documented seizure since admission. On 09/15/25, the facility notified the MD/NP/PA via an online physician's messaging app around 4 pm in the afternoon that Resident #1 had a seizure earlier in the morning. PA E ordered for the resident to have a Keppra lab (not stat). The family had Resident #1 sent to the ER later that evening when they observed the resident having seizures on the AEM and were unaware there had been a seizure episode earlier that morning due to not being notified. There was no documented evidence that the facility monitored the resident's neurological status or assessed her after the seizure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675822	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beltline Healthcare Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675822	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beltline Healthcare Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete and accurate clinical records for one (Resident #2) of five residents reviewed for hospitalizations. 1. The facility failed to complete an incident report after Resident #2 fell, struck her head and had to be sent to the ER due to excessive bleeding. 2. The facility failed to ensure Resident #2's clinical record included hospital documentation following a return to the facility from the ER after a fall with head strike and sutures. These failures placed residents at risk for unmet medical needs, delayed treatment, poor clinical decision-making, and placed them at risk for decline, injury or other adverse outcomes. Findings included: Record review of Resident #2's Face Sheet dated 09/19/25 reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. Her active diagnoses were listed as hyperlipidemia (abnormally high levels of fats in the blood) and diabetes (a chronic metabolic disorder characterized by elevated blood glucose levels due to impaired insulin production). Record review of Resident #2's e-chart reflected due to being a new admission, she did not have an MDS completed yet. Record review of Resident #2's initial care plan dated 09/15/25 reflected the following focus areas: 1. Focus: The resident is risk for falls [Date Initiated: 09/15/2025]; Interventions: Anticipate and meet the resident's needs, [NAME] the resident's call light is within reach and encourage the resident to use it for assistance as needed, Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs, Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility, Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in w/c, Keep furniture in locked position, Keep needed items, water, etc., in reach, Pt evaluate and treat as ordered or PRN, Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes, Staff to assist with transfers, Fall r/t weakness- send to er, therapy notified, educated -falls-safety [revised 09/19/25], The resident needs a safe environment with: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; handrails on walls, personal items within reach) [Revised 09/19/25]2. The resident has a bruise [Start date 09/15/25]-Interventions: Attempt to determine the cause of the bruising, if known attempt to alleviate that factor, Monitor bruising every shift for 72 hours. Note color and characteristics. If negative changes report to the MD, Monitor for and treat pain as indicated.3. The resident has a skin tear, laceration, or abrasion [Date Initiated: 09/15/2025]-Interventions: The residents skin injury will resolve without complications, Assess reason for skin injury occurrence. Notify staff of cause; determine measures to prevent further skin injuries, Monitor and treat pain as indicated, Monitor the skin injury every shift for 72 hours. Assess for bleeding, signs of infection (increased redness, warmth, drainage, odor) Notify the MD for any negative changes, perform any wound care as ordered. Record review of Resident #2's written by LVN B revealed, [Resident #2 was transferred to a hospital on [DATE] 12:45 PM related to fell [sic] and hit her head. This is intended serve as notice of an emergency transfer. There were no other details provided. Record review of Resident #2's nursing progress notes from 9/14/25 to 09/17/25 reflected no documentation related to a fall. Review of an incident report started on 09/17/25 for Resident #2 by LVN B revealed the form was incomplete and no required areas were assessed on the form until 09/19/25 and 09/20/25 when the DON and LVN B did late entry documentation . There was no immediate incident description at the time of occurrence, no documentation of immediate actions taken, no injury assessment, no mental status assessment, and no narrative notes describing the fall or subsequent clinical follow-up. Multiple fields in the form read, No records found. An interview with LVN G on 09/17/25 at 1:20 PM revealed she was not at the facility when Resident #2 fell and had to be sent to the ER but came back the next day and there were no new orders or clinical documentation, so she did not know if Resident #2 sustained any injuries. LVN G stated if a resident came back from the hospital with no documentation, then the charge nurse on duty needed to document it and report it to the nursing management who could follow up to obtain them. LVN G stated it was out the charge nurses' control if the resident came back with no hospital documentation and the nurse would not know what happened as a result. An interview and observation with Resident #2 on 09/17/25 at 1:30 PM revealed she was in a wheelchair by the nurses station with non-slip socks on. She was observed with a large fading greenish yellow bruise around her right eyebrow extending down into her right eyelid about three inches in diameter. Resident #2 had approximately a one inch cut with stitches above her right eyebrow. She was