

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675948	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Avir at Belton		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 interview and record review the facility failed to establish a system of record of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation for 1 of 4 medication carts (Medication Aide Cart for 100,300,500 Halls) reviewed for medication storage and labeling. The facility failed to ensure residents were free of any significant medication errors for one (Resident #54) of five residents reviewed for significant medication errors. The facility failed to record receipt and reconciliation of medication aide cart for 100,300,500 each shift change. The facility failed to ensure Resident #54 was administered her prescribed nighttime medications within the allotted time. This failure could place residents at risk of drug diversions and could result in diminished health and well-being. This failure could place residents at risk of not receiving the intended therapeutic benefit of the medications and supplements or could result in worsening or exacerbation of chronic medical conditions. Findings Include:Record review of the Change of Shift Narcotic Count Sheets on the Medication Aide Cart for 100,300,500 Halls revealed missing narcotic receipt and reconciliation documentation from MA A on 1/04/2026 for the 6am-6pm on-coming Shift.Review of Resident #54's face sheet dated 01/08/2026 reflected a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cellulitis of abdominal wall (a serious bacterial skin infection in the dermis and subcutaneous tissue of the belly), chronic kidney disease, stage 3 unspecified (your kidneys have moderate damage, filtering blood less effectively, spondylosis, unspecified (a general descriptive term for any age-related, degenerative wear and tear changes in the spine without specifying the exact location or underlying cause of symptoms), bradycardia, unspecified (an abnormally slow heart rate, generally fewer than 60 beats per minute (bpm) for adults at rest), dementia (condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain). Review of Resident#54's MDS Assessment, dated 10/09/2025, reflected Resident #54 had a BIMS score of 13, which indicated resident's cognition was intact. Review of Resident #54's care plan, on 02/03/2023, reflected that the resident was at risk for adverse reaction r/t polypharmacy, 9+ (when you take several medications each day, often defined as five or more.) Goal: Resident will be free of adverse drug reactions through next review date. Intervention: Administer medications as ordered. Monitor/document for side effects and effectiveness. Record review of Resident #54's Physician's orders and medication audit report reflected night-time medications were supposed to be administered at 8:00 PM daily. Medications can be administered an hour prior at 7:00 PM or an hour later at 9:00 PM. The following dates and times reflected when the medications were administered: 12/07/2025 at 9:21 PMLatanoprost 0.005% (for glaucoma) Fluticasone Propionate (for sinus drainage)Levocetirizine Dihydrochloride 5 MG (for allergies)Melatonin 3 MG (for insomnia)Prazosin HCl 1 MG (for nightmares) 12/08/2025 at 9:06 PMLatanoprost 0.005% (for glaucoma)Fluticasone Propionate (for sinus drainage)Levocetirizine Dihydrochloride 5 MG (for allergies)Melatonin 3 MG (for insomnia)Prazosin HCl 1 MG (for nightmares) 12/11/2025 at 10:56 PMLatanoprost 0.005% (for (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	glaucoma)Fluticasone Propionate (for sinus drainage)Levocetirizine Dihydrochloride 5 MG (for allergies)Melatonin 3 MG (for insomnia)Prazosin HCl 1 MG (for nightmares) 12/12/2025 at 10:34 PMLatanoprost 0.005% (for glaucoma)Fluticasone Propionate (for sinus drainage)Levocetirizine Dihydrochloride 5 MG (for allergies)Melatonin 3 MG (for insomnia)Prazosin HCl 1 MG (for nightmares) 12/20/2025 at 9:16 PM Latanoprost 0.005% (for glaucoma)Fluticasone Propionate (for sinus drainage)Levocetirizine Dihydrochloride 5 MG (for allergies)Melatonin 3 MG (for insomnia)Prazosin HCl 1 MG (for nightmares) 12/21/2025 at 9:24 PMLatanoprost 0.005% (for glaucoma)Fluticasone Propionate (for sinus drainage)Levocetirizine Dihydrochloride 5 MG (for allergies)Melatonin 3 MG (for insomnia)Prazosin HCl 1 MG (for nightmares) 12/22/2025 at 9:08 PMLatanoprost 0.005% (for glaucoma)Fluticasone Propionate (for sinus drainage)Levocetirizine Dihydrochloride 5 MG (for allergies)Melatonin 3 MG (for insomnia)Prazosin HCl 1 MG (for nightmares) 12/23/2025 at 9:11 PMLatanoprost 0.005% (for glaucoma)Fluticasone Propionate (for sinus drainage)Levocetirizine Dihydrochloride 5 MG (for allergies)Melatonin 3 MG (for insomnia)Prazosin HCl 1 MG (for nightmares) 12/27/2025 at 10:04 PMLatanoprost 0.005% (for glaucoma)Fluticasone Propionate (for sinus drainage)Levocetirizine Dihydrochloride 5 MG (for allergies)Melatonin 3 MG (for insomnia)Prazosin HCl 1 MG (for nightmares) During an observation and interview on 01/06/2026 at 11:30 am, Resident #54 was in her room along with her family members. She was pleasant and communicative. She stated she has been receiving her night medication late. Resident #54 stated she received her 8 PM medications at 10:30 PM and it is happening often especially when the facility is short staff. She stated she thinks there is only one person giving medications at night. Resident #54 stated she stayed up until she received her medication. She wakes up at 5 AM every morning and she falls asleep at the breakfast table, but she must take a nap during the day to make up for the time. During an interview with MA A on 1/07/2026 at 8:30am, she stated that it was required for the off-going and on-coming staff to count the narcotic medications and sign the narcotic count sheet. She stated that a negative outcome of not consistently following the narcotic count expectations was the possibility of drug diversion. She states she forgot to sign off on the narcotic count sheet on 01/04/2026 for Medication Aide Cart 100,300,500 Halls. During an interview with LVN A on 1/07/2026 at 2:15pm, she stated that it was required for the off-going and on-coming staff to count the narcotic medications and sign the narcotic count sheet. She stated that a negative outcome of not consistently following the narcotic count expectations was a possibility of drug diversion. During an interview on 01/07/26 at 03:50 PM, the DON stated their medication administration policy on timeliness is to pass the medication as close to time as possible. One hour before or after the time when the medication should be administered. The DON stated they monitor MAR times to make sure they were not given out the scheduled time by looking at the MAR every morning to be sure there are not any missed medications. If there is an issue, they will contact the doctor to hold medications or if the medications are not available. She stated she was not aware night medications were being administered late. She stated there could be a negative outcome; it just depends on what medication it is. The DON denied any residents had complained to her regarding receiving their medication late. During an interview with DON on 1/8/2026 at 4:15pm, she stated that it was required for the off-going and on-coming staff to count the narcotic medications and sign the narcotic count sheet. She also stated that staff were trained in this expectation during new employee orientation. She stated that a negative outcome of not consistently following the narcotic count expectation was the possibility of drug diversion. Record review of the policy Dispensing and Reconciling Controlled Substances (not dated) reflected, Controlled substances inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. The nurse coming on duty and the nurse going off duty making the count together and document and report any discrepancies to the director of nursing services. Review of the facility's Administering Medications Policy, revised April 2019, reflected the following:Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders, including any required time frame.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR) Level I assessment accurately reflected the resident's status for (Resident #2) reviewed for PASRR Level I screenings. 1. The facility failed to ensure the accuracy of the PASRR Level 1 screening for Resident #2. The PASRR Level 1 screening did not indicate a diagnosis of mental illness, although the diagnosis (post-traumatic stress disorder with an onset date of 02/16/23) was present upon Resident #2's admission date on 02/16/23. This failure could place residents who had a mental illness at risk of not receiving a needed assessment (PASRR Evaluation), individualized care, or specialized services to meet their needs. Findings included: Record review of Resident #2's face sheet, dated 01/8/26, reflected she was a [AGE] year-old female, admitted to the facility initially on 2/16/2023 and readmitted on [DATE]. Her diagnoses included post-traumatic stress disorder (a mental health condition that's caused by an extremely stressful or terrifying event - either being part of it or witnessing it), vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a type of dementia caused by reduced blood flow to the brain, often due to conditions affecting the blood vessels, such as strokes or chronic high blood pressure. This condition leads to cognitive decline, impacting memory, problem-solving, and other cognitive functions), and cognitive communication deficit (difficulties in communication that arise from impairments in cognitive processes rather than from primary language or speech disorders). Record review of Resident #2's quarterly MDS assessment, dated 10/13/25, reflected that she had a BIMS score of 09, which indicated resident's cognition was moderately impaired. The MDS assessment reflected Resident #2 was dependent on staff for toileting and bathing and required substantial/maximal assistance with personal hygiene. Record review of Resident #2's PASRR Level 1 Screening, dated 02/16/23, reflected that Section C Mental Illness was marked as no, which indicated Resident #2 did not have a mental illness. Record review of Resident #2's care plan dated 09/08/25 reflected Resident #2 was at risk for declining cognition, behavior, and physical condition due to PTSD. Goal: Resident will continue to participate with care as condition allows no complication due to medications, no injury to self or others due to behaviors, needs will be met by staff as needed through next review date. Intervention: Disregard inappropriate comments, provide redirection, verbal cue as needed. Encourage and allow residents to express/discuss concern about disease process. Encourage and assist with physical activities as able. Follow up with Neurologist as indicated. Observe for change in condition and notify Physician, and family. In an interview on 01/06/26 at 3:07 PM, Resident #2 stated she has lived there too damn long (she laughed). She feels safe living at the facility, and they come when her call light is active. Resident#2 had no concern with living at the facility. In an interview on 01/06/26 at 03:20 PM, the DON stated the PASSR list the resident's diagnosis is the facility process of identifying residents with a possible MD, ID, or a related condition prior to admission. Also, the facility identifies residents with newly evident or possible serious MD, ID or a related condition after admission to the facility if the residents are exhibiting behaviors, they will try to refer to psych. They can also reach out to the doctor. DON stated it is usually the social worker's or the MDS Coordinator's responsibility to make the referral to the appropriate state-designated authority when a resident is identified as having an evident or possible MD, ID or related condition. The DON stated if the PASSR I is not completed accurately, the residents will not receive services due to them. In an interview on 01/06/26 at 03:32 PM, ADON stated the facility's process for identifying residents with a possible MD, ID or a related condition prior to (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission, is to send over the PASSR before the residents are accepted into the facility. The facility identifies residents with newly evident or possible serious MD, ID or a related condition after admission. Once the nurses assessed the resident they would put in a referral to the psych or the physician. The SW is responsible for making the referral to the appropriate state-designated authority. The ADON stated if the resident had an identified MD, ID, or related condition and a referral was not made, it could be due to inaccurate assessment or no communication. ADON stated the residents can miss out on follow-up for medications and mental health treatments. In an interview on 01/06/26 at 03:41 PM, Social Worker stated the MDS Coordinator is responsible for completing the PASSR. She stated they identify residents with newly evident or possible ID, MD, or related conditions after admission by their history and diagnosis, along with interviews. If they suspect the residents need more, they will set up another interview to discuss services. The SW stated it is the MDS Coordinator's responsibility to make the referral to the appropriate state designated authority. SW stated if the referral is not made, it can be due to communication breakdown, or they just missed the diagnosis. She stated but it should not happen. In an interview on 01/06/26 at 03:58 PM, the MDS Coordinator stated the PASSR form is the facility process of identifying residents with a possible MD, ID, or a related condition prior to admission. The facility identifies residents with newly evident or possible serious MD, ID or a related condition after admission to the facility with updated progress notes. The MDS Coordinator stated it is the social worker's responsibility to make the referral to the appropriate state-designated authority when a resident is identified as having an evident or possible MD, ID or related condition. The MDS Coordinator stated if PASSR is positive it alerts MHMR, and they are out within 72 hours and provide what follow up is needed. If the PASSR II is not completed, the residents will not receive the services they qualify for. MDS Coordinator stated she had not heard of PASSR II. Record review of the facility's policy, PASRR for Nursing Facility revised 07/29/25 reflected: Policy: The PASRR program aims to ensure that individuals with mental illness or intellectual disabilities receive appropriate care and services. It assesses whether the nursing home is the most suitable setting for the individual's needs.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview and record review, the facility failed to develop and implement a baseline care plan within 48 hours of admission that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for (Resident #9) reviewed for baseline care plans. The facility failed to complete a baseline care plan within 48 hours of admission for Resident #9. This failure could place residents at risk of not receiving care and services to meet their needs. Findings included: Review of Resident #9's Face Sheet, dated 01/07/2026, reflected a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of traumatic subdural hemorrhage with loss of consciousness status unknown, subsequent encounter (type of bleeding near your brain that can happen after a head injury), pressure-induced deep tissue damage of other site (localized damage to skin and underlying soft tissues from prolonged pressure, often over bony areas, appearing as deep red, purple, or maroon skin (intact or blistered) or a dark wound bed, indicating severe damage beneath the surface that can quickly worsen), other fracture of base of skull, subsequent encounter for fracture with routine healing (a patient receiving follow-up care for a non-specific skull base fracture, where the bone is progressing normally toward healing, indicating a normal recovery phase rather than an initial treatment or complication). Review of Resident #9's MDS Assessment, dated 12/18/2025, reflected Resident #9 had a BIMS score of 00, which indicated resident's cognition was severely impaired. The MDS assessment reflected Resident #9 was dependent on staff for toileting and bathing and personal hygiene. Record review of Resident #9's care plan dated 1/6/26 reflected Resident #9 had impaired cognitive function/dementia or impaired thought process r/t head injury, traumatic brain injury. Goal: Resident will maintain current level cognitive functions through next review date. Intervention: Administer medications as ordered. Monitor/document for side effects and effectiveness, ask yes/no questions to determine the resident's needs. There was no baseline care plan. An observation on 01/06/26 at 11:07 AM revealed Resident #9 was observed lying in a hospital bed, in the lowest position, with a fall mat positioned next to the bedside. Resident #9 was lying flat on his back and appeared not to be in any distress. Resident #9 was not interview able as he has a communication deficit. In an interview on 01/06/26 at 03:20 PM, the DON stated the care plans are updated and communicated to direct care staff through reporting at shift changes. Also, it is put in their task list, so they are aware. The DON stated that helps with breakdown in communication. If the care plans are not followed bad outcomes can happen. The DON stated care plans are audited for accuracy and follow-ups are done by MDS Coordinator and she will remind the team, so they know it is correct. The DON stated the timeframe to complete a care plan is 21 days and it is updated quarterly. The DON stated she think Resident #9 baseline care plan was not done timely, because the baseline care plan must be initiated by an RN and she think she may have accidentally deleted it because she didn't initiate it. In an interview on 01/06/26 at 03:32 PM, ADON stated care plan updates are communicated to direct care staff in their electronic reporting system and in the Kardex (a desktop file system that gives a brief overview of each patient and is updated every shift). They also are advised verbally. The ADON stated to avoid a breakdown in communication between departments, changes are discussed in morning stand-up meetings. The MDS Coordinator is responsible for accuracy and follow-throughs of the changes of the care plans. The timeframe to complete a care plan is seven days and updated quarterly. She did not know the care plan was not completed timely. In an interview on 01/06/26 at 04:18 PM, the Administrator stated she (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is responsible for leading and documenting and changes in condition through communication in the IDT meetings. ADM stated care plan updates are communicated to direct care staff by the DON, adding the information to the Kardex, in-services, and one on one meetings. ADM stated to ensure consistency across shifts, they used PCC (their electronic system Point Click Care), dashboard, and feedback from nurses. They handle breakdowns in communications by providing in-services, meetings, and identifying problems. ADM stated care plans are audited for accuracy by the DON and herself. The regional nurse can also look at them. She stated the care plans are completed within 7 days after they are initiated, but she is unsure when they are updated. ADM stated Resident #9 admissions assessment would have given information from the paperwork that was given to complete the care plan. Record review of the facility's policy, Care Plans, Comprehensive Person-Centered revised March 2022 reflected: Policy: A comprehensive. Person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.		