

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/19/2025
NAME OF PROVIDER OR SUPPLIER Bel Air at Teravista		STREET ADDRESS, CITY, STATE, ZIP CODE 4105 Teravista Club Drive 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)
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600</p> <p>Based on record review and interviews, the facility failed to ensure completion of a discharge summary including a recapitulation of the resident's stay and final status of discharge for three of three (Resident #1, Resident #2, Resident #3) reviewed for discharge summary.</p> <p>The facility failed to complete a discharge summary and recapitulation for Resident #1, Resident #2 and Resident #3.</p> <p>This failure could place residents at risk of not having complete records, necessary services, or information after permanent discharge from the facility.</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet dated 05/19/2025 revealed an [AGE] year-old man admitted on [DATE] and discharged on [DATE] with diagnoses of erosive (osteo) arthritis (severe form of joint inflammation and bone erosion in hand), muscle weakness, cognitive communication deficit (problem with communication that results in impaired thought processes), mild cognitive impairment (condition where a person experiences more memory or thinking problems than expected for their age), and other symptoms and signs involving cognitive function and awareness (problems with memory, attention, and awareness of surroundings).</p> <p>Review of Resident #1's care plan dated 05/19/2025 reflected Resident #1 wished to be discharged home.</p> <p>Review of Resident #1's discharge MDS dated [DATE] reflected a BIMS score of 10 which indicated moderate cognitive impairment.</p> <p>Review of Resident #1's physician orders reflected an order dated 04/29/2025 that indicated Resident #1 could discharge home on 04/30/2025 with home health and medications.</p> <p>Review of Resident #1's discharge instruction form reflected a date of 05/19/2025. Form included scheduled follow up appointments details of scheduled appointment with PCP for follow up and medication refills by 05/25/2025 despite Resident #1 discharge on 04/30/2025. Further review reflected dietary, skin, patient education/teaching, and patient /RP signature method used (electronic or hand written) was left blank.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #1's recapitulation of stay form dated 04/30/2025 reflected complete this form when the resident is discharged . All items must be addressed. Nursing services section was incomplete and did not include physical function stats, if assistive devices were needed, if any therapies were planned at discharge, disposition of medications, and condition of skin. Activities section was. Dietary section was incomplete as well as rehabilitation services section.</p> <p>Review of Resident #1's progress notes from 04/07/2025 to 04/30/2025 reflected no discharge note was completed.</p> <p>Review of Resident #1's medical chart reflected no discharge summary was completed or uploaded.</p> <p>During an interview on 05/19/2025 at 11:06 AM, FM stated that at discharge of Resident #1 a nurse went into his room and kind of went over medications but did not provide a copy of medication list or the last time the medication was administered. The FM stated that medications were sent home at discharge, but no paperwork was provided. The FM stated that there was no follow up information provided at discharge and the paperwork that was provided was from Resident #1's hospital stay.</p> <p>Review of Resident #2's face sheet dated 05/19/2025 reflected an [AGE] year-old male admitted on [DATE] and discharged on [DATE] with diagnoses of generalized anxiety disorder (persistent and excessive worry), Parkinson's disease with dyskinesia (involuntary jerky movements as a side effect of some medications), polyneuropathy (disease affecting nerves and can cause weakness, numbness or pain), and unspecified fracture of left acetabulum (break in the socket of the hip joint).</p> <p>Review of Resident #2's discharge MDS dated [DATE] reflected a BIMS score of 0 which indicated severe cognitive impairment.</p> <p>Review of Resident #2's physician orders dated 05/13/2025 reflected Resident #2 to discharge to assisted living on 05/15/2025.</p> <p>Review of Resident #2's discharge instruction dated 05/15/2025 reflected an incomplete form that did not include dietary recommendations, skin condition, patient instructions/teaching, and the resident or RP signature method.</p> <p>Review of Resident #2's progress note dated 05/15/2025 reflected Resident #2 was discharged to an assisted living with belongings and medication was sent with driver.</p> <p>Review of Resident #2's medical chart reflected there was no discharge summary or recapitulation of stay completed or uploaded.</p> <p>Review of Resident #3's face sheet dated 05/19/2025 reflected an [AGE] year-old man admitted on [DATE] and discharged on [DATE] with diagnoses of aftercare following joint replacement surgery, unspecified cirrhosis of liver (condition characterized by chronic liver damage), hypokalemia (low potassium levels), and hyperlipidemia (high level of fats in the blood).</p> <p>Review of Resident #3's discharge MDS dated [DATE] reflected a BIMS of 15 which indicated no cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #3's physician orders revealed an order for Resident #3 to discharge on 05/12/2025 dated 05/09/2025.</p> <p>Review of Resident #3's recapitulation of stay dated 05/12/2025 reflected and incomplete document with only vitals and weight generated in the form.</p> <p>Review of Resident #3's medical chart reflected there was no discharge summary completed or uploaded.</p> <p>During an interview on 05/19/2025 at 2:06 PM, LVN B stated that she was made aware a resident was going to discharge from the SW. LVN B stated the SW let the nurses know and put in a discharge order. LVN B stated that the process to discharge a resident was to print out their orders, review medications and instructions with the resident or family. LVN B stated that she also counted the medications that were going to be sent with the resident. LVN B stated if the medication was less than a week's supply or the resident was not going to see their PCP for more than a week, then she asked the NP to send a prescription. LVN B stated that the resident or family signed discharge paperwork and instructions at discharge. LVN B stated that the discharge paperwork included medication list and what the medication was for, last time they took the medication and home health information. LVN B stated the discharge summary was started by the social worker and included where the resident was going, and the nurses inputted their part so it was completed together by the SW and nurse.</p> <p>During an interview on 05/19/2025 at 2:11 PM, RN A stated that she was made aware of a resident's discharge by the order the SW put in. RN A stated that medications were verified with the NP and the resident was sent with a week's worth of medication. If the resident did not have a week's supply for they did not have an appointment within a week to see their PCP then the NP may have provided a prescription. RN A stated during discharge medications were reviewed with the resident and reviewed with the resident or the family if the resident was not considered alert and oriented. There was a form that was reviewed and the family or resident was supposed to sign it. RN A stated the form included upcoming appointments, medication list and home health care information. RN A stated this also included a medication list and the last time a resident took the medications. RN A stated on the discharge summary the NP summarized their part and information was added by therapy and the SW. RN A stated the SW was supposed to put an order in for discharge and any DME the resident needed.</p> <p>During an interview on 05/19/2025 at 2:27 PM, the SW stated that as a team it was decided when a resident was medically stable to discharge or met their goals with therapy. The SW stated that the resident could have received notification of non-coverage and she spoke with the family and let them know an anticipated day. The SW stated a discharge list went out to management that included who was going to be discharged. The SW stated that it was also discussed during the morning meeting and confirmed the time and day of discharge and communication was made with the nurses. The SW stated at discharge residents should have received a discharge form, list of medications and any home health information that has been set up. The SW stated she opened the discharge form at the time she put in the discharge order and it had where the resident was going and home health information. SW stated nursing completed the rest of the form. The SW stated home health information was usually documented on the discharge instruction form.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/19/2025 at 3:56 PM, the DON stated that for discharge, medications were sent with the resident, a discharge summary a medication list, and any personal belongings. The DON stated the discharge summary included where the resident will be discharged to, background information of the resident and if they were going home with home health. The DON stated a recapitulation of stay was completed by the IDT members and they each had their own section. The DON stated it was definitely completed before discharge. The DON stated it was not usually sent with the resident and stated it was usually the discharge summary that was sent.</p> <p>During a subsequent interview on 05/19/2025 at 4:25 PM with the DON, he stated that the discharge summary was its own UDA and was specifically titled discharge summary.</p> <p>During an interview on 05/19/2025 at 4:50 pm, the ADM stated that at discharge she expected the resident to have had a clear plan of where the resident was discharging to, plan of care (home health care, hospice or sitter services), medication list, and equipment to have the tools the resident needed to be successful. The ADM stated she expected that the resident had all the documentation to shower their baseline, where they began and ended and if they reached their goals so it painted a clear picture. The ADM stated the SW was responsible to ensure the discharge summary and recapitulation was initiated and completed. The ADM stated that there was not a process that checked that the information was completed other than a 30-day call back process and discussing any hospitalization after discharge. The ADM stated she expected discharge information to be in PCC so that the facility was aware of where the resident went and who is following them (home health/ hospice).</p> <p>Review of facility policy titled Discharge Summary and Plan dated October 2022 reflected when a resident's discharge is anticipated, a discharge summary and post-discharge plan is developed to assist the resident with discharge. Further review reflected the discharge summary includes a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of discharge in accordance with established regulations. Discharge summary should included, current diagnoses, medication history, course of illness, physician and mental functional status and ability to perform ADLs. A copy of the following is provided to the resident and receiving facility and a copy will be filed in the resident's medical records: a. An evaluation of the resident's discharge needs; b. The post-discharge plan; and c. The discharge summary.</p>		