STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455497	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Terrace Rehabilitation	1555 Powell Avenue Belton, TX 76513

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to submit a complete and accurate request for nursing facility specialized services in the LTC Online Portal within 20 business days after the date of the Interdisciplinary Team meeting for 1of 1 resident (Resident #1) reviewed for PASARR nursing facility specialized services. The facility failed to submit a Nursing Facility Specialized Service (NFSS) request by the specific deadline for Resident #1 for a customized manual wheelchair. This failure could place residents at risk of not receiving or benefiting from specialized equipment and services required and could affect her quality of life. Findings included:Record review of Resident #1's Face Sheet dated 11/17/2025 reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Cerebral Palsy (neurological disorder affecting movement, posture, balance and muscle coordination), Unspecified lack of coordination (clumsy movements, difficulty with balance and poor muscle control impacting walking, speaking and fine motor skills), and muscle weakness (lack of strength in muscles). Record review of the MDS assessment dated [DATE] reflected that Resident #1's BIMS score was 14, indicating intact cognition, and her functional abilities required the use of a wheelchair for mobility. Record review of Resident #1's Care Plan dated 11/18/2025 reflected Resident #1 was PASARR positive due to diagnoses of cerebral palsy and intellectual disability.In an interview and observation on 12/12/2025 at 15:59pm of Resident #1, she was observed sitting in her room in a wheelchair, however not the customized wheelchair that she required. Resident #1 stated she had been in the facility for 7 months and had not received her new wheelchair yet but stated she was advised that it had been ordered. In an interview with the Administrator on 12/12/2025 at 3:08PM she confirmed that the request for the medical equipment should have been submitted by the 20th day after the Interdisciplinary Team meeting in which Resident #1's needs were identified. Per the Administrator the MDS nurse is responsible for ensuring that all documents required are sent in timely for services. this could affect her quality of life. In an interview with the MDS Coordinator on 12/12/2025 at 4:31PM she confirmed that the request for the medical equipment should have been submitted by the 20th day after the Interdisciplinary Team meeting in which Resident #1's needs were identified. She stated the request for customized manual wheelchair was submitted on 12/12/2025. The MDS nurse is responsible for ensuring that all documents required are sent in timely for services. This could affect the resident's ability to move around freely; this could also affect her quality of life without having the customized wheelchair. Record review of Resident #1's IDT meeting documentation reflected the IDT meeting was held on 8/6/202 and a customized manual wheelchair was recommended for Resident#1., The MDS nurse is responsible for ensuring that all documents required are sent in timely for services. This could affect the resident's ability to move around freely, this could affect her quality of life without having the correct wheelchair.

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