| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676345 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bel Air at Teravista | 4105 Teravista Club Drive<br>Round Rock, TX 78665 |

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097<br><br>Based on interviews and record reviews the facility failed to ensure residents remained free from accidents, hazards and each resident received adequate supervision and assistance when being transferred for 1 of 7 residents reviewed for accidents and hazards.<br><br>CNA A failed to transfer Resident #1 received assistance with the mechanical lift on 12/14/2024.<br><br>This failure could result in residents receiving injuries.<br><br>The noncompliance was identified as PNC. The IJ began on 12/14/24 and ended on 12/16/24. The facility had corrected the noncompliance before the survey began.<br><br>Findings included:<br><br>Record review of Resident #1's Face sheet dated 12/31/2024 revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included cognitive communication deficit (problems with communication), pressure ulcer of right heel (wound on heel), dysphagia (difficulty swallowing), difficulty walking, repeated falls, lack of coordination, osteoarthritis (joint disease), cerebrovascular disease (a range of conditions that affect the blood flow to the brain), nutritional deficiency,.<br><br>Record review of Resident #1's admission MDS, dated [DATE], reflected a BIMS score of 12, indicating she was moderately impaired. Her Functional Status reflected she required substantial/maximal assistance with transfers.<br><br>Record review of Resident #1's care plan, dated 10/7/24, reflected she was a mechanical lift transfer. The care plan also revealed two persons assist with all transfers.<br><br>Record review of facility investigation dated 12/20/2024 revealed CNA A did not see anyone in the area, so she attempted to transfer the resident from her wheelchair to bed by herself. She was unable to transfer the resident and lowered the resident to a sitting position on the floor. It was noted that the resident was not injured at the time of incident.<br><br>(continued on next page) |



| 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 | Record review of employee coaching and counseling record dated 12/14/2024 revealed CNA A documented under employee remarks Resident did not fall! I tried to pivot the resident from chair to bed. When at the bedside resident begun to go down, so I sat the resident on the floor and went for help.<br><br>During an interview with Residents on 12/31/2024 starting at noon revealed that Residents did not have any concerns about their care. Residents stated the staff transfer them correctly and were not afraid of being transferred by staff.<br><br>A telephone interview with CNA A attempted on 12/31/2024 at 3:49pm was unsuccessful. She did not call surveyor back.<br><br>A telephone interview attempt with CNA A on 01/14/2025 at 2:05 pm was unsuccessful; at 5:26 pm another attempt was made to CNA A; she answered the telephone. CNA A stated she had not had any in-services, but she did state she was trained on how to operate a mechanical lift. CNA A then stated she was at work, and she would contact me back. No return call was received.<br><br>During an interview with CNA B on 12/31/2024 at 3:15pm revealed he had been trained on transfers, abuse and neglect and fall prevention. He said he was at the nurse's station when CNA A came to get him and asked him for help. He said the resident had come back from being out on pass at round 9:00pm. He said that CNA A asked him for help at 9:30pm. He said the mechanical lift sling was under the resident, and he went to get the mechanical lift. He said when he got to the room Resident #1 was sitting on the floor. He said he told CNA A she needed to have the nurse evaluate the resident before they moved her. He said Resident #1 complained of pain in her left shoulder and told the nurse she had the pain before the fall. He said Resident #1 was a two-person mechanical lift transfer.<br><br>During an interview with LVN C on 12/31/2024 at 3:48pm revealed she had been trained on transfers, abuse and neglect and fall precautions. She said the resident came back from pass with her family. He said the CNA A went to put the resident in bed and tried to transfer the resident by herself. He said CNA A knew the resident was a two-person mechanical lift transfer. He said CNA A came and told him what happened, and she needed to be assessed. He said when he arrived at the room to assess Resident #1, she was sitting on the side of the bed on her buttocks. LVN C performed a head-to-toe assessment on Resident #1 including vitals and pain assessments, ROM to all extremities with no negative findings. LVN C stated he asked the resident was she in pain and she stated she was hurting but she had been hurting all day. LVN C stated after the he completed the assessment of the resident, LVN C along with CNA A and CNA B transferred the resident with the mechanical lift to the bed. LVN C then notified the NP, RP and DON of the incident. LVN C stated a while back (no specific time given) that the resident wore a sling on her left arm. LVN C stated Resident # 1 did not complain of any pain the rest of the night.<br><br>During an interview with the ADM on 12/31/2024 at 4:17pm revealed she and staff have been trained on transfers. She said the staff can find the transfer status of a resident in their care plan. She said CNA A did not see anyone in the hall or at the nurse's station to help transfer Resident #1. She said CNA A told her she thought she could transfer the resident by herself. She said CNA A realized she made a mistake and lowered the resident to the floor and went to get CNA B to help her. She said CNA B told CNA A she needed to have the nurse evaluate Resident #1 before transferring her since she was sitting on the floor. ADM stated LVN C advised her Resident #1 advised him she had been hurting since earlier in the day. The ADM stated she received a call from the SW on 12/15/2024 and she stated the family decided Resident #1 will not be returning to the facility.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview with the DON on 01/14/2025 at 1:50pm revealed Resident #1 was out on pass with her family on or about 4:30/5:00pm and returned to the facility at 9:00pm. He received a call from LVN C that CNA A attempted to transfer Resident #1 to the bed by herself and without the mechanical mechanical lift. DON stated LVN C stated CNA A advised him she did not see anyone to assist her with transferring the resident. DON stated Resident #1 has been a 2 person assist since he has been employed at the facility for the last 2 years. DON stated he was advised Resident #1 ended up on the floor because CNA A attempted to lift resident by herself, and she could not hold her. DON stated Resident #1 always complained on/off about left arm pain. DON stated when you reposition her you must be careful. DON stated after the incident occurred, he spoke with the RP and advised her they would be reporting the improper fall incident to the state. DON stated they decided to do an x-ray because Resident #1 started to complain of the arm pain the next day. The DON stated he contacted the RP and did not want Resident #1 to go to the hospital because it was late, and she did not want her to be disoriented due to her having dementia. DON advised her of the results of the x-ray and Resident #1 was complaining of arm pain and it was protocol to send a resident to the hospital for further care. DON stated there is always someone around that could have assisted and she was just impatient. DON stated in-services on Mechanical Lift, Abuse and Neglect, and timely Incident Reporting, Prevention of Falls and Significant Injuries by Utilizing Daily Care guides. DON stated CNA A was off on 12/15/2024 and returned to work on 12/16/2024 in which she was suspended pending the investigation and terminated on 12/18/2024. DON stated the self-report was completed, pain assessment completed, interviewed staff of abuse and neglect, also filled out the forms with the resident if they witness or happened to have had abuse or neglect and interview the staff on abuse and neglect. DON stated Resident #1 was a heavy wetter and wondered how the family handled Resident #1 when out on pass regarding incontinent care. DON stated the resident would be out with the family at a minimum of 4 to 5 hours.<br><br>During an interview with the RP on 01/14/2025 at 1:10pm revealed Resident #1 was out on leave with her sibling, and she was returned to the facility at 9:00pm on 12/14/2024. RP stated prior to Resident #1 leaving out on pass, she stated CNA A was rude to her. Upon Resident #1 return and CNA A trying to place her in the bed, Resident #1 was advised to hug CNA A so she can pick her up. RP stated Resident #1 figured she was trying to be nice to her because she was rude to her earlier. RP stated she received a call stating her mom had a fall, but she was alright. It was explained to her CNA A attempted to pick her up by herself. RP stated she asked was the mechanical lift used because her mother had been using the mechanical lift since she had been at the facility since 2018. RP stated she was advised the next day her mother complained of arm pain and the NP had an x-ray done and it revealed she had a humeral fracture. RP stated she did not want her to go the hospital because she did not want her to be disoriented due to her dementia that time of the night. RP stated there was no documentation of her having any pain. RP stated the hospital advised her to send Resident #1 to another facility with her having sub-acute fractures which appeared to be a few weeks old. RP stated she did not have a fall or complain of any pain while she was out on pass with her sibling. RP stated the other time she fell was when she about a month in the facility. Resident #1 was reaching for something, and she hurt her shoulder when she fell out of her wheelchair. Her arm was placed in a sling. RP stated Resident #1 had a bedside table that tipped over on her and she had an x-ray on her toes it was just swelling. Resident #1 complained her foot was hurting in the ER and they showed a fracture on her toes. She has a shoe on her foot. RP stated it happened a couple of months ago.<br><br>Record review of CNA A's employee coaching and counseling record dated 12/14/2024 revealed the fall during the transfer may have been preventable with adherence to proper facility protocol, including using assistive devices, foot ware, timely reporting to the charge nurse and asking for assistance from colleague. CNA A was placed on suspension on 12/16/2024 and terminated on 12/18/2024.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of the facilities investigation summary report dated 12/14/2024 revealed the ADM and ADON contact with CNA A and obtained the statement: CNA A stated it was the end of her shift and she did not see anyone in the area, so she attempted to move her from the wheelchair to the bed herself. This was unsuccessful, resulting in CNA A lowering the Resident #1 to a sitting position on the floor. CNA A requested assistance from CNA B who directed her to the LVN to report the fall requires an assessment. CNA A notified LVN C of the incident and he responded to assess Resident #1 and there were no negative findings, LVN C completed a Coaching and Counseling record for CNA A regarding improper transfer, adhering to facility protocol including using assistive devices; footwear; timely notifications. CNA A insisted she tried to pivot Resident #1, and when she was unable to complete the turn, she then lowered her to the floor and asked for help.<br><br>During an interview with the ADM on 12/31/2024 at 2:13pm with the Transfer policy was requested but was not provided prior to exit.<br><br>Record review of the facility CNA Job Description revised in January 2017 revealed staff were to comply with requirements of procedures for safe lifting an/or safe transfer of patients per established policies and procedures.<br><br>Record review of Resident#1 x-ray dated 12/15/2024 at 8:37pm revealed the bones appear diffusely demineralized. Left humeral neck fracture with no mature callus seen. No joint dislocation. No comparison studies.<br><br>During an interview with NP on 01/14/2025 revealed she was not the NP on call that weekend, and she only read the results from the x-ray. She stated Resident #1 was discharged when she came in on Monday. NP stated she does not have permissions at the hospital to collect any information regarding the resident. She stated she would attempt to get in contact with the NP that was on call.<br><br>During an observation on 1/14/2025 at 5:25pm, CNA B, CNA C, CNA D, and CNA E was observed properly operating the mechanical lift with 2 residents.<br><br>Record review of Skills checks on Transfers revealed that staff had been done on 12/16/2024.<br><br>Record Review of in-services completed on 12/15-12/16/2024 on Mechanical Lifts, Abuse and Neglect, and timely Incident Reporting, and Prevention of Falls and Significant Injuries by Utilizing Daily Care guides revealed staff had been trained.<br><br>Record review revealed that Resident #1 was discharged to the hospital on 12/15/2024 and did not return to the facility.<br><br>The noncompliance was identified as PNC. The IJ began on 12/14/24 and ended on 12/16/24. The facility had corrected the noncompliance before the survey began. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097<br><br>Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals) for 1 (Resident #2) of 1 reviewed for pharmaceutical services.<br><br>MA D left Resident #2's medications with her and walked out without observing Resident #2 taking the medications.<br><br>This failure could place residents at risk for not receiving a therapeutic effect or another resident getting the medication.<br><br>The findings were:<br><br>Record review of Resident #2's face sheet dated 12/31/2024 revealed she was an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of fracture, pain, heart disease, sleep disorder, muscle spasm, injury of head, weakness and gastroesophageal reflux disease without esophagitis (reflux).<br><br>Record review of Resident #2's admission MDS, dated [DATE], reflected a BIMS score of 15, indicating she was cognitively intact.<br><br>Record review of Resident #2's care plan, dated 12/31/24, revealed there was no care plan for Resident #2 to self-administer her medications.<br><br>Record Review of Resident #2 medical chart on 12/31/2024 revealed Resident #2 did not have a self-administer evaluation.<br><br>During an observation on 12/31/2024 at 1:43pm MA D come into the room and give Resident #2 pills and walked away without watching the resident take the medication. Resident #2 was observed asking MA D for water as MA D was leaving.<br><br>During an interview with MA D on 12/31/2024 at 1:53pm revealed some residents do not want her to stay in the room with them while they take their pills. She said in those cases she would leave the pills and check back later. She said she does know she was supposed to watch the resident take the medication. She said the resident could choke on the medication if not supervised. She said she did not watch Resident #2 because she did not like her watching her take her medication.<br><br>During an interview with Resident #2 on 12/31/2024 at 2:13pm revealed that MA D normally watches her take her medication before leaving the room. She said this was the first time she had walked out without watching her take the medication.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with UM on 12/31/2024 at 2:15pm revealed staff who pass medication to residents were to watch and ensure the resident took the medication. She said if staff were not watching a resident take the medication a resident could have a swallowing issue that staff do not know about. She also said they could save the medication or give it to another resident. She said she was not aware that MA D had left medication with Resident #2.<br><br>During an interview with the ADON on 12/31/2024 4:00pm revealed residents were to have a self-administration assessment before staff can leave medication with a resident. She said Resident #2 did not have a self-administration assessment at the time MA D left the medication with Resident #2. She said MA D was supposed to ensure that Resident #2 took the medication. She said MA D should have stayed in the room with Resident #2 until she took the medication. She said that if a resident was not able to self-administer medication and staff did not supervise it put the resident at risk of choking. She said she did not know why MA D did not stay and supervise Resident #2 taking her medication.<br><br>During an interview with the ADM on 12/31/2024 at 4:17pm revealed staff who passed medication were to supervise the resident while taking the medication. She said that staff were to stay and supervise unless they were able to self-administer medication. She said for a resident to self-administer medication the facility had to do a self-administration assessment and put it in the resident's care plan. She said if staff did not monitor residents who did not have a self-administration assessment the resident could choke. She said MA D said the resident did not want to be watched when taking medication. She also told MA D that the residents must be supervised unless they are allowed to self-administer medication.<br><br>During an interview on 12/31/2024 at 2:09pm.with ADM the Medication administration policy was requested but was not received prior to exit. |