STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676345	A. Building B. Wing	04/01/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure the resident had the right to be informed of, his or her treatment which includingrights.ht to be informed in advance, by the physician or other practitioner or professional, of the risk and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she preferred, for 1 of 5 residents (Resident #1) reviewed for resident rights .The facility failed to provide information to Resident #1's FM about the change of medication from Lantus (Insulin) to Metformin and its risks and benefits and other alternative options available.This failure could place residents at risk of receiving medications without their prior knowledge or consent.The findings include:Record review of Resident #1's face sheet dated 04/01/26 revealed a [AGE] year-old male admitted on [DATE]. His diagnoses were dementia, dysphasia (swallowing difficulty), type 2 diabetes, pain, hypothyroidism (Low thyroid hormone level), protein-calorie malnutrition, muscle wasting, acute kidney failure, adult failure to thrive, hemiplegia and hemiparesis (paralysis of one side of the body) and muscle weakness.Record review of Resident #1's quarterly MDS dated [DATE] revealed that the BIMS could not be completed as the resident was rarely or never understood. As per the MDS, one of Resident #1's active diagnoses was DM, and the resident required substantial assistance with eating, oral hygiene, and personal hygiene.Record review of Resident #1's Care Plan dated 02/25/26 reflected Resident #1 had DM, and the relevant interventions were providing diabetes medication as ordered by the doctor and monitoring /documenting the side effects and effectiveness.Record review of NP D's order reflected: Lantus Subcutaneous Solution (Insulin Glargine): Inject 8 units subcutaneously at bedtime for DM.-Start Date-12/15/2025 2000 -D/C Date-01/14/2026. Metformin HCL oral tablet 500 mg (metformin HCL): Give 1 tablet by mouth two times a day related to type 2 diabetes mellitus with unspecified complications.-Start Date- 01/25/2026, -D/C Date-01/28/2026 Metformin HCl Oral Tablet 1000 MG (Metformin HCl): Give 1 tablet by mouth every morning and at bedtime for DM.-Start Date-01/28/2026, -D/C Date-02/03/2026 Insulin Glargine Solution 100 UNIT/ML: Inject 6 units subcutaneously at bedtime related to type 2 diabetes mellitus with unspecified complications. Hold for BS less than 100.-Start Date-02/03/2026Record review of Resident #1's January and February 2026 MARs reflected that the medications were administered as per the orders. During a phone interview conducted on 01/04/26 at 9:30 a.m., the FM stated that Resident #1 had been on insulin for his diabetes for an extended period, which was effective without any issues. She reported that, sometime in mid-January 2026, NP D discontinued the insulin and initiated Metformin without informing the family or obtaining their consent. The FM indicated that Resident #1 was on Metformin for approximately two weeks and experienced serious side effects. She expressed that if she had been aware of this beforehand, she would not have permitted NP D to make such a change. The FM stated she conducted extensive online research about Metformin and its side effects. She stated that after having Metformin, Resident #1 developed swollen lips and throat, decreased appetite, dysphagia, stomach ulcers, and other complications. The FM also reported informing the ADM in January that she did not want NP D to take care of Resident #1. She stated NP E was involved in Resident #1's treatment team thereafter and she had no concerns with that. She mentioned that she disclosed the (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Metformin issue to the current ADM, who started working at the facility in March 2026, to ensure measures were taken to prevent similar incidents from occurring in the future.During a phone interview on 01/04/26 at 10:45 a.m., NP D stated she was the NP for Resident #1 in January 26. She stated she changed Resident #1's insulin to metformin for better outcome for his Type 2 Diabetes as Resident #1's BSL was historically very inconsistent. She stated she had taken into consideration of Resident #1's health status and made sure that it was okay to start Metformin. She stated the resident was doing well with Metformin and there were no serious side effects from it. She stated Resident #1 was [AGE] years old with diagnosis of adult failure to thrive. She said he already had issues like dysphagia and lack of appetite before commencing Metformin. She stated Resident #1 had issues related to hypothyroidism and some of these issues could be resolved by increasing the dose. NP D said she could not do this due to the resistance from the family to do so. NP D stated Metformin was relatively a safe medication with very little side effects considering its therapeutic benefits. She stated she never had come across any residents having any serious side effects from metformin, during her seven years of career as NP. NP D stated she had not consulted the family prior to replacing the insulin with Metformin. She stated, she made a mistake by not informing and discussing the therapeutic benefit of the new treatment plan and getting the consent of the family. She stated now she knew that it was resident and their family's right to know about any change in the treatment plan.During a phone interview conducted on 01/04/26 at 11:10 a.m., the MD stated that he was aware of the Metformin incident involving Resident #1 that occurred in January 2026. The MD stated that NP D was supposed to discuss any change in the treatment plan and obtain the family's consent before initiating it. He noted that he would have most likely approved the treatment plan change; however, NP D did not discuss it with him prior to making the change. The MD stated that if she had informed him, he would have advised her to obtain the family's consent beforehand, as this is part of resident rights. He further explained that he had discussed the issue with the family and that the side effects they described were consistent with his assessment of Resident #1's declining health due to other diagnoses, making it unlikely that these symptoms were caused by Metformin.During an interview on 04/01/26 at 12:10 p.m., RN A stated that he attended an in-service on resident rights approximately two weeks ago. He explained that residents had the right to know what medications they were taking, to be informed of any changes to their medications, and to understand the effects and side effects of those medications. He said additionally, residents should be informed of alternative therapies if available.During an interview on 04/01/26 at 12:20 p.m., RN B stated that it is one of the residents' rights to know which medications they were taking, as well as their therapeutic effects and side effects. She added that residents also have the right to refuse any medications if they choose. She mentioned that she attended an in-service on resident rights on 03/20/26.During an interview on 04/01/26 at 12:30 p.m., RN C stated that it was the nurse's responsibility to ensure that residents and their families were informed about any medication changes. He explained that usually the NP placed the order, and if it was a new medication, the nurse in charge verifies whether the NP had communicated the change to the resident and family. If not, it was the nurse in charge to educate the resident and family about the new medication. He stated that residents always have the right to accept or decline medications. He also mentioned that he attended an in-service on resident rights approximately two weeks ago.During an interview on 04/01/26 at 2:00pm, the DON stated that the resident was initially on insulin therapy, which was subsequently changed to Metformin. The family expressed concerns that the resident experienced serious issues, such as a swollen throat and lack of appetite, which they attributed to the use of Metformin. The DON reported that NP D was responsible for changing the resident's medication to Metformin and indicated that she did not communicate the change in medication to the FM. He stated the FM complained about it on 02/11/26 and the issue was resolved immediately after that at FM's satisfaction. The DON further explained that the resident was in his 90s and experiencing a decline in overall health. He noted that the issues raised by the FM as potential side effects of the medication were likely related to the natural aging (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	process, hypothyroidism and health decline in general. The DON mentioned that the resident had a thyroid issue, and the family chose not to pursue treatment for it to avoid additional medications, which may have contributed to the resident's declining physical health as well. The DON stated that the resident was a candidate for hospice care; however, the family was reluctant to pursue this option, as they were struggling to come to terms with his health status. The DON stated that since the change in practitioners, a new practitioner is now in charge of the resident's care, and Resident#1's family had no issues with her.During an interview on 04/01/26 at 2:30pm , the ADM stated that he began working at the facility on March 26. He reported that an incident involving the failure to inform the FM of a change in the treatment plan occurred approximately two months prior, on January 26. He stated the FM's intention was to bring this issue to his attention as the new ADM, to ensure that such an issue would not be repeated. The ADM stated that residents and their families had the right to be informed about treatments, medications, and any changes thereto. He said that NP D did not inform the resident and family about the change, which was identified as inappropriate. Subsequently, he stated that NP D was replaced by NP E on February 26. Since this change, the family has expressed satisfaction with the communication. The ADM stated that the facility had already resolved the issue in February. He added however once he was informed by the family on 03/19/26 about the incident, he had re conducted interventions once again to make sure the issue was resolved effectively and permanently. He said a care plan meeting was held on March 20, 2026, with the FM to discuss the past concerns. The FM reported being satisfied with the outcome and indicated that the issue was resolved.Interviews and record review on 04/01/26 starting from 2:00pm with the ADM, DON and MD, revealed, the facility implemented the following prior to the surveyor's entrance to the facility on [DATE]. The Metformin of Resident #1 was discontinued and reinstated Lantus on 02/03/26.Resident was sent to hospital for further evaluation on 02/11/26The service of NP D was discontinued as requested by the FM.The MD was notified on 02/04/26 and 03/19/26.In person care plan conference conducted with FM on 03/20/26 to discuss past concerns.A psychosocial wellbeing assessment conducted on 03/19/26Self-report to state within 2 hours on 3/19/26Ad Hoc QAPI meeting conducted on 03/20/26In service on resident rights, abuse and neglect and physician order notification changes were conducted for the staff on 03/20/26.The facility maintains ongoing and positive rapport with the family.Record review of the facility's policy revised on 12/01/2025 , titled Resident Rights reflected: Policy: The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.Planning and implementing care. The resident has the right to be informed of, and participate in, his or her treatment.d. The right to be informed by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.