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 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bel Air at Teravista	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 2 residents (R#2), reviewed for pharmaceutical services, in that:The facility failed to ensure Resident #2 had her physician ordered Robaxin (muscle relaxer) 1 500 mg tablet by mouth every 8 hours for pain, available on 01/10/2026.This failure could place residents at risk for not receiving medication as ordered. Findings included: Review of Resident #2 admission record dated 01-08-2026 revealed a [AGE] year-old female that was admitted to the facility on [DATE]. Her diagnoses included Type 2 Diabetes, Chronic kidney disease, Nonalcoholic cirrhosis of the liver (Chronic inflammation of the liver causing gradual scarring), Compression Fracture of the Lumbar Vertebra, (vertebra collapse due to excessive pressure), Malignant breast cancer (producing death or deterioration) and Recurrent Depressive Disorders (multiple episodes of major depression characterized by feelings of sadness, hopelessness and loss of interest in activities). Record Review of Resident #2's MDS, dated [DATE], Section C (Cognitive Patterns) revealed a BIMS score of 12 (moderately impaired cognition). Section G (Functional Limitation in Range of Motion) residents have impairment on both sides of upper extremities. Record Review of Resident #2's Care Plan dated 11/18/2025, revealed, Resident will participate actively in making choices/decisions for care regarding pain management. Record Review of R # 2 's orders dated 01/12/2026 revealed,Tramadol HCl 50 MG was ordered on 01/10/2026 @ 5 p.m.1 tablet by mouth every 6 hours as needed for pain.Fentanyl patch (12 MCG/HR) every 72 hoursMethocarbamol (Robaxin)Oral Tablet 500 MG 1 dose by mouth every 8 hours for painHydrocodone -Acetaminophen 325 MG given for pain 1 tablet by mouth every 6 hours was discontinued on 01/10/2026. Record review of R # 2's MAR dated 01/12/2026 revealed,Tramadol administered PRN on 01/11/2026 at 5:00 PM.Fentanyl patch was ordered on 01/10/2026 and was administered 01/11/2026 at 7:42 AM.Methocarbamol (Robaxin) Order was received on 01/10/2026 at 5:00 p.m and was entered into R2's orders on 11/12/2026. Robaxin was started 01/12/2026 at 12 AM. Missed 1 dose of Robaxin on 01/11/2026 and missed 2 doses on 01/12/2025. During an interview and observation on 01/12/2026, R#2 stated, her daughter told her that she had not received her pain medication on Saturday night. R# 2 stated, she recalled the pain level on Saturday to be 5 out 10. R#2 said she did not ask any of the nursing staff for pain medication on Saturday. R# 2 sated she was not afraid of not getting her medications and she thinks the fentanyl patch is helping reduce the pain. During an interview on 01/12/2026 at 10:25 a.m. Family member reported R#2 was without pain medication from 01/10/2026 at 3:00 p.m. until 01/11/2026 at 4:00 p.m. Family member stated she is making complaints for the purpose of helping R#2 and other residents in the facility. During an interview on 01/12/2026 at 11:18 a.m. DON stated, R#2 was administered the following medications between 01/10/2026- 01/12/2026: Saturday 01/10/1016:- Gabapentin 7 p.m.- [NAME] pass pain patch 8 a.m.- Hydrocodone at 9 am, 3 p.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

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NAME OF PROVIDER OR SUPPLIER: Bel Air at Teravista		STREET ADDRESS, CITY, STATE, ZIP CODE: 4105 Teravista Club Drive Round Rock, TX 78665	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no evening dose because orders were changed around 5 p.m. Saturday.DON stated that LVN A changed orders in the PCC at 5:00 p.m. The new orders were supposed to include scheduled Robaxin 500 mgs every 8 hours in addition to Robaxin PRN. DON stated, LVN A recorded a change of orders to reflect discontinuation of Hydrocodone, but she forgot to put the scheduled Robaxin in the orders.DON stated the following: - Robaxin was ordered and none was given to R#2. He stated, according to the orders, it should be given on the same day as the orders were received.- Tramadol was ordered PRN and none was given to R# 2. - New orders added fentanyl patch every 72 hours and tramadol 50 mg every 6 hours and PRN.- DON stated, the orders did not specificity a time to start the Fentanyl patch however, the Doctor was expecting us to administer tramadol PRN.- New orders discontinued Tylenol, Hydrocodone (scheduled dose and PRN dose) as of 5 p.m. on 01/10/2026.Sunday 01/11/2026: - Robaxin 9:13 a.m. -Tramadol 5 p.m. -Fentanyl 72-hour patch at 7:42 p.m.During an interview on 01/12/2026 at 12:30 p.m., it was revealed that LVN A was responsible for updating orders in R#2's chart. LVN A stated she received orders by text from RN on 01/10/2026 at 4:36 p.m. She stated she updated R#2s chart to include orders to discontinue Hydrocodone (scheduled dose and PRN dose), added fentanyl patch (to be ordered by the physician), Tramadol, PRN and Robaxin was to be changed from PRN to every 8 hours. LVN A stated, I was the charge nurse, and I do take responsibility for not updating the orders immediately.LVN A stated the expectation for starting administration of new medications was to administer them as per orders, immediately.LVN A stated a resident could potentially be in a lot of pain if medications are not given by physician orders. Record review of facility Policy Medication Orders with a revised date of 11/1/2025 revealed: Policy Statement:This facility shall use uniform guidelines for the Ordering of medication.1. Medications should be administered only upon the signed order of a person lawfully authorized to prescribe.2. Verbal orders should be received only by licensed nurses, or pharmacists, and confirmed in writing by the physician, on the next visit to the facility.4. Documentation of Medication Orders:a. Each medication order should be documented with the date, time and signature of the person receiving the order. The order should be recorded on the physician's order sheet and the Medication Administration Record (MAR).e. When a new order changes the dosage of a previously prescribed medication, discontinue previous entry as per the electronic software instructions and enter the new order.f. Ensure the new order is in the electronic [NAME]. Notify resident's sponsor/ family of new medication orders.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents were free from significant medication errors for 1 of 2 residents (R #1) reviewed for medication administration.The facility failed to administer R#1's physician ordered 4 units of Insulin Lispro Injection solution, prescribed to treat Type 2 Diabetes Mellitus, (elevated blood sugar levels) on 12/19,12/22,12/23,12/24,12/25,12/28,12/29 and 12/30/2025. These deficient practices placed residents at risk for not receiving the therapeutic effects of their prescribed medications.Findings include: Record review of R1's admission record reflected a [AGE] year-old female who was admitted to the facility on [DATE]. R1 had diagnoses which included TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (elevated blood sugar levels), HYPOTHYROIDISM (when the thyroid gland doesn't make enough thyroid hormone), BIPOLAR DISORDER (a condition that causes extreme mood swings). ANXIETY DISORDER (Characterized by feelings of fear or apprehension about what's to come and persistent and excessive worry). Resident was discharged to the hospital on [DATE]. Record review of R1's admission MDS assessment, dated 12/25/25, reflected that R1 had a BIMS score of 12 out of 15, which indicated moderate problems with thinking and memory. R1 did not exhibit behavioral symptoms (physical or verbal behavioral symptoms directed towards others). MDS indicated R1 needed some help with everyday functional abilities such as dressing and eating. Record review of R1's care plan reflected a focus of need for insulin as ordered and interventions Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Record review of R1's MAR report indicates R1 received insulin injections on 12 occasions when R1's blood sugar levels were outside the parameters Hold for +BS less than 150 or if patient is not eating. Hypoglycemic protocol for FSBS less the 60. Record review of Physician Orders revision on 12/20/2025: Insulin Lispro Injection Solution(Insulin Lispro) Inject 2 unit subcutaneously three times a day related to Type 2 Diabetes Mellitus without Complication. Order 12/182025. Record review of in-service revealed the following topics were in-serviced on 01/02/2026: Medication Administration and policy review of, abuse and neglect and resident rights.Record review of LVN B's employment file revealed she had a hire date of 03/04/2015 and an official termination date of 01/05/2026. During an interview on 01/09/2026 at 04:05 PM, DON revealed he performed an audit of medication administration on 01/02/2026. The audit revealed that between 12/19/2025 and 12/30/2025 R#1 was administered insulin 12 times outside the prescribed parameters. DON revealed that per R1s MAR, in December of 2025 LVN B administered insulin outside of blood sugar parameters for R1 on December 19th ,22, 23, 24, 25 27, 28, 29 and 30. DON stated, on 12/31/2025 at 6:30 a.m. R1 was reported to have stoke-like symptoms to include lethargy and slurred speech. R1 was transported to the hospital by EMS. DON revealed a record review of R1's blood sugar readings, insulin intake and meal intake were as follows: R1's BS readings on 12/30/2025 at 11:30 a.m. was 117 (outside parameters), 5:00 p.m. reading was 148 (outside parameters). On 12/30/2025 at 11:30 a.m. R1 was administered insulin and 5:00 p.m. resident was not administered insulin. DON stated, on 12/31/2025 R1's scheduled insulin was scheduled to be administered at the upcoming breakfast time at around 8:00 a.m. On 12/30/2025 R1's meal intakes recorded R1 consumed 51-75 % of breakfast and lunch meals, and 76-100 % of dinner meal was consumed by R1. DON stated R1's Diagnosis from hospital is hypoglycemia. (Low blood sugar). Interview on 01/12/2026 AT 12:21 P.M., NP revealed insulin is acting short, and on 12/30/2025 it would have worn off by 5:00 p.m. NP stated, since the resident's food intake was good, the 11:30 a.m. dose would not have affected her BS at 6:00 a.m. the next day. NP stated, R1 was often noncompliant regarding her food intake but, if she had been eating, then I can't say the insulin being given at 11;30 a.m. would have caused her BS to tank at 6:00 a.m. the next day. Policy (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for Mediation Administration. No date listed on this policy 2 The 6 Rights of Medication Administrationc. Right Dose. Verify the label to MAR, these must match. d. Right Dosage Form. Verify the MAR to label, these must match, Tabs, caps and liquid are not always directly interchangeable.e. Right Time. Confirm med-pass time window (1 hr. before to 1 hr. after administration time on MAR. Also includes giving those meds before or after meals or other meds as instructed on either the mediation label or MAR13 Administration of Intravenous Medication b. Verify provider orders prior to administration.