

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 11/07/2024
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 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193</p> <p>Based on observation, interview, and record review the facility failed to provide, based on the comprehensive assessment and care plan, both facility-sponsored group and individual activities and independent activities designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident for 1(Residents #5) of 6 residents reviewed for activities.</p> <p>The facility failed to provide individualized and group activities for Resident #5. The facility failed to ensure Resident #5 had an individualized activity care plan.</p> <p>These failures could place resident at risk for decline in quality of life, social and mental psychosocial wellbeing.</p> <p>Findings included:</p> <p>Record review of Resident #5's face sheet dated 11/07/24 reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #5's active diagnoses included respiratory failure, dysphagia (difficulty swallowing), muscle weakness, gastrostomy status (surgical opening in the abdomen that provides a route for feeding or draining the stomach), lack of coordination, hypertension (chronic condition where the pressure of blood in your arteries is consistently too high).</p> <p>Record review of Resident #5's MDS assessment dated ,d+[DATE] reflected she had a BIMS score of 15, which indicated no cognitive impairment. Resident #5 was usually understood. Resident #5 required minimum to total assistance with activities of daily living.</p> <p>Record review of Resident #5's care plan initiated 12/23/22 and last revised on 08/16/24 reflected, Focus, (Resident #5) expresses preferred activities pursuits. Goal, (Resident #5) will be able to participate in enjoyable activities during their stay. Interventions, Assist (Resident #5) in obtaining any supplies or materials needed for independent activity pursuits. Provide an activities calendar and assist (Resident #5) in planning as needed.</p> <p>Review of Resident #5's clinical chart and assessments between May, 2024 and November, 2024 reflected no documented evidence of an activities assessment.</p> <p>Review of Resident #5's progress notes from May 2024 through November 2024 reflected no documented evidence of any activities progress notes.</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 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation and interview on 11/05/24 at 11:23 AM revealed Resident #5 in bed. She was awake and alert watching the television. Resident #5 stated she spent all her time in bed and mostly watching television. When asked if she participated in activities, Resident #5 stated she had not participated in in-room or group activities. Resident #5 stated she would like to participate in group activities like bingo and shakers which she liked. Resident # 5 stated no one had asked her if she wanted to participate in group activities. Follow up with Resident #5 on 11/07/24 at 10:34 AM she stated she had participated in group activities on 11/05/24 and 11/06/24 and liked it, and she would attend the 2 pm bingo that was scheduled on 11/07/24.</p> <p>In an interview on 11/05/24 at 11:33 AM CNA A stated she provided care to Resident #5. Resident #5 was alert and oriented and she did not attend activities. CNA A stated on admission Resident #5 participated in group activities and liked bingo. CNA A stated she did not know why Resident #5 did not attend activities. CNA A stated the Activity Director got the resident from the rooms who participated in activities. CNA A stated the Activity Director had not informed her Resident #5 needed to attend group activities. CNA A stated a resident's lack of activities could lead to isolation.</p> <p>In an interview on 11/05/24 at 11:41 AM with the Activity Director, she stated she had worked in the facility for about 6 months and Resident #5 had not participated in any activity. She stated the resident was to receive in-room activities because she was mostly in bed. The Activity Director stated she checked on the resident in the mornings and the resident was asleep, so she was not able to complete any activity with the resident. The Activity Director stated she had not met with the resident to find out the best time for the resident to complete the in-room activities. The Activity Director stated she would assess the resident and find out the best time to complete the in-room activities. The Activity Director stated the resident required activities to be active and prevent the resident being isolated and keep the mind busy.</p> <p>In an interview on 11/05/24 at 01:15 PM with the DON, she stated Resident #5 was alert and oriented. The DON stated she was notified. That the resident liked to spend time watching television, the DON did not mention the time she was notified. The DON stated she was not aware why Resident #5 was not attending activities. The DON stated she was to follow up and find out why the resident was not attending activities.</p> <p>In a follow up interview with the DON on 11/05/24 at 02:45 PM she stated she had talked with Resident #5 and the resident wanted to get up to play bingo, and the resident was able to participate. The DON stated the resident required to participate in activities prevented the loss of social interaction, decreased the quality of life, and isolation or depression.</p> <p>In an interview on 11/07/24 at 12:34 PM with RN B, she stated she had not observed Resident #5 being involved in any activities and had not seen the Activity Director completing any in-room activity with the resident. The resident was at risk of isolation, depression if she was not completing any activity.</p> <p>Review of the facility policy, undated and titled activity program calendar reflected, The Activity Director and staff will inform residents, staff, family, visitors, and volunteers of a monthly program schedule, utilizing Calendars, daily announcements, and personal invitation. 6. Individual programs are scheduled for those residents who cannot or choose not to attend group programs.</p> <p>A. This schedule reflects days and frequency of each resident's individual program.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>45053</p> <p>Based on observation and interview, and record review, the facility failed to maintain an environment as free of accident hazards as is possible for 4 of 4 areas (1 storage room and 2 shower rooms and 1 activity room), reviewed for accidents and hazards.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure that the mechanical lift (Mechanical lifts are devices used to assist with transfers and movement of individuals who require support for mobility beyond the manual support provided by caregivers alone) in the Activity Room was locked and secured when not in use. 2. The facility failed to ensure that the sit-to-stand lift (a device that helps move a resident from a seated position to a standing position) in the Activity Room was locked and secured when not in use. 3. The facility failed to ensure that the Shower Room door on Station 1 was locked and secured. 4. The facility failed to ensure that the Shower Room door on Station 2 was locked and secured. 5. The facility failed to ensure that the door to the Medical Supply Storage Room on Station 1 was locked and secured. <p>These failures could place residents at risk of accidents, injury, or consuming hazardous personal care products.</p> <p>Findings Include:</p> <p>Observation of the facility's Shower Area on Station 1 on 11/06/24 at 9:50 AM, revealed that there was not an exterior lock on the door. The door was observed ajar and was not locked and secured. Upon entry into the Shower Room, there was a wooden cabinet with a hole for a lock, but the lock was not on the wooden cabinet. Inside of the wooden cabinet were the following items: 1 open bottle labeled, Cleanser for shampoo and body wash. 1 container of deodorant, 2 bottles of shaving cream (1 bottle was open), 1 container of mouthwash, 1 container of Vaseline petroleum jelly, 1 rubber band and 1 unlocked master lock.</p> <p>An observation of the facility's Shower Area on Station 2 on 11/06/24 at 10:01 AM, revealed there was an exterior keypad on the door, but the door was not locked and secured. Upon entry into the Shower Room, there was a wooden cabinet with a hole for a lock, but the lock was not on the wooden cabinet. Inside of the wooden cabinet were the following items: 3 razors, 1 hair clipper, 1 beaded necklace, 1 box of denture cleanser tablets (90 tabs), 1 package of 25 pack lemon glycerin swab sticks. On the floor in the shower room was an open bottle of 1 gallon of Total Bath and Skin and Hair Cleanser.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with LVN C on 11/06/24 at 10:13 AM, she stated that she had been employed at the facility for 1 month. LVN C was escorted to the Shower Area on Station 2 and informed about the findings in the Shower Room. She stated that the open bottle of 1 gallon of Total Bath and Skin and Hair Cleanser on the floor was used by staff during the evening shift the day before. She stated that she was the charge nurse on Station 2 but had not perform walkthroughs of the Shower Room areas during her shift. She stated that staff have been educated and trained on in-services regarding safety and the bottle of 1 gallon of Total Bath and Skin and Hair Cleanser on the floor should have been sealed and stored in a safe area to prevent ingestion. She stated that the razors in the wooden closet should have been locked and secured to prevent injury. She stated that she felt that there were not any risks to residents being hurt or harmed because of the wooden closet where the 3 razors were located. She stated that there were not any risks for any residents to ingest the open bottle of 1 gallon of Total Bath and Skin and Hair Cleanser on the floor because the facility currently does not have any residents that are confused and disoriented.</p> <p>Observation of the facility's Medical Supply Storage Room on Station 1 on 11/06/24 at 3:20 PM, revealed that the door had a keypad, but was ajar and was unlocked. Upon entry into the Medical Supply Storage Room, there were four metal racks that had medical supplies. The medical supplies observed included several boxes of lancets, and syringes, supplies for tube feeding, gastrostomy tubes and tracheostomy tubes and other medical liquids. , such as intravenous (IV) fluids, saline solutions, antiseptic solutions, sterile irrigation fluids, topical medications, and cleaning solutions.</p> <p>In an Interview with LVN C on Station 1 on 11/06/24 at 3:28 PM, she was informed about the door to the Medical Supply Storage Room being opened. She stated, Did you leave the door open? LVN C was told that the door to the Medical Supply Storage Room was already open. LVN C stated that the door to the Medical Supply Storage Room was not supposed to be open and unsecured to prevent a resident from having access to the items in the room and possibly hurting or harming themselves.</p> <p>Observation of the facility's Activity Room on 11/06/24 at 3:39 PM, revealed an unlocked and unsecured mechanical lift parked against the wall adjacent to the entryway of the Activity Room.</p> <p>Observation of the facility's Activity Room on 11/06/24 at 3:41 PM, revealed an unlocked and unsecured sit-to-stand lift parked against the wall adjacent to the entryway of the Activity Room.</p> <p>In an interview with LVN G on 11/06/24 at 3:52 PM, revealed that they had several residents on the unit's Station 2 that required usage of the mechanical lift and the sit-to-stand lift for assistance. LVN G stated that she was unaware that the mechanical lift and sit-to-stand lift were unlocked. She stated that both devices were supposed to be locked when not in use. She stated that all staff and the facility have been trained via in-service training on safety and locking both devices when not in use. She stated that the risks of both devices being unlocked when not in use can cause injury to any resident who tries to lift up on either device. LVN G stated that a resident can sustain an injury including a fracture if the devices were not locked when not in use.</p> <p>Observation of the facility's Medical Supply Storage Room on Station 1 on 11/06/24 at 4:03 PM, revealed that the door was ajar and was unlocked.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with the DON on 11/06/24 at 4:11 PM, revealed that all equipment including mechanical lifts and wheelchairs were to be locked and always secured. The DON revealed that everyone was responsible for ensuring safe storage and maintenance of all facility equipment. She stated that the staff have been in-serviced on safety, accidents, and abuse and neglect. She stated that staff have been told on several occasions that if they see something, such as the mechanical lifts and sit-to-stand lifts not secured, they were to lock and secure them and report what they observed to management. The DON revealed that razors were to be kept in a secured area, which means they were to be always locked and never to be kept in an unlocked compartment. She reported that Station 1 currently does not have any residents and only Station 2 is occupied with residents. She stated that she was unaware that both Shower Rooms on Station 1 and Station 2 were unlocked with the doors ajar. She stated that the door lock for Shower Room in Station 2 sometimes does not lock. She stated that there is a piece on the inside of the door if hit will cause the door not to lock. She stated that she would speak with the Maintenance Director to repair the locks for the doors for the Shower Rooms on Station 1 and Station 2, and the Medical Supply Storage Room. She revealed that risks of improperly storing equipment could be residents potentially cutting or injuring themselves. She stated that the harm of having any liquids not stored properly could be the resident ingesting the liquid which will lead to sickness and possibly death. The DON stated that no liquids should be stored on any floors in the facility and should be locked and always secured. She stated that if supplies in the Shower Rooms and Medical Storage Supply Room areas were accessible to a resident, they could harm themselves by hurting themselves, or someone else such as another resident or staff. She stated that access to a sharp instrument can possibly cause death.</p> <p>On 11/07/24 at 3:20 PM, a request was made to the facility's for policies related to mechanical lifts, sit-to-stand lifts, razor blade storage and accidents and hazards. On 11/07/2024 at 3:27 PM, received policies for hydraulic lifts and the policies did not reflect any pertinent information. The facility did not provide a policy related to mechanical lifts, sit-to-stand lifts, razor blade storage and accidents and hazards.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193</p> <p>Based on observation, interview and record review, the facility failed to provide treatment and services to prevent complications of enteral feeding for one of one resident (Resident #5) reviewed for feeding tubes.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure LVN B flushed Resident #5's G-Tube with 30 cc of water prior to the medication administration per physician's orders. 2. The facility failed to ensure LVN B flushed Resident #5's G-Tube with 10 cc of water in between each medication. 3. The facility failed to ensure LVN B checked Resident #5's G-Tube placement and residual (the process of aspirating (drawing out) a small amount of fluid from the stomach through the feeding tube to measure the volume of liquid remaining in the stomach) during medication administration. <p>These failures could affect residents by placing them at risk of abdominal discomfort and obstruction of the G-tube.</p> <p>Findings included:</p> <p>Record review of Resident #5's face sheet dated 11/07/24 reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #5's active diagnoses included respiratory failure, dysphagia (difficulty swallowing), muscle weakness, gastrostomy status (surgical opening in the abdomen that provides a route for feeding or draining the stomach), lack of coordination, hypertension (chronic condition where the pressure of blood in your arteries is consistently too high)</p> <p>Record review of Resident #5's Physicians Order Report dated 11/07/24 with order date of 10/24/24 reflected, Flush feeding tube with 30 ml of water before and after feeding and medication administration. Flush tube feeding with 10 ml of water between each medication.</p> <p>Observation on 11/05/24 at 07:51 AM and 09:36 AM revealed RN B administering the following medications via the G-Tube to Resident #5: tramadol 50 mg 1 tablet, acetazolamide 250 mg, cetirizine 10 mg, One-day vitamin, gemtesa 75 mg, Vitamin B-6 50mg. RN B crushed the medications on the medication cart in different medication cups. RN B then proceed to Resident #5's room and paused the feeding tube. Then RN B disconnected the G-Tube feeding from the pump machine. RN B then mixed the medications in each medication cup with 5-10 cc of water. RN B then proceeded to administer the medications without flushing the G-Tube, she did not check for placement or check for residual before medication administration.</p> <p>(continued on next page)</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 11/05/24 at 08:08 AM with RN B, she stated she checked the residual by placing the open syringe on the g-tube and if there was nothing coming out then the resident did not have residual. RN B was asked if that was the right procedure for checking residual, and she stated that was how she checked for residual. RN B stated she did not check for placement and flush before medications administration. RN B stated she did not flush in between medications because there was no order to flush in between medications. RN B stated she would check the orders for the flushes.</p> <p>In an interview on 11/06/24 at 04:37 PM with the DON, she stated she talked with RN B regarding G-Tube medication administration, and she noted she had made some mistakes. The DON stated she expected RN B to follow the physician's orders by flushing before and after medication administration and she was supposed to flush in between medications. The DON stated RN B was supposed to check the resident's G-Tube for placement and residual before medication administration. The DON stated she had in-serviced the nurses on the right way to administer medication administration. The DON stated the staff were to follow the physician's orders and facility policy during G-Tube medication administration to prevent complications like the G-Tube clogging and aspiration (When food, liquid, or other material is accidentally inhaled into the lungs. This can occur when swallowing or when material comes back up from the stomach.)</p> <p>In an interview on 11/07/24 at 01:09 PM with RN B, she stated she was not aware of the flushing in between medications but if the order stated she was supposed to flush in-between meds, then she was expected to flush to prevent the g-tube from clogging and medication interactions. RN B stated she was expected to check the resident's G-Tube placement to confirm the g-tube was at the right place and she was supposed to check for residual G-Tube to make sure the resident was absorbing the feeding well and if she did not and she was having too much in the stomach that could lead to aspiration.</p> <p>Review of the facility policy dated 1/25/13 and titled enteral medication administration reflected, 6. Check the placement of the tube by aspiration of contents or auscultation. Elevate the resident per facility policy.</p> <p>7. Flush the tube with 30ml water or according to physician order.</p> <p>8. Administer one medication at a time with a flush of 5-10 ml water or the amount ordered by the physician, between each medication and after the final medication is administered. Verify that medication cups are clear of any remnants of crushed pills or liquid medication. Alternate fluid may be used if the facility policy and diet orders permit.</p> <p>9. Once all medications have been administered, flush the tube with 30ml water or according to physician order.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45053</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed, in that:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure food in the facility's refrigerator, was labeled and dated according to guidelines. 2. The facility failed to ensure that 2 dented cans were removed and separated from the other canned food. 3. The facility failed to seal open items in plastic bags in the dry storage pantry. 4. The facility failed to ensure that expired items in the dry storage pantry and refrigerator were removed. <p>These deficient practices could affect residents who received meals and/or snacks from the main kitchen and place them at risk for cross contamination and other air-borne illnesses.</p> <p>Findings Included:</p> <p>Observation of the kitchen during the brief initial tour of the kitchen on [DATE] at 7:21 AM, revealed that inside the large refrigerator were 3 clear plastic containers of watermelon, 2 clear plastic containers of apple sauce, 1 clear plastic container of grated cheese and all items were not labeled and dated. The refrigerator also contained 1 clear plastic container with a yellow liquid substance which was not labeled and dated. There were also 5 pans of cheesecake that were not sealed and were exposed to air in the refrigerator. Inside the second refrigerator, there was an opened box with 6 Activia Low Fat Yogurt (3 strawberry and 3 peach) 4 ounce containers with an expiration date of [DATE] on each yogurt container. The label on box reflected, an expiration date of [DATE]. The dry storage pantry revealed 3 Twist Lemonade packages with an expiration date of [DATE]. There was an open package of 2.75 oz of Lemon Gelatin Mix, a box of 22 packages of Hidden Valley Ranch which included 15 packages that expired on [DATE]. There were 2 packages of [NAME] Italian Pasta and both packages were open and were not sealed and exposed to air. There was 1 package of the [NAME] Italian Pasta that had a hole in the bottom of the bag . There was 1 package of [NAME] Pasta 10 lb. bag that was not sealed and exposed to air. There were 4 packages of Pioneer Complete Cornbread Mix 5 lb. bags that were dated [DATE] . There was a 6 pack of V8 Vegetable Juice with an expiration date of [DATE] . There was 1 package of 16 oz. Snowflake shredded coconut that was open, unsealed and exposed to air. There was 1 package of 16 oz. [NAME] Cornstarch that was open, unsealed and exposed to air . In the dry storage area, there were 2 dented 15 oz. cans of dark red kidney beans on the shelf with the other canned goods.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with the [NAME] F on [DATE] at 7:45 AM, she was informed about the dented cans in the kitchen. She stated that the Dietary Manager was responsible for storing the canned goods in the dry storage pantry area. She stated that she did not observe the two dented 15 oz. cans of dark red kidney beans on the shelf in the dry storage pantry. She stated that the dented cans were to be separated and placed in a separate area for the dented cans. She stated that the risk of a resident possibly ingesting foods from a dented can could cause the resident to become sick and ill.</p> <p>In an Interview with the Dietary Manager on [DATE] at 8:15 AM, he stated that it was his responsibility to ensure that there were not any dented cans in the dry storage area with the other canned goods. He stated that he has a routine of checking the dry storage area to ensure that everything is labeled, dated and that there were not any dented cans on the shelf with the other canned goods. He stated that during his routine of checking the dry storage and refrigerator, he will also ensure that there are not any expired food or beverages in both areas. He stated that the risks of expired items being in the dry storage and refrigerators is that giving a resident expired food can cause the resident to become sick and ill and that he would not like to ingest any food that was expired. He stated that if food is not properly sealed, it could cause air-borne illness to occur and can get the residents who eat the food at the facility sick. He stated that he recently received a shipment of the Twist Lemonade from his vendor. He stated that the vendor delivered the items, and they were expired. He reported that he signed the shipment from the manufacturer for the delivery.</p> <p>In an Interview with the Administrator on [DATE] at 1:15 PM, he was informed about the findings in the kitchen during the initial tour of the kitchen. He stated that he was surprised to hear about the findings in the kitchen because he recently conducted a Mock Survey prior to the visit to the facility and he did not have any concerns. He stated that the residents, himself and staff have eaten from the kitchen, and no one has gotten sick from the food, and he had not received any reports from anyone regarding the food that is served from the kitchen. He stated that the risk to anyone that eats food from the kitchen can cause them to get sick, if they were to eat any expired food from the kitchen.</p> <p>Record review of the facility's undated policy, Food and Storage Sanitation .Dented or otherwise damaged cans will not be used. Once identified, dented cans should be stored in a separate area of the storeroom to be returned to vendor or discarded.</p> <p>Record review of the facility's undated policy, Food Storage and Dry Storage Supplies, revealed,</p> <p>4. Open packages of food are stored in closed containers with covers or in sealed bags, and dated as to when opened .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. When items are received from the vendor, they should be first examined for expiration date, and if an expiration date is present, it is beneficial to mark it by circling it so it is readily visible and noticeable. It is important to distinguish between an expiration date and a production date, or a best by or use by date. Production dates indicate when the product was manufactured, not when it expires, and should not be interpreted as a best by or use by date. Best by or use by dates indicate when a product will have best flavor or quality and are not an indicator of the product's safety. As the quality may deteriorate after the date passes, the dietary manager should closely inspect any products that are past the best by date to determine if they are still good quality. If in doubt, discard the product. If any stamped date is unclear, contact the food vendor for clarification. If an item does not have a date designated by the manufacturer as an expiration date, then the item should be dated as to when it is received, and shelf-stable items will be stored in a first in, first out manner, to be used within one year. After one year, any product that is shelf stable will be inspected by the dietary manager to ensure that it is good quality before it is used. Any product with a stamped expiration date will be discarded once that date passes.</p> <p>7. According to the USDA fact sheet on Food Product dating, product dating on manufactured goods is not required by federal regulations except baby formula. For this reason, products without a dated shipping label should be dated when they are received by the facility so there is a method to keep track of the age of the product. These dates do not indicate that the product is no longer safe after one year, but give a method to track the age of a product so that it can be evaluated for quality before service.</p> <p>8. On perishable foods, microorganisms such as molds, yeasts, and bacteria can multiply and cause food to spoil. Spoiled foods will develop an off odor, flavor or texture due to naturally occurring spoilage bacteria. If a food has developed such spoilage characteristics, it should not be eaten. There are two types of bacteria that can be found on food: pathogenic bacteria, which cause foodborne illness, and spoilage bacteria, which causes foods to deteriorate and develop unpleasant characteristics such as an undesirable taste or odor making the food not wholesome, but do not cause illness. Perishable foods have been processed/treated and sealed to eliminate pathogenic bacteria, but spoilage bacteria can multiply and this is what causes the food to deteriorate in quality and taste. If perishable food items are not stored at the proper temperature, spoilage bacteria can grow faster than anticipated and food becomes spoiled and should not be served. Food items such as loaves of bread or dairy products with a stamped best-by or use by date do not need to be labeled when opened as this will not affect the date by which they should be used. However, if possible food spoilage is observed prior to the best by date, the product will be discarded.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>9. Perishable and non-perishable foods are classified based on their pH and water content Food manufacturers must determine whether their products meet the perishable criteria when determining whether they are required to declare expiration dates according to the Food and Drug Administration which regulates their manufacturing processes. If a manufacturer is not required to declare an expiration date, then that means that time is not a criteria in determining whether the product is safe to consume. Non-perishable foods meet the criteria in the Texas Food Establishment rules for classifying foods as non-time and temperature controlled for safety foods (NTCS). NTCS foods do not use time or temperature as a criteria for determining food safety. These non-perishable foods are still dated when received if they do not have an expiration date and once opened, but do not need to be discarded within 7 days after opening. Perishable items that are refrigerated are dated once opened and used within 7 days (if they do not have an expiration date or best by/use by date), but non-perishable items that are refrigerated once opened should be dated when opened but do not need to be discarded until their expiration date or until the quality has deteriorated .</p> <p>Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S , d+[DATE].18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts ,d+[DATE] - ,d+[DATE].</p>

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45053</p> <p>Based on interview and record review the facility failed to ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, for 1 of 6 residents (Resident #11) reviewed for hospice services.</p> <p>The facility did not update Resident #11's care plan to reflect that she was on hospice.</p> <p>This failure could place residents at risk for not receiving appropriate care and intervention to meet their current needs.</p> <p>The findings were:</p> <p>Record review of Resident #11's Face Sheet, dated 11/07/24, revealed that she was a [AGE] year-old male with an initial admitted to the facility of 06/08/23 and readmitted to the facility on [DATE]. Resident #11's active diagnoses included: dysphagia (difficulty swallowing), dementia, behavioral disturbance, psychotic disturbance, anxiety, hyperthyroidism (occurs when the thyroid gland produces too much thyroid hormones), hyperlipidemia (a condition where there are abnormally high levels of lipids in the blood), and heart failure.</p> <p>Record review of Resident #11's MDS dated [DATE] revealed she had a BIMS score of 11/15 indicating a moderate cognitive impairment. Section O - Special Treatments, Procedures, and Programs revealed no documentation of for Hospice Services.</p> <p>Record review of Resident #11's Hospice Binder revealed a Hospice Contract starting Hospice Services with [Hospice Company] on 09/20/24.</p> <p>Record Review of Resident #11's Physician Order revealed that Resident #11 was to begin on hospice services on 09/20/24.</p> <p>Record review of Resident #11's progress notes reflected: Hospice Care Changes. 09/20/24 .</p> <p>Record review of Resident #11's Significant Change MDS dated [DATE] revealed she had a BIMS score of 6/15 indicating a severe cognitive impairment. Section O - Special Treatments, Procedures, and Programs revealed that Resident #11 had Hospice Care while a resident at the facility.</p> <p>Record review of Resident #11's Care Plan, no date indicated, did not reveal that she was on hospice.</p> <p>In an interview with Resident #11 on 11/05/2024 at 2:11 PM, she stated that she had been at the facility for almost a year. Resident #11 stated that she had dementia and was forgetful at times. She stated that she was currently on hospice and had someone from the hospice come visit her on a regular basis.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the ADON on 11/05/2024 at 2:11 PM she confirmed that Resident #11 was on hospice and receives hospice services. She stated that she was not sure why Resident #11's care plan did not reflect that she received Hospice Services. She stated that the risk of Resident #11's Care Plan not reflecting that she is on Hospice can affect the care she receives from staff at the facility.</p> <p>In an interview with the DON on 11/06/2024 at 4:11 PM, revealed that she was not aware that Resident #11's Care Plan reflects that she was not on Hospice. She stated that Resident #11 started hospice services on 09/20/24. She stated that she was responsible for updating Resident #11's Care Plan to reflect that she is on hospice. She stated that she has several residents to update information for and that the revision and update of Resident #11's Care Plan, must have fell through the cracks. She stated that she is responsible for updating each resident's Care Plan. She stated that the risk of Resident #11's Care Plan not being updated to reflect that she is on Hospice can affect the care she receives from staff. She stated that if a resident, such as Resident #11 is on hospice, the residents care is provided by the hospice company, and they are notified of any changes if they occur with the residents.</p> <p>A record review of the facility's undated policy, Comprehensive Care Planning reflected:</p> <p>The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The comprehensive care plan will describe the following -</p> <p>-The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .</p> <p>Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.</p> <p>Through the care planning process, facility staff will work with the resident and his/her representative, if applicable, to understand and meet the resident's preferences, choices and goals during their stay at the facility. The facility will establish, document and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. Care planning drives the type of care and services that a resident receives.</p> <p>Care plans will be person-centered and reflect the resident's goals for admission and desired outcomes. Person-centered care means the facility focuses on the resident as the center of control, and supports each resident in making his or her own choices. Person-centered care includes making an effort to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident's life before coming to reside in the nursing home.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Residents' goals set the expectations for the care and services he or she wishes to receive. Measurable objectives describe the steps toward achieving the resident's goals, and can be measured, quantified, and/or verified.</p> <p>The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented.</p> <p>When developing the comprehensive care plan, facility staff will, at a minimum, use the Minimum Data Set (MDS) to assess the resident's clinical condition, cognitive and functional status, and use of services.</p> <p>If a Care Area Assessment (CAA) is triggered, the facility will further assess the resident to determine whether the resident is at risk of developing, or currently has a weakness or need associated with that CAA, and how the risk, weakness or need affects the resident. Documentation regarding these assessments and the facility's rationale for deciding whether or not to proceed with care planning for each area triggered will be recorded in the medical record.</p> <p>There may be times when a resident risk, weakness or need is identified within the context of the MDS assessment, but may not cause a CAA to trigger. The facility will address these areas and will document the assessment of these risks, weaknesses or needs in the medical record and determine whether or not to develop a care plan and interventions to address the area. If the decision to proceed to care planning is made, the interdisciplinary team (IDT), in conjunction with the resident and/or resident's representative, if applicable, will develop and implement the comprehensive care plan and describe how the facility will address the resident's goals, preferences, strengths, weaknesses, and needs.</p> <p>In situations where a resident's choice to decline care or treatment (e.g., due to preferences, maintain autonomy, etc.) poses a risk to the resident's health or safety, the comprehensive care plan will identify the care or service being declined, the risk the declination poses to the resident, and efforts by the interdisciplinary team to educate the resident and the representative, as appropriate. The facility's attempts to find alternative means to address the identified risk/need should be documented in the care plan.</p> <p>In addition to addressing preferences and needs assessed by the MDS, the comprehensive care plan will coordinate with and address any specialized services or specialized rehabilitation services the facility will provide or arrange as a result of PASARR recommendations. If the IDT disagrees with the findings of the PASARR, it will indicate its rationale in the resident's medical record. The rationale should include an explanation of why the resident's current assessed needs are inconsistent with the PASARR recommendations and how the resident would benefit from alternative interventions. The facility should also document a resident's the resident's preference for a different approach to achieve goals or refusal of recommended services.</p> <p>Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The comprehensive care plan will address a resident's preference for future discharge, as early as upon admission, to ensure that each resident is given every opportunity to attain his/her highest quality of life. This encourages facilities to operate in a person-centered fashion that addresses resident choice and preferences.</p> <p>Comprehensive Care Plans</p> <p>A comprehensive care plan will be-</p> <p>Developed within 7 days after completion of the comprehensive assessment.</p> <p>Prepared and/or contributed to by an interdisciplinary team .Prepared and/or contributed to by an interdisciplinary team .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>37193</p> <p>Based on observations, interviews, and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 4 (#85, #5,#24, & #8) of 8 residents observed for infection control.</p> <ul style="list-style-type: none"> - The facility failed to ensure RN B cleaned the glucometer in between each resident's use. - The facility failed to ensure LVN C disinfected the blood pressure cuff in between each resident's blood pressure checks. <p>These failures could place residents at risk for infection and cross contamination of pathogens and illness.</p> <p>Findings included:</p> <p>Observation on 11/06/24 at 07:35 AM revealed RN B getting a glucometer machine from the medication cart and proceeded to Resident #24 and checked her blood sugar. After checking the resident's blood sugar RN B placed the glucometer on top of the medication cart, took off gloves her and completed hand hygiene. RN B documented and proceeded to administer the resident's medication. After administering Resident #24's medications RN B proceeded to Resident #5's room. RN B got the same glucometer she had used that was on top of the medication cart, put on gloves and proceeded to Resident #5's room and checked her blood sugar. After checking the blood sugar RN B returned to the medication cart and placed the glucometer machine on top of the medication cart and did not clean and glucometer. RN B took off her gloves, completed hand hygiene and administered insulin to Resident #5. After she was done with Resident #5, RN B proceeded to Resident #85's room. RN B checked the resident's blood sugar with the same glucometer that she had not cleaned between the residents. After she checked the resident's blood sugar, she did not clean the glucometer machine and then placed the glucometer machine in the cart.</p> <p>In an interview on 11/06/24 at 08:15 am with RN B she stated she was supposed to clean the glucometer in between resident use, but she forgot. She stated she was supposed to clean the glucometer to prevent cross contamination. She stated had an in-service on infection control about 1 week ago.</p> <p>Observation on 11/05/24 at 08:40 AM revealed LVN C checking Resident #27's blood pressure then administered the resident's medication, LVN C did not clean the blood pressure machine. LVN C completed hand hygiene after medication administration and proceeded to Resident # 8's room and with the same blood pressure machine checked the resident's blood pressure. After checking the blood pressure LVN C did not clean the blood pressure machine. LVN C then proceeded to Resident #20's room and used the same blood pressure machine to check the residents blood pressure. LVN C was observed using the blood pressure machine and did not clean in between resident use.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/05/25 at 09:18 with LVN C regarding cleaning the blood pressure machine between resident's use, LVN C stated she was no longer required to clean the blood pressure machine between the residents LVN C stated staff were only required to clean the blood pressure machine during a covid out break and since there were no cases of covid she did not need to clean the blood pressure machine between residents use.</p> <p>In an interview on 11/06/24 at 04:37 PM with the DON she stated she started re-educating the nurses on 11/05/24 on making sure the glucometer machine and blood pressure machines were cleaned in between resident use to prevent contamination from one resident to another. The DON stated she expected the staff to clean any shared machines/equipment used with multiple residents due to infection control.</p> <p>Review of the facility policy titled infection control policy and procedure manual 2019 reflected, .Resident care equipment and articles.3. Non-invasive resident care equipment is cleaned daily or as needed between use . Equipment that is visibly with blood or body fluids will be cleaned immediately with an approved disinfectant .</p>