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	12/30/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 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 observation, interview, and record review, the facility failed to ensure the residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident #1) of 5 residents reviewed for quality of care. - The facility failed to ensure the NP's order on 12/17/25 for a UA was completed for Resident #1, after the resident's RP expressed concerns for a UTI. This failure placed residents at risk of a delay in medical evaluation and treatment, which could result in worsening of condition or serious harm.Findings included: Record review of Resident #1's face sheet, dated 12/30/25, reflected a [AGE] year-old female who admitted to the facility on [DATE]. Resident #1 had diagnoses that included: dementia (brain disorder that affects memory, thinking, and behavior), congestive heart failure, chronic kidney disease, hx cerebral infarction (stroke), and hx malignant neoplasm of breast (cancer of the breast). Record review of Resident 1's quarterly MDS assessment, dated 10/26/25, reflected the resident's BIMs score was 12, which indicated moderate cognitive impairment. The MDS Assessment under Section GG-Functional Status (self-care), reflected Resident # 1 required substantial assistance with most ADLs. The MDS Assessment under Section H-Urinary Toileting Program, reflected Resident #1 was always incontinent. Record review of Resident 1's care plan, dated 11/14/25, reflected the resident had an ADL self-care performance deficit with interventions that included a 2-person assist with toileting. The document also reflected Resident #1 had bladder incontinence with interventions that included: incontinent care at least every 2 hours with application of barrier cream after every episode, monitoring and documenting s/sx of UTI (pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating pattern), and monitoring, documenting and reporting s/sx to the MD. Record review of Resident #1's progress notes, dated 12/17/25 at 11:25 AM by the ADON, reflected the following: [Resident #1's] family requested that UA to be done on [Resident #1] that she is feeling discomfort, notified DON and sent a message to [MD], awaiting his response at these [sic] time. [Family] also brought a pressure pad for [Resident #1] whenever they get her up these [sic] morning that they should spread it on [Resident #1's] bed, DON to look at it first before usage. Record review of a facility document titled 24-Hour Nurse Report, dated 12/28/25, reflected in part the following: [Resident #1] - [Family] wants to rule [sic] UTI. [MD] notified Record review of a facility document titled 24-Hour Nurse Report, dated 12/29/25, reflected in part the following: [Resident #1] - [Family] requesting [MD] to rule out UTI. [MD] notified, no order received. No complain [sic] Record review of Resident #1's EHR reflected there was no order entered for a UA or one completed on or after 12/17/25. In an interview and observation on 12/30/25 at 10:30 AM, Resident #1 was lying awake in bed and visiting with family. Resident #1 was alert, but her thoughts were slightly scattered, and she was not a good historian. When asked how she was doing, Resident #1 stated I guess I'm okay. Observation of Resident #1 revealed she was clean with no odors or visible marks or bruises. Resident #1's family stated the charge nurse never followed up on concerns they had regarding Resident #1's health and proceeded to call another family member on the phone to provide further details. The family stated Resident #1 complained that it hurt when she urinated and that she felt discomfort. The family stated Resident #1 was confused sometimes due to her dementia, so they asked her on multiple occasions, and she consistently complained about the discomfort, so it was reported to the charge nurse. The family was unable to provide the name of the charge nurse; however, she informed the family that the MD would be notified so a UA could be completed. The family stated that it happened weeks ago, and no one had followed up with any results. The family stated someone visited Resident #1 daily and the nurses could never give an answer about whether the UA was completed, and they could never speak with the MD. In an interview on 12/30/25 at 12:20 PM, the MD stated the expectation was for the nurses to notify him of any changes in a resident's condition and they were typically good about doing so. The MD stated he could not recall being notified that Resident #1's family had concerns that the resident might have a UTI, but his NP might have received the notification. The MD stated some s/x of a UTI included an altered mental status, chills, nausea, and continued discomfort and he had not been informed that Resident #1 was experiencing any of those symptoms. The MD checked the messaging system and found a note from the NP on 12/17/25 approving an order to collect a UA from Resident #1. The MD stated he was not sure why the UA was not collected and followed up on. The MD stated a delayed UA to test for a