| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675948 | A. Building<br>B. Wing | 11/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avir at Belton | 810 E 13th Ave<br>Belton, TX 76513 |

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 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(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 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 6 residents (Resident #1) reviewed for accidents hazards and supervision, in that: The facility failed to ensure on 10/16/2025 Resident #1 was transferred by CNA A and RN A using standing pivot transfer x 2 staff without a gait belt. During transfer Resident #1 became too heavy for CNA A and RN A and Resident # 1 was lowered to the floor causing Resident # 1 knees to be in a bent position while sitting on the floor. Resident #1 was sent to the hospital and diagnosed with a displaced periprosthetic distal Femoral fracture (broken thigh bone near a hip implant that has shifted out of position) The non-compliance was identified as past noncompliance (PNC). The noncompliance began on 10/16/25 and ended on 10/27/2025. The facility had corrected the noncompliance before the investigation began. This failure could place residents at risk of falls with injuries. Findings include: Record review of Resident # 1's face sheet revealed a 91-year -old female admitted to the facility on [DATE] with readmission on [DATE]. Her diagnoses include Muscle Weakness (Generalized) (a lack of muscle strength or the inability to control voluntary muscle force), Lack of Coordination (condition that affects the ability to control and execute smooth, and precise movements), restless leg syndrome (disorder characterized by irresistible urge to move the legs), acute respiratory failure and mild cognitive impairment. Record review of Resident # 1's change of condition MDS assessment dated [DATE], reflected a BIMS of 11(moderate cognitive impairment). Section GG reflected Resident #1 required partial/moderate assistance with transfers. Record review of Resident #1's Care Plan dated 7/28/2025 reflected Resident #1 required staff assistance with transfers and staff to provide assistance using a gait belt, if physical assistance needed for transfers. Resident#1 was at risk for falls due to unsteady gait, lack of coordination, CVA, mood decline, restless leg syndrome, muscle weakness, altered respiratory status, decreased balance, medications, and poor safety awareness. Record review of Resident #1's Kardex on 10/28/2025 reflected Resident #1 required 2-person physical assistance using gait belt for transfers. Record review on 10/28/2025 of the administrator's investigation report (not dated) reflected on 10/16/2025 around 8:30PM RN A and CNA A assisted Resident #1 to the floor while attempting to transfer Resident #1 from bed to wheelchair. RN A noted Resident #1 knees were in a bend position while sitting on the floor and CNA A held her up while RN A went to get assistance from CNA B because the resident was too heavy for a 2-person transfer. CNA B stated he assisted RN A and CNA A in transferring Resident #1 from the floor into the wheelchair. CNA A and CNA B stated Resident #1 did not scream in pain. After the accident Resident #1 complained of knee pain and stated, knees are broken, and she can never walk around again due to her being placed on the ground. Record review of medication administration revealed Resident #1 was given Hydrocodone-Acetaminophen 7.5-325 mg tablet on 10/16/2025 for complaint of generalized pain of 7 out of 10. Record review of nurse note dated 10/17/2025 at 1:15PM from RN A revealed she called Resident #1's hospice care team to request an x-ray which was denied but stated they would notify her case manager. Nurse A notified the on-call physician and obtained an order for stat x-ray, which was done onsite at the facility. Nurse A contacted Resident #1's responsible party to inform them of the incident and the party responsible requested Resident #1 be sent to the Hospital Record review of the radiology report dated 10/17/2025 on 3:53AM confirmed the right knee had a displaced periprosthetic distal femoral fracture. Record review of hospital records revealed, Resident # 1 was admitted on [DATE] with displaced right periprosthetic distal femoral fracture. On 10/18/2025 Resident #1 received Intramedullary rod to right femur. Resident #1 was discharged home on [DATE]. Record review of CNA A's interview with the ADON and DON dated 10/17/2025 revealed CNA A and Nurse A each lifted Resident #1 under each arm to transfer Resident #1 from the bed to her wheelchair and then when they were unable to transfer Resident #1 they sat her back on the bed to regroup and try again. They again tried to transfer Resident #1 by standing her up and holding her brief with one hand and another arm under her arm. They were unable to turn her safely, so they sat her gently on the floor. In an interview with CNA B on 10/28/2025 at 12:11 PM, he stated that he walked into Resident #1's room to assist RN A and CNA A with transferring Resident #1 from the floor to the wheelchair. He and CNA A each lifted Resident #1 under the arm and RN A lifted her legs. They placed Resident #1 in the wheelchair, and she did not complain of pain at that time. He stated they did not use a gait belt. He stated that's where we messed up. We should have used a gait belt for her (Resident #1) transfer. He stated that it was documented in Resident #1 Kardex and care plan to use a |