

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 11/21/2025
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that residents who needed respiratory care were provided with such care, consistent with professional standards of practice, for 5 of 7 residents (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5) reviewed for quality of care. The facility failed to ensure Resident #1, Resident #2, Resident #3, Resident #4, Resident #5's nebulizing masks and/or oxygen canulas were bagged for sanitation when not in use on 11/06/25. This failure could place residents at risk for respiratory infections. The findings included: Record review of Resident #1's face sheet, dated 11/06/25, revealed a [AGE] year-old male, admitted on [DATE]. His diagnoses were multiple fractures of ribs, pulmonary embolism (block by blood clot in lung's artery), Parkinson's disease (kind of neurological disorder), acute respiratory failure with hypoxia (less oxygen), abnormalities of gait and mobility and muscle wasting and atrophy. Resident #1 was sent out to the hospital on [DATE] and returned to the facility on [DATE]. Record review of Resident #1's initial MDS assessment, dated 11/03/25, revealed a BIMS score of 10 indicating his cognition was moderately impaired. Record review of Resident #1's care plan, dated 10/23/25, reflected Resident #1 had altered respiratory status/difficulty breathing r/t acute respiratory failure due to PE. The relevant intervention was administering medication/puffers as ordered and monitoring for effectiveness and side effects. Record review of Resident #1's physician's order reflected: Albuterol Sulfate Nebulization Solution (2.5 MG/3ML) 0.083% 3 milliliters: Inhale orally via nebulizer every 6 hours as needed for wheezing. -Start Date- 11/01/2025. During an observation and interview on 11/06/25 at 10:45 a.m., Resident #1 was in his room. It was observed the mask of his nebulizer was on the side table beside the nebulizing machine. It was exposed to the air and was not in a protective bag. Resident #1 stated he used the nebulizer as needed but not often. Record review of Resident #2's face sheet, dated 11/06/25, revealed an [AGE] year-old female, admitted [DATE]. Her diagnoses were dementia, type 2 diabetes, chronic respiratory failure (Lungs cannot get enough oxygen and remove carbon dioxide), chronic obstructive pulmonary disease (breathing difficulty), muscle weakness, hypertension and chronic cough. Record review of Resident #2's quarterly MDS assessment, dated 09/01/25, revealed a BIMS score of 15 indicating her cognition was intact. Record review of Resident #2's care plan, dated 05/22/25, reflected Resident #2 had emphysema/COPD (lung disease that causes breathing difficulties). The relevant intervention was giving aerosol or bronchodilators as ordered and monitoring /documenting any side effects and effectiveness. Record review of Resident #2's physician's order reflected: Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 3 ml: Inhale orally via nebulizer every 4 hours as needed for SOB or wheezing related to chronic obstructive pulmonary disease, unspecified. -Start Date- 07/20/2025. During an observation and interview on 11/06/25 at 11:20 a.m., Resident #2 was in her room relaxing in her wheelchair. The nebulizer and its mask were on her bed among the pillows and blanket. Resident #2 stated she was able to self-administer medication via nebulizer; however, staff also helped her with it. She stated no one instructed her to put the mask in a protective bag. An observation at that time revealed there was no protective bag available in her room. She stated she did not get any education on storing the mask. Record review of Resident #3's face sheet, dated 11/06/25, revealed a [AGE] year-old female, admitted [DATE]. Her diagnoses were acute respiratory failure, heart failure, shortness of breath, obstructive sleep apnea, type 2 diabetes, hemiplegia and hemiparesis (one side paralysis), muscle weakness, cognitive communication deficit, and anxiety disorder. Record review of Resident #3's initial MDS assessment, dated 05/06/25, revealed a BIMS score of 12 indicating her cognition was moderately impaired. Record review of Resident #3's care plan, dated 06/10/25, reflected Resident #3 had oxygen therapy r/t respiratory failure with hypoxia (low oxygen level in blood), acute on CHF. The relevant intervention was providing oxygen as ordered and medications as ordered by physician and monitoring/ documenting side effects and effectiveness. Record review of Resident #3's physician's order reflected: Albuterol Sulfate Nebulization Solution (2.5 MG/3ML) 0.083% 3 milliliter: Inhale orally via nebulizer every 4 hours as needed for Shortness of breath/wheezing. -Start Date- 07/20/2025. During an observation and interview on 11/06/25 at 1:35 p.m., Resident #3 was in her room lying in her bed awake. She stated she received medication via nebulizer for shortness of breath on an as needed basis. It was observed that her nebulizer with its mask was on the side table. There was no protective bag available for the mask and it was exposed to the air. Record review of Resident #4's face sheet dated 11/06/25 revealed a [AGE] year-old female, admitted [DATE]. Her diagnoses were acute and</p>		