STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675948	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Belton	810 E 13th Ave 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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure prompt resolution of grievances regarding the resident's right to file a grievance for 4 of 4 residents (Resident #1, Resident #2, Resident #3 and Resident #4) reviewed for grievances.The facility failed to notify residents in writing of the findings and actions of the grievances they filed. This failure could affect resident's right to a written decision regarding the resolution of their grievance.Findings Included:1. Record review of Resident #1 face sheet, dated 04/29/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included vascular dementia (lack of blood that carries oxygen and nutrients to a part of the brain), type 2 diabetes mellitus with unspecified complications (high blood sugar), morbid obesity, Alzheimer's disease (progressive disease that destroys memory and other important mental function), and heart failure. Record review of Resident #1's admission MDS assessment, dated 03/01/2026, reflected Resident #1 had a BIMS score of 06, which indicated severe cognitive impairment. Record review of Resident #1's physician orders, dated 2/27/2026, reflected Quetiapine Fumarate Oral Tablet 25mg (Quetiapine Fumarate) Give 1 tablet by mouth at bedtime for Sundowning. Record review of Resident #1's MAR reflected Quetiapine Fumarate Oral Tablet 25mg (Quetiapine Fumarate) Give 1 tablet by mouth at bedtime for Sundowning (increased confusion, agitation and restlessness typically occurs in the afternoon) was scheduled to be given at 8:00p.m. The MAR also revealed staff did not give Resident #1 her Quetiapine Fumarate Oral Tablet 25mg until 10:03p.m. on 2/27/2026. Record review of Resident #1's Care Plan, dated 03/08/26, reflected [Resident #1] had impaired cognitive function and impaired thought processes related to Alzheimer's, vascular dementia. Interventions were: Administer medications as ordered. Monitor/document for side effects and effectiveness. During an interview with FM of Resident #1 on 04/29/2026 at 2:45 p.m., revealed the facility was not giving Resident #1 her sundowning medication on time. He said there were times when Resident #1 would not get her medication until 10:00 p.m. or 11:00 p.m., and the medication would not be affected. 2. Record review of Resident #2 face sheet, dated 04/29/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included type 2 diabetes mellitus without complications (high blood sugar), morbid obesity, respiratory failure, hypertension (high blood pressure), cognitive communication deficit (problems with communication), and difficulty in walking. Record review of Resident #2's admission MDS assessment, dated 03/02/2026, reflected Resident #2 had a BIMS score of 99, which indicated unable to complete the interview. The MDS also reflected Resident #2 required supervision or touching assistance for showers. Record review of Resident #2's Care Plan, dated 04/03/26, reflected [Resident #2] had a seizure disorder. Interventions were Give seizure medication as ordered by doctor. Monitor/document side effects and effectiveness. [Resident #2] required assistance with ADLs related to traumatic brain injury, and chronic respiratory failure. Interventions were: Provide extensive assistance of one staff with bathing/showering. Provide showers/bathing per schedule and PRN. Record review of Resident #2's MAR revealed levetiracetam oral tablet 2000 mg given by mouth twice a day for seizures was scheduled to be given at 8:00 a.m. (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
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MAR also reflected staff did not give Resident #2 her levetiracetam oral tablet 2000 mg until 12:56 p.m. on 04/26/2026. Record review of Resident #2's shower log, dated April 2026, reflected Resident #2 did not get her showers on 04/04/2026, 04/09/2026, 04/14/2026, 04/18/2026, 04/23/2026, 04/25/2026 and 04/28/2026. During an interview with Resident #2 on 04/30/2026 at 2:04 p.m., she said she was not getting her seizure medication on time. she said there were times she would not get her morning medication until the afternoon. She said the staff were always late giving her medication. She said she still was not getting her showers regularly. She said she had asked staff for her shower and she never got it. She said she wanted her showers regularly. She said she did not feel good when she could not take a shower. 3. Record review of Resident #3 face sheet, dated 04/29/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included paroxysmal atrial fibrillation (irregular heartbeat that comes and goes), obesity, heart failure, respiratory failure, depression (mood disorder causing a persistent feeling of sadness), chronic pain, obstructive sleep apnea (breathing pauses while sleeping), and lack of coordination. Record review of Resident #3's admission MDS assessment, dated 04/04/2026, reflected Resident #3 had a BIMS score of 15, which indicated intact cognitive response. The MDS also revealed Resident #2 required supervision or touching assistance for showers. Record review of Resident #3's Care Plan, dated 04/03/26, reflected [Resident #3] Resident is at risk for chest pains, irregular pulse, edema (Swelling) and adverse reaction related to medication due to history of cardiovascular disease. Interventions were Provide medications as ordered. Check vital signs prior to giving as ordered. [Resident #3] is at risk for skin breakdown related to decreased mobility, incontinence, equipment, and nutritional status. The resident requires staff assistance with ADL's. Interventions were Provide shower/bed bath per schedule and PRN. [Resident #3] needs assist of (1 - 2) staff to transfer with assist of wheelchair, shower chair. Once resident is stable with wheelchair/shower chair resident needs assist of 1 to 2 staff for mobility out of the room. Record review of Resident #3's MAR reflected apixaban oral tablet 5mg (Apixaban) was scheduled to be given at 8:00 a.m. The MAR also reflected that staff did not give Resident #3 his levetiracetam oral tablet 2000 mg until 01:03 p.m. on 04/15/2026. Resident #3 was also scheduled to get apixaban oral tablet 5mg (Apixaban) was scheduled to be given at 4:00 pm. Resident #3 did not get his apixaban oral tablet 5mg (Apixaban) was scheduled to be given at until 6:41 p.m. on 04/15/2026. Record review of Resident #3's shower log, dated 04/2026, reflected Resident #3 did not get his showers on 04/02/2026, 04/04/2026, 04/09/2026, 04/11/2026, 04/14/2026, 04/18/2026, 04/21/2026, 04/23/2026, 04/25/2026, and 04/28/2026. During an interview with Resident #3 on 04/29/2026 at 10:59a.m., he said staff did not give him his mediations on time. He said he mentioned it to the administrator. He said the nurse did not have time to pull out the medications and take care of the resident because the facility did not have enough staff. He said he still had not gotten a shower. He said he was around a lot of ladies and did not want to smell bad. He said a man his size would smell if not cleaned. He said he felt like there was not enough staff for to give showers regularly. 4. Record review of Resident #4 face sheet, dated 04/29/26, reflected a [AGE] year-old female who was admitted on [DATE]. Resident #4's diagnoses included Cardiomegaly (enlarged heart), hypomagnesemia (electrolyte disorder), muscle weakness, lack of coordination and heart failure. Record review of Resident #4's admission MDS assessment dated [DATE] revealed that Resident #4 had a BIMS score of 15 indicating intact cognitive response. The MDS also revealed that Resident #2 was supervision or touching assistance for showers. Record review of Resident #4's Care Plan dated 03/20/26 reflected that Resident #4 was wheelchair bound and did not have any information on showers. The care plan also said the resident required substantial to max assess of 1-2 staff with use of gate belt to move between surfaces when transferring. Record review of Resident #4's shower log revealed she did not get her showers on 04/02/2026, 04/04/2026, 04/07/2026, 04/09/2026, 04/11/2026, 04/14/2026, 04/16/2026, 04/18/2026, 04/21/2026, 04/23/2026, and 04/28/2026. During an interview with Resident #4 on 04/29/2026 at 04:24 p.m., she said she last got a shower on (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	04/25/2026. She said she had to wipe herself down to prevent herself from having skin issues. She said she wanted to take her showers regularly. She said it upset her because she could not get her showers. During an interview with CNA E on 04/29/2026 at 1:25 p.m., she said she did not feel like the facility had enough staff for the CNAs to do their job. She said the facility took away the MAs, so she had to go to CNA. She said residents complained about getting medications on time and not getting their showers. She said residents were complaining about a couple of weeks. She said she told the ADM and DON and was told to do the best they could. During an interview with LVN C on 04/29/2026 at 9:14a.m., he said he did not feel like the facility had enough staff. He said they took the MAs away and now the nurses passed medication. He said doing wound care treatments were out of the question now. He said the facility said they had someone for treatments, but he was not sure. He said he had gotten complaints about medications being late, and showers not being given. He said he told the ADM and that he was told to do the best he could. During an interview with the DON on 05/01/2026 at 11:31 a.m., she said she was trained on ADLs. She said if staff showed up for work the facility would have enough staff. She said staff would be able to get medications out on time and showers done. She said she did not have the staff willing to do the work. She said she got complaints about showers, and she handled the complaints at that time. She said residents complained with medication being late and she would try to help the nurse and see what was going on. She said they were not getting a lot of grievances on showers or medications because most of them went directly to her. She said the ADON and the DON monitored to ensure the staff were doing their job. She said they checked the MAR and shower logs and other reports. She said she did not know why residents were not getting their showers she said it was just the aides. She said she did not know why the nurses could not get medication to the residents on time. She said with two nurses and three CNA's for 60 residents was do-able. During an interview with the ADM on 05/01/2026 at 1:27 p.m., she said the policy was to have adequate staff to take care of the residents. She said the ADM was responsible for ensuring there were staff who could provide for the resident. She said she felt like the facility hired enough staff and the staff did not show up and administration had to step in. She said the facility had an increase in the last month in grievances. She said she had not received anything outside of showers on the grievances. She had not received anything as far as medication grievances, but residents told her their medications had been late. She said the facility was hiring more staff. She said the facility was going to bring back the MA position. She said the ADM and the DON monitored to ensure staff were showing up and doing their job through staffing sheet, and a chat group that was used when someone called in. She said she had let corporate know about the staffing issue. She said they were hiring but people were not coming back. She said residents were not getting showers and medication on time because everyone needed to be responsible and do their job. During an interview with the Corporate Nurse on 05/01/2026 at 12:42p.m., revealed she had been trained on ensuring the facility had enough staff. She said the policy was staffing was based on what the residents' needs were such as how many residents needed assistance with dinging, how many tracheostomy, gastrostomy tubes, and a resident's level of care. She said she felt like the facility had enough staff to provide for the needs of the residents. She said she knew the building had been experiencing an increase in problems. She said the administrator and the DON were responsible for ensuring the staff were getting the job done and there were enough staff for the residents to get the care they needed. She said if the staff were not doing their job or enough staff the residents needs will not be met. She said if the facility had staffing concerns the ADM and DON would reach out to corporate. She said the ADM and DON had not reached out to her personally. She was not sure if they had reached out to anyone in corporate office. The corporate monitored by observation and watching the labor in the building. She said they were aware of issues in the building. Record review of Grievances for April 2026 reflected six grievances about nursing services. All six complaints were regarding medications being late and some had showers not being done on them.Record review of Staffing, Sufficient and Competent Nursing Policy, dated 8/2022, reflected Our facility provides sufficient numbers of nursing (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 3 of 3 residents (Resident #2, Resident #3 and Resident #4) reviewed for quality of life.The facility failed to ensure Resident #2, Resident #3 and Resident #4 received regular showers.This failure could place residents at risk of not receiving services or care, diminished quality of life, infections, rashes, and decreased self-esteem.Findings include:1. Record review of Resident #2's face sheet, dated 04/29/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included type 2 diabetes mellitus without complications (high blood sugar), morbid obesity, respiratory failure, hypertension (high blood pressure), cognitive communication deficit (problems with communication), and difficulty in walking. Record review of Resident #2's admission MDS assessment, dated 03/02/2026, reflected Resident #2 had a BIMS score of 99, which indicated unable to complete the interview. The MDS also revealed Resident #2 required supervision or touching assistance for showers. Record review of Resident #2's Care Plan, dated 04/03/26, reflected [Resident #2] required assistance with ADLs related to traumatic brain injury, and chronic respiratory failure. Interventions were: Provide extensive assistance of one staff with bathing/showering. Provide showers/bathing per schedule and PRN. Record review of Resident #2's shower log, dated April 2026, reflected Resident #2 did not get her showers on 04/04/2026, 04/09/2026, 04/14/2026, 04/18/2026, 04/23/2026, 04/25/2026 and 04/28/2026. During an interview with Resident #2 on 04/30/2026 at 2:04 p.m., she said she still was not getting her showers regularly. She said she asked staff for her shower and she never got it. She said she wanted her showers regularly. She said she did not feel good when she could not take a shower. Resident #2 did not have an odor and appeared to be clean. 2. Record review of Resident #3's face sheet, dated 04/29/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included paroxysmal atrial fibrillation (irregular heartbeat that comes and goes), obesity, heart failure, respiratory failure, depression (mood disorder that causes a persistent feeling of sadness), chronic pain, obstructive sleep apnea (breathing pauses while sleeping), and lack of coordination. Record review of Resident #3's admission MDS assessment, dated 04/04/2026, reflected Resident #3 had a BIMS score of 15, which indicated intact cognitive response. The MDS also revealed Resident #2 required supervision or touching assistance for showers. Record review of Resident #3's Care Plan, dated 04/03/26, reflected [Resident #3] is at risk for skin breakdown related to decreased mobility, incontinence, equipment, and nutritional status. The resident requires staff assistance with ADL's. Interventions were Provide shower/bed bath per schedule and PRN. [Resident #3] needs assist of (1 - 2) staff to transfer with assist of wheelchair, shower chair. Once resident is stable with wheelchair/shower chair resident needs assist of 1 to 2 staff for mobility out of the room. Record review of Resident #3's shower log, dated 04/2026, reflected Resident #3 did not get his showers on 04/02/2026, 04/04/2026, 04/09/2026, 04/11/2026, 04/14/2026, 04/18/2026, 04/21/2026, 04/23/2026, 04/25/2026 and 04/28/2026. During an interview with Resident #3 on 04/29/2026 at 04:00 p.m., he said he still had not gotten a shower. He said he was around a lot of ladies and did not want to smell bad. He said a man his size will smell if not cleaned. He said he felt like there was not enough staff for to give showers regularly. He did not have an odor however his shirt was dirty. 3. Record review of Resident #4's face sheet, dated 04/29/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4's diagnoses included Cardiomegaly (enlarged heart), hypomagnesemia (electrolyte disorder), muscle weakness, lack of coordination and heart failure. Record review of Resident #4's admission MDS assessment, dated 03/25/2026, reflected Resident #4 had a BIMS score of 15, which indicated intact cognitive response. The MDS also revealed Resident #2 required supervision or touching assistance for showers. Record (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of Resident #4's Care Plan, dated 03/20/26, reflected [Resident #4] was wheelchair bound and did not have any information on showers. The care plan also said the resident required substantial to max assess of 1-2 staff with use of gate belt to move between surfaces when transferring. Record review of Resident #4's shower log reflected she did not get her showers on 04/02/2026, 04/04/2026, 04/07/2026, 04/09/2026, 04/11/2026, 04/14/2026, 04/16/2026, 04/18/2026, 04/21/2026, 04/23/2026 and 04/28/2026. During an interview with Resident #4 on 04/29/2026 at 04:24 p.m., she said she last got a shower on 04/25/2026. She said she had to wipe herself down to prevent herself from having skin issues. She said she wanted to take her showers regularly. She said it upset her because she could not get her showers. During an interview with CNA E on 04/29/2026 at 1:25 p.m., she said she had been trained on ADL care and resident rights. She said the policy for showers was that all residents were to get three showers a week and PRN. She said the CNAs were responsible for giving the residents their showers. She said if the residents did not get their showers regularly the resident may feel terrible. She said she got a lot of complaints from the residents about not getting their showers. She said the nurse and the DON monitored to ensure residents were getting their showers. She said the nurse and DON monitored through observations. She said some residents were not getting their showers because at one point there were only two CNA for 63 residents. She also added no residents refused their showers. She said she did not know why Resident #2, Resident #3 and Resident #4 did not get their showers regularly. During an interview with CNA G on 04/29/2026 at 1:39 p.m., she said she was trained on ADL care and resident rights. She said the policy for showers was that all residents were to get three showers a week. She said the CNAs were responsible for giving the residents their showers. She said if the residents did not get their showers regularly the resident may get a rash or infection. She said she got a lot of complaints from the residents about not getting their showers. She said if it was a resident who was assigned to her she would try to find a way to fit them in. She said the nurse and the DON monitored to ensure residents were getting their showers. She said the nurse and DON monitored through observations. She said Resident #2, Resident #3 and Resident #4 did not get their showers regularly due to the lack of staff. During an interview with CNA F on 04/29/2026 at 3:44 p.m., she said she was trained on ADL care and resident rights. She said the policy for showers was that all residents were to get three showers a week. She said the CNAs were responsible for giving the residents their showers. She said if the residents did not get their showers regularly the resident may feel awful because they could not take a shower. She said she got a lot of complaints from the residents about not getting their showers. She said she would tell the resident she would do her best to get them their shower. She said the nurse monitored to ensure residents were getting their showers. She said the nurse monitored through observations. She said Resident #2, Resident #3 and Resident #4 did not get their showers regularly because the facility did not have enough staff. During an interview with the DON on 05/01/2026 at 11:58 a.m., she said she was trained on ADLs. She said the policy was the staff should give the showers three times a week. She said depending on the resident's preference the shower should be given during the day or at night. She said it was the responsibility of the entire nursing team to ensure residents were getting their showers. She said the resident could have skin breakdown, increased wounds, or body odors if they did not get showers regularly. She said the nurse, ADON and DON monitored to ensure the staff gave the residents showers. She said the charge nurse, ADON and DON monitored by checking the residents' charts. She said she did not know why Resident #2, Resident #3 and Resident #4 were not getting their showers regularly. During an interview with the ADM on 05/01/2026 at 1:34 p.m., she said she was trained on ADLs and resident rights. She said the policy for showers was that the residents were to have showers according to their preference day; so, they had good grooming and hygiene. She said the direct care staff were responsible for providing the residents with showers. She said the residents should be getting showers three times a week. She said if the residents did not get their shower, they could become sick or not have good hygiene. She said the DON monitored to ensure residents got their showers. She said the DON monitored by (continued on next page)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, 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 3 of 3 residents (Resident #1, Resident #2 and Resident #3) reviewed for pharmacy services. 1. The facility failed to ensure medications were administered in a timely manner to Resident #1. 2. The facility failed to ensure medications were administered in a timely manner to Resident #2. 3. The facility failed to ensure medications were administered in a timely manner to Resident #3. These deficient practices could place residents at risk for adverse effects and not receiving the therapeutic effects of the medication or treatment. Findings include: 1. Record review of Resident #1's face sheet, dated 04/29/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included vascular dementia (lack of blood that carries oxygen and nutrients to a part of the brain), type 2 diabetes mellitus with unspecified complications (high blood sugar), morbid obesity, Alzheimer's disease (progressive disease that destroys memory and other important mental function), and heart failure. Record review of Resident #1's admission MDS assessment, dated 03/01/2026, reflected Resident #1 had a BIMS score of 06, which indicated severe cognitive impairment. Record review of Resident #1's physician orders, dated 2/27/2026, Quetiapine Fumarate Oral Tablet 25mg (Quetiapine Fumarate) Give 1 tablet by mouth at bedtime for Sundowning. Record review of Resident #1's MAR reflected Quetiapine Fumarate Oral Tablet 25mg (Quetiapine Fumarate) Give 1 tablet by mouth at bedtime for Sundowning was scheduled to be given at 8:00 p.m. The MAR also revealed staff did not give Resident #1 her Quetiapine Fumarate Oral Tablet 25 mg until 10:03 p.m. on 2/27/2026. Record review of Resident #1's Care Plan, dated 03/08/26, reflected [Resident #1] had impaired cognitive function and impaired thought processes related to Alzheimer's, vascular dementia. Interventions were: Administer medications as ordered. Monitor/document for side effects and effectiveness. During an interview with FM of Resident #1 on 04/29/2026 at 2:45 p.m., revealed the facility was not giving Resident #1 her sundowning medication on time. He said there were times when Resident #1 would not get her medication until 10:00 p.m. or 11:00 p.m., and the medication would not be affected. 2. Record review of Resident #2's face sheet, dated 04/29/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included type 2 diabetes mellitus without complications (high blood sugar), morbid obesity, respiratory failure, hypertension (high blood pressure), cognitive communication deficit (problems with communication), and difficulty in walking. Record review of Resident #2's admission MDS assessment, dated 03/02/2026, reflected Resident #2 had a BIMS score of 99, which indicated unable to complete the interview. Record review of Resident #2's Care Plan, dated 04/03/26, reflected [Resident #2] had a seizure disorder. Interventions were Give seizure medication as ordered by doctor. Monitor/document side effects and effectiveness. Record review of Resident #2's physician orders, dated 4/24/2026, levetiracetam oral tablet 2000 mg given by mouth twice a day. Record review of Resident #2's MAR revealed levetiracetam oral tablet 2000 mg given by mouth twice a day for seizures was scheduled to be given at 8:00 a.m. The MAR also revealed staff did not give Resident #2 her levetiracetam oral tablet 2000 mg until 12:56p.m. on 04/26/2026. During an interview with Resident #2 on 04/30/2026 at 2:04p.m., she said she was not getting her seizure medication on time. She said there were times she would not get her morning medication until the afternoon. She said the staff were always late giving her medication. 3. Record review of Resident #3 face sheet, dated 04/29/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included paroxysmal atrial fibrillation (irregular heartbeat that comes and goes), obesity, heart failure, respiratory failure, depression (mood disorder causing a persistent feeling of (continued on next page)

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	675948	A. Building B. Wing	05/01/2026

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sadness), chronic pain, obstructive sleep apnea (breathing pauses while sleeping), and lack of coordination. Record review of Resident #3's Care Plan, dated 04/03/26, reflected [Resident #3] is at risk for chest pains, irregular pulse, edema (swelling) and adverse reaction related to medication due to history of cardiovascular disease. Interventions were Provide medications as ordered. Check vital signs prior to giving as ordered. Record review of Resident #3's admission MDS assessment, dated 04/04/2026, reflected Resident #3 had a BIMS score of 15, which indicated intact cognitive response. Record review of Resident #3's physician orders, dated 03/03/2025, apixaban oral tablet 5mg (Apixaban) give 1 tablet by mouth two times a day for paroxysmal atrial fibrillation. Record review of Resident #3's MAR revealed apixaban oral tablet 5mg (Apixaban) was scheduled to be given at 8:00 a.m. The MAR also revealed staff did not give Resident #3 his levetiracetam oral tablet 2000 mg until 01:03p.m. on 04/15/2026. Resident #3 was also scheduled to get apixaban oral tablet 5mg (Apixaban) was scheduled to be given at 4:00 p.m. Resident #3 did not get his apixaban oral tablet 5mg (Apixaban) was scheduled to be given at until 6:41 p.m. on 04/15/2026. During an interview with Resident #3 on 04/29/2026 at 10:59a.m., he said staff did not give him his mediations on time. He said he mentioned it to the administrator. He said the nurse did not have time to pull out the medications and take care of the resident because the facility did not have enough staff. During an observation and interview with LVN C administering medication on 4/30/2026 at 10:47 a.m., he said he was still passing 8:00a.m. medications. Observation of LVN C at the time revealed he was still giving medications to residents. During an interview with LVN C on 04/30/2026 at 9:14 a.m., revealed he was trained on medication administration. He said the policy was medications had to be given within one hour before and one hour after the scheduled time. He said the nurses were responsible for giving the medication to the residents on time. He said if medication was not given on time the resident may have an adverse effect. He said he did not think anyone monitored to ensure medication was given timely. He said he was late passing medications due to having to take care of residents. He said he did not feel like the facility had enough staff for him to get medications out on time. During an interview with RN D on 04/30/2026 at 8:24 a.m., she said she was trained on medication administration. She said the policy was medication was supposed to be given within an hour of the scheduled time. She said the nurse was responsible for giving medication to the residents on time. She said if medication was not given timely some medication may not be affective. She said she had gotten a lot of complaints about medications being late. She said the DON monitored to ensure medication was given timely. She said the DON monitored by checking the MARs. She said medications were late because she would come in because someone called in and she would get a late start passing medications. During an interview with the DON on 05/01/2026 at 12:07 p.m., she said she was trained on medication administration. She said the policy was to give medication as ordered, no pre-popping pills, medication was to be given an hour before and an hour after to be compliant. She said the charge nurses were responsible for ensuring the residents were getting their medication on time. She said if the resident was not given their medication on time; depending on what medication it was it could make the medication not affective. She said the ADON and DON monitored to ensure the residents were getting their medication on time. She said they monitored by checking the MAR and making sure medication was given on time. She said she did not know why LVN C and RN D were not giving medications on time to residents. During an interview with the ADM on 05/01/2026 at 1:42 p.m., she said she was trained on medication administration. She said the policy was to give medication to the right patient, the right dose, the right time, and staff were to make sure the resident took the medication and. She said the staff were to give the medication at the prescribed time and the staff had an hour before an hour after the scheduled time. She said the nurse was responsible for ensuring the residents got their medications on time. She said the DON and ADM monitored to ensure staff were giving medication on time. She said the DON and ADON monitored by checking documentation. She said if the residents did not get their medication on time they could become ill. She said she did not know why LVN C and RN D were not giving medication on time. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Administering Medications Policy, dated 04/2019, reflected Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frames. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 2 of 4 medication carts (MC #1, and MC #3) reviewed for drug storage and labeling.1. The facility failed to ensure MC #1, was locked, medications secured, and not accessible to other staff, residents, or visitors.2. The facility failed to ensure MC #2, was locked, medications secured, and not accessible to other staff, residents, or visitors.These failures could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missing medications. Findings include:Observation of hall four on 04/28/2026 at 5:27a.m., revealed LVN B was in a residents room with the door cracked open and the medication cart was along the wall unattended and unlocked.During an observation on 04/30/2026 at 7:30 a.m., revealed MC #1 revealed against the hall two walls unattended and unlocked. LVN A went down the hall three to do something leaving the medication cart unlocked and unattended. MC #1 contained residents' prescription drugs, over the counter medications, and narcotics in a locked box. Residents were walking past the medication cart.During an interview with LVN A on 04/30/2026 at 07:45a.m., she said she was trained on medication storage. She said the policy was staff must lock the medication carts any time the nurse walked away from the medication cart or turned their back. She said the nurse was responsible for locking the medication cart. She said if staff left the medication cart unlocked and unattended a resident could get into the medication cart and take medication that did not belong to them. She said the nurses monitored to ensure the medication carts were locked. She said the nurses monitored the medication carts through observation. He said she had left the medication cart unlocked because she was trying to get ready for the day and was not mindful of the cart.During an observation of the nurses' station on 05/01/2026 at 7:15 a.m., revealed MC #2 was up against the hall-one wall unattended and unlocked. LVN B was sitting at the nurses' station with her back to the medication cart. MC #2 contained residents' prescription drugs, over the counter medications, and narcotics in a locked box. Staff and residents were passing by the medication cart.During an interview with LVN B on 04/30/2026 at 7:24 a.m., she said he was trained on medication storage. She said the policy for medication storage was to immediately lock the medication cart when not in use. She said the nurse or MA who was assigned to the medication cart was responsible for ensuring the medication cart was locked. She said if the medication cart was left unlocked or unattended an unknown person or a resident could get into the medication cart. She said the DON, ADON, ADM and peers monitored to ensure staff were locking the medication carts. She said the DON, ADON, ADM and peers monitored through observation. She said she did not lock her medication cart because she went to answer the phone. She added there was not an excuse for leaving the medication cart unlocked. She said she did not notice the state surveyor took pictures or opened the drawers on the medication cart.During an interview with the DON on 05/01/2026 at 12:07 p.m., she said she was trained on medication storage. She said the policy was if the medication cart was locked when staff were not attended to or when staff walked away from the medication cart. She said the nurse who was on the medication cart was responsible for ensuring the medication cart was locked. She said if the medication cart was left unlocked and unattended someone could get into the medication cart and take medications. She said management monitored to ensure staff locked the medication cart. She said management monitored by doing observations. She said she did not know why LVN A and LVN B left the medication carts unlocked.During an interview with the ADM on 05/01/2026 at 1:38 p.m., revealed she was trained on medication administration. She said the policy for medication storage was that the medication cart was to always be locked. She said no medication was to be left on the medication cart and no (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication left in the resident's room. She said the nurse who was on the medication cart or the MA on the cart was responsible for ensuring the medication cart was locked. She said if the medication cart was left unlocked and unattended anyone could enter the cart and take medication or the facility could have a drug diversion. She said the DON monitored to ensure the staff were locking the medication cart. She said the DON monitored by doing observations. She said she did not know why LVN A and LVN B left the medication cart unlocked.Record review of Storage of Medications Policy, dated February 2023, reflected The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available others.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete and accurately documented for 3 of 3 residents (Resident #2, Resident #3 and Resident #4) reviewed for complete and accurate records. ^ The facility failed to ensure RN D documented medications at the time administered to Resident #2, Resident #3, and Resident #4. This failure could place residents at risk of harm or not receiving desired outcomes from medications not administered according to physician's orders and manufacturer's specifications. Findings include: 1. Record review of Resident #2 face sheet, dated 04/29/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included type 2 diabetes mellitus without complications (high blood sugar), morbid obesity, respiratory failure, hypertension (high blood pressure), cognitive communication deficit (problems with communication), and difficulty in walking. Record review of Resident #2's admission MDS assessment, dated 03/02/2026, reflected Resident #2 had a BIMS score of 99, which indicated unable to complete the interview. Record review of Resident #2's Care Plan, dated 04/03/26, reflected [Resident #2] had a seizure disorder. Interventions were Give seizure medication as ordered by doctor. Monitor/document side effects and effectiveness. During an interview with Resident #2 on 04/30/2026 at 2:04 p.m., she said she was not getting her seizure medication on time. She said there were times she would not get her morning medication until the afternoon. She said the staff were always late giving her medication. 2. Record review of Resident #3 face sheet, dated 04/29/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3had diagnoses which included paroxysmal atrial fibrillation (irregular heartbeat that comes and goes), obesity, heart failure, respiratory failure, depression (mood disorder causing a persistent feeling of sadness), chronic pain, obstructive sleep apnea (breathing pauses while sleeping), and lack of coordination. Record review of Resident #3's Care Plan, dated 04/03/26, reflected [Resident #3] Resident is at risk for chest pains, irregular pulse, edema and adverse reaction related to medication due to history of cardiovascular disease. Interventions were Provide medications as ordered. Check vital signs prior to giving as ordered. Record review of Resident #3's admission MDS assessment, dated 04/04/2026, reflected Resident #3 had a BIMS score of 15, which indicated intact cognitive response. Record review of Resident #3's MAR reflected RN D gave Resident #3 furosemide oral tablet 40 mg Give 1 tablet by mouth one time a day for edema at 5:09 a.m. but did not document she gave the medication until 6:09a.m. on 4/24/2026. During an interview with Resident #3 on 04/29/2026 at 10:59 a.m., he said staff did not give him his mediations on time and did not documents giving the medication until hours. He said he mentioned it to the administrator. He said the nurse did not have time to pull out the medications and took care of the resident because the facility did not have enough staff. 3. Record review of Resident #4's face sheet, dated 04/29/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included Cardiomegaly (enlarged heart), hypomagnesemia (electrolyte disorder), muscle weakness, lack of coordination and heart failure. Record review of Resident #4's admission MDS assessment, dated 03/25/2026, reflected Resident #4 had a BIMS score of 15, which indicated intact cognitive response. Record review of Resident #4's Care Plan, dated 03/20/26, reflected [Resident #4] uses psychotropic medications related to depression. [Resident #4] is at risk of mood decline. Interventions were Administer medications as ordered. Monitor/document for side effects and effectiveness. Record review of Resident #4's MAR reflected RN D gave Resident #4 fluoxetine HCl oral capsule 40 mg give 1 capsule by mouth two times a day for depression at 08:22 a.m. but did not document she give the medication until 10:24 a.m. on 4/29/2026. During an interview with Resident #4 on 04/29/2026 at 04:24 p.m., she said staff did not give her mediations on time. She said (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she asked a few times about her medications. She said she did not know why she could not get her medications on time. During an interview with RN D 04/30/2026 at 8:24a.m., she said she was trained on medication administration documentation. She said the policy was medication administration documentation was medication was to be documented at the time given. She said the nurse was responsible for documenting medication at the time given. She said if medication was not documented at the time given staff did not have a true picture of what was going on. She also said if she did not document at the time given the other shift might give the medication again and cause an issue with the resident. She said the DON monitored to ensure medication was documented when given. She said the DON monitored by checking the MARs. She said she was trying to get Resident # 2, Resident #3 and Resident #4 their medications on time. During an interview with the DON on 05/01/2026 at 12:15 p.m., she said she had been trained on medication administration documentation. She said the policy for medication documentation was that the staff should be documented in the MAR when the medication was given. She said the nurse was responsible for documenting the medication when given. She said if the nurse did not document at the time the medication was given it could cause a resident to be over medicated because someone may think the resident did not get the medication. She said the DON and ADON monitored to ensure they were documenting at the time the medication was given. She said the DON and ADON monitored by checking the MAR. She said she did not know why RN D was not documenting at the time medication was given. During an interview with the ADM on 05/01/2026 at 1:45 p.m., she said she was trained on medication administration documentation. She said the policy for medication documentation was to document all medication given at the time it was given. She said the nurse or MA who was giving the medication was responsible for documenting the medication at the time given. She said if staff did not document at the time medication was given the staff member may not remember and give the resident the medication twice. She said the DON and ADM monitored to ensure staff were documenting at the time medication was given. She said the DON and ADM checked the MAR documentation. She said she did not know why RN D was not documenting at the time given. Record review of the Documentation of Medication Administration dated 11/2022 reflected A medication administration record is used to document all medications administered. nurse or certified medication aide (where applicable) documents all medications administered to each resident on the resident's medication administration record. Administration of medication is documented immediately after it is given.