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	01/09/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 50042 Resident #24 FTag Initiation Resident #47 FTag Initiation Resident #48 FTag Initiation 01/09/25 08:07 AM RESIDENT'S ROOM OBSERVED W/ DIRTY WALLS, SCUFFED SHEETROCK, DIRTY AIR FILTERS; PICS TAKEN Resident #84 FTag Initiation

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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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** 47243 Based on interview and record review, the facility failed to ensure the Pre-Admission Screening and Resident Review (PASARR) Level I assessment accurately reflected the resident's status for 1 of 3 residents (Resident #92) reviewed for PASARR Level I screenings. 1. The facility failed to ensure the accuracy of the PASARR Level 1 screening for Resident #92. The PASARR Level 1 screening did not indicate a diagnosis of mental illness, although the diagnosis (post-traumatic stress disorder PTSD with an onset date of 11/08/2024) was present upon Resident #92's admitted on 11/11/24. The facility did not complete a 1012 form to update the PASARR Level 1 with the new diagnosis until surveyor intervention on 01/08/2025. This failure could place residents who had a mental illness at risk of not receiving a needed assessment (PASARR Evaluation), individualized care, or specialized services to meet their needs. Findings included: Record review of Resident #92's face sheet, dated 01/08/25, reflected he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included Post-Traumatic Stress Disorder (a condition of persistent mental and emotional stress occurring as a result of injury or severe psychological shock, typically involving disturbance of sleep and constant vivid recall of the experience, with dulled responses to others and to the outside world.) with an onset date of 11/08/2024 and Vascular Dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a group of symptoms that affect memory, thinking, and behavior caused by brain damage from reduced blood flow) with an onsite date of 11/09/2024). Record review of Resident #92's quarterly MDS assessment, dated 11/12/24, reflected he had a BIMS score of 12, which indicated intact cognition. Resident #92 also took an antipsychotic medication during the assessment window. The MDS assessment reflected Resident #92 required partial/moderate assistance with eating, required substantial/maximal assistance for toileting, showering, and required assistance with personal hygiene. Record review of Resident #92's PASARR Level 1 Screening, dated 11/08/2024, reflected that in Section C Mental Illness was marked as no, which indicated Resident #92 did not have a mental illness. Record review of Resident #92's care plan dated 12/16/24 reflected Resident #92 had a diagnosis of post-traumatic stress disorder and was at risk for side effects to antidepressant medications. Goal: Resident will be prescribed the lowest effective dose of medication. Interventions included Assess resident's functional status prior to initiation of drug use to serve as a baseline. Monitor and report signs of sedation, hypotension, or anticholinergic symptoms. Refer to psychological services as indicated. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/08/2025 at 12:29 PM, Resident #92 stated was doing fine, and staff treated him great. He stated she used her call light if he needed help and staff got to her quickly when he called. He stated he felt safe in the facility, and he had no concerns. In an interview on 01/10/2025 at 03:45 PM, the MDS Coordinator A who stated the PASARR's are done by MDS Coordinator B. She stated she helps her when she is on vacation. She stated if they are PASARR positive, they have services they can miss out on that can be beneficial for their well-being. She stated her expectations is to make sure the PASARR's are completed accurately and done timely. In an interview on 01/10/2025 at 03:45 PM, MDS Coordinator B stated the MDS assessment for Resident #92, was completed incorrectly by the hospital when Resident #92 admitted . She stated there should have been a Y for yes placed in the PASARR Level 1 Screening where the form asks if the resident has evidence or an indicator of a mental illness. She stated the PASSAR II is done if there is a yes on the PASARR evaluation. She stated she was responsible to complete the PASARR's. She stated someone was looking for the PASARR policy and that sparked them to check. She stated they just did Resident #92 PASARR evaluation II on 1/9/2025 because of his PTSD which she learned on 01/09/2025. An in-service and audit on all PTSDs in the building and created 1012. She stated if a PASARR screening was not completed correctly, residents may not receive the services there were entitled to. In an interview on 01/10/2025 at 03:30PM the DON stated the MDS nurses are responsible for making sure PASARR's are done. She stated if it is not completed accurately, it could prevent residents from receiving services. She stated her expectation is that PASARR's will be completed timely. In an interview on 01/10/2025 at 03:10 PM ADM stated that usually the hospital completes the PL1 prior to residents' admission, but if it's not done by the hospital then the facility's MDS Nurses will complete them. She stated if PL1 are not completed, the facility would be out of compliance and the residents would not get the services they need. Record review of the facility's policy dated 06/09/2023, Preadmission Screening and Resident Review (PASARR) stated: Federal requirements to help ensure individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care. PASARR required that 1) all applicants to a Medicaid-certified nursing facility be evaluated for serious mental disorder and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and 3) the services they need in those settings. General Guidelines for PASARR: 4. PASARR requires that: Individual seeking admission to a Medicaid Certified nursing facility (NF) receives a PASARR Level I Screen for intellectual disability (ID) or development disability (DD) or mental illness (MD) before or upon admission. 5. If the PASARR Level I screen indicates the individual may have an ID, DD, or MI diagnosis, follow the state-specific process for completion of the Level II evaluation. 6. If the Level II evaluation confirms an ID, DD, or MD diagnosis, the Facility will collaborate with the community resources when special services are necessary or required. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. If special services are required, the Facility will coordinate services per State policy and develop a care plan that addresses the specific needs.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47243 FACILITY Kitchen 01/07/25 10:09 AM During the initial walk through of the kitchen, everything was clean. The freezer had no open food or containers. Everything was boxed up and no open packages. The refrigerator had lunch bags that were correctly dated with made and used by dates. The pantry items were package up properly. No open bags were found opened. The perishable items were all either ziplocked or wrapped up properly with dates of when it was open. The ice machine was clean and no mold or any substance in the cooler. The overall environment of the kitchen was clean. Regular diet the resident had Chicken (180) taco (with lettuce and tomato), refired beans (170). Mechanical diet: Enchilada ground casserole (170) and refried beans (172). Puree casserole (174), puree beans (172). On 1/7/2025, the menu was supposed to be beef ravioli, lima beans, garlic toast, cream pie. The meal prepared was chicken tacos, refried beans with a cup of fruit. On 1/8/2025, the menu was supposed to be cheese pizza, tossed salad, breadstick, cinnamon baked apples. Pizza was served (pepperoni not cheese), and it was not fully baked, there was no breadstick nor cinnamon baked apples. It was a tasteless cup of fruit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50042 Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program (IPCP) designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections in 1 of 1 dining room observed for infection control in that: LVN A failed to practice proper hand hygiene between residents while distributing food in the dining room. This failure placed residents at risk of cross contamination and the spread of infection. Findings included: During observation of dining services and food distribution to residents in the dining room on 1/7/2025 from 11:40AM to 12:30PM revealed: LVN A removed a used and contaminated cup of water from a resident's dining table and disposed of the cup of water. LVN A failed to wash or sanitize his hands before obtaining and distributing a cup of lemonade to another resident. LVN A grabbed both handles of a resident's wheelchair and rolled the resident to a dining table for meal service but failed to wash or sanitize his hands before and after. LVN A poured a resident coffee from a communal coffee pot but failed to wash and sanitize his hands before placing a plastic lid on top of the coffee cup and placing the coffee cup in front of the resident for consumption. LVN A touched the top of a cup of iced tea on a tray waiting to be served but failed to wash or sanitize his hands before. LVN A distributed a cup of iced tea to a resident but failed to wash or sanitize his hands prior to distribution. LVN A handled and opened a resident's personal plastic storage bag of what appeared to be sugar or a sugar substitute, removed the plastic lid on top of the resident's coffee cup with his bare hands, and poured the substance into the resident's coffee cup. LVN A failed to wash or sanitize his hands before the preparation and service. LVN A placed a consumed and contaminated plate of food on a tray on a rolling cart. LVN failed to wash or sanitize his hands after. LVN A used his bare hands to push open the swinging doors of the kitchen to obtain a frozen dessert cup for a resident. LVN A distributed the frozen dessert cup to the resident. LVN A failed to wash or sanitize his hands before and after distribution. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN A placed contaminated food service items (plate, cup, utensils) on a tray and placed the tray on a food cart. LVN A failed to wash or sanitize his hands after. LVN A used his bare hands to push open the swinging doors of the kitchen to obtain a salad and salad dressing for a resident. LVN A failed to wash or sanitize his hands before and after. LVN A opened a drawer and obtained mayonnaise. LVN A failed to wash or sanitize his hands before and after. LVN A distributed the salad, salad dressing, and mayonnaise to the resident. LVN A failed to wash or sanitize his hands before. During an interview on 1/7/2025 at 12:12PM, LVN A stated that he is a charge nurse. LVN A stated that he assists with dining service and was familiar with the dining service times and process, including seating, set-up, and distribution. During an interview on 1/9/2025 at 2:21PM, the MS stated that he was responsible for ordering hand sanitizer for the facility. He stated that there has never been a shortage of hand sanitizer in the facility, and they have never run out. Staff were observed using a hand sanitizer dispenser in the dining room along with the sink and soap and personal hand sanitizers they kept on their person. There was also a bottle of hand sanitizer observed on the half wall in the dining room that was being utilized by staff periodically. During an interview on 1/9/2025 at 2:29PM, the ADON acknowledged the facility has a hand hygiene policy that she is familiar with and educated on. The ADON provided proper and extensive examples on hand hygiene procedures to demonstrate her competency. Regarding hand washing and dining service, the ADON stated that staff are required to wash their hands prior to passing dining trays and drinks. Thereafter, staff should practice hand hygiene in between tray and drink passes by washing their hands or using hand sanitizer. The ADON stated hand hygiene is very important to prevent the spread of infection. The ADON stated that staff should wash their hands or use hand sanitizer in between contact with each resident or each resident's equipment, even if there has been no known skin to skin contact or bodily fluid contact. She said staff are trained on this procedure and regularly receive in-service education on this topic. During an interview on 1/9/2025 at 2:40PM, the ADM stated that the facility's policy and procedures regarding hand hygiene is contained in their Infection Prevention and Control Plan policy and procedures. The ADM stated that the facility's DON conducts staff education and competency evaluations regarding hand hygiene . The ADM stated that her expectation regarding hand hygiene, specifically during dining service, is for staff to sanitize or wash their hands in between each tray pass and that cups should not be grabbed around the rim, even if they are covered. She stated that staff should wash or sanitize their hands in between contact with residents or resident equipment, even if there is no known skin to skin contact or bodily fluid contact. The ADM stated hand hygiene is important to prevent the spread of infection. The ADM stated that in-service education on this topic is regularly provided to staff, as well as annual competency evaluations. During an interview on 1/9/2025 at 3:00PM, the DON stated that all staff are expected to practice proper hand hygiene. The DON stated that staff should wash or sanitize their hands thoroughly using the proper technique after any resident contact. The DON stated that all nursing staff undergo proficiency and competency checkoff's every year . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Infection Prevention and Control Policies and Procedures, dated May 15, 2023 (complete revision), regarding Infection Prevention and Control Program and Plan, states the facility's procedures include in part: 1. Operational Direction: C. 8). The facility will implement the Infection Prevention and Control Facility of Excellence Program and maintain the associated standards . 6. Staff Development: D. Quarterly infection control education to all staff with validation of core competencies completed (e.g., handwashing, donning/doffing PPE, and equipment cleaning) . E. Staff is provided with information and training on: 1.) Infection Prevention and control information and plans 2.) Federal, state, and local regulations impacting the facility infection prevention and control requirements, and employee protection, including the Bloodborne Pathogen Standard, Tuberculosis and required OSHA education/training. This training is provided in accordance with regulatory requirements: a) At the time of hire. b) At least every 12 months. c) When job activities change . d) Updated education and training when policies and procedures are revised or when there is special circumstance . 3.) Hand hygiene, including hand washing and alcohol-based hand rub (ABHR) . 6.) Proper handling of linens, wastes, equipment, and supplies. 10.) Cleaning, disinfecting and sanitation procedures . 8. Department Responsibilities A. All department managers are oriented to infection control and prevention policies and procedures that relate to their department. B. Department Managers take responsibility for implementing such standards, and to verify staff (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	understand and take an active role in infection prevention and control . Record review of the facility's Staff Education/Orientation Policies and Procedures, dated January 12, 2024 (complete revision) states the facility policy regarding orientation is: The facility will provide orientation and training that is integral to fulfilling the organization's mission thus creating a culture that fosters self-development and continued learning. The facility procedures regarding orientation states: 1. Day 1: All new employees receive the general facility orientation program on day one of employment and it is completed with the designated member of the facility staff . The facility's day one General Orientation Checklist includes the following topics in part: COVID Related Training which includes but is not limited to handwashing. Infection Control which includes but is not limited to universal precautions, handwashing and hand hygiene, equipment cleaning and disinfecting, and Infection Prevention Pledge. Environment, Safety & Health. Record review of the facility's Staff Education/Orientation Policies and Procedures regarding Nursing Policies and Procedures hand hygiene competency dated 2018 (Complete Revision: 7/1/2013; Email Revision: 8/31/2018) shows that nursing department staff must meet competency and performance criteria for hand hygiene and alcohol-based hand rub (ABHR). Record review of the facility's Inservice Attendance Records show the following topics covered in part for the last 90 days: 9/17/2024-Staff: Nursing, Topics: Infection Control, including Perform hand hygiene following facility policy; before and after patient care, meal service, when hands are visibly soiled. 9/17/2024, 9/24/2024-Staff: Nursing, Topics: Dining Room & Meal Service, which states in part, Please follow the below guidance during meal service and in dining room to honor resident rights and practice good infection control processes .Staff must perform hand hygiene when serving meal trays. Staff must use hand sanitizer between tray passes up to 3 times. After third use of hand sanitizer staff must wash their hands. 10/21/2024-Staff: All Staff, Topics: Norovirus Dietary, which states in part, Please note that we have several residents with GI symptoms to include nausea, vomiting, and diarrhea. Please see below for information about Norovirus, how to care for symptomatic residents and preventative measures .Preventing Norovirus: Frequent hand hygiene. Always perform hand hygiene before and after care and before and after serving meals. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN A did not attend the above in-service sessions as evidenced by the lack of his printed and/or signature on the attendance records. 50360

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49048 Based on observations, interviews, and record reviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 9 of 9 A/C units/filters inspected in that: The facility failed to ensure air conditioner filters and vents were safe and sanitary. This deficient practice could place residents at risk of respiratory and other illness and cause significantly restricted airflow and reduced efficiency of the heating and cooling system. Being in an environment that is not safe and/or sanitary. The findings included: An observation on 1/9/2025 at 9:34 AM in facility conference room revealed an A/C grate on the wall, near the door had a thick layer of dust and dirt which had accumulated on its surface. The filter had a grayish, brown coating. An observation on 1/9/2025 at 9:58 AM in resident room [ROOM NUMBER] revealed an A/C filter had a thick layer of dust and dirt which had accumulated on its surface. The filter had a grayish, brown coating. The vents on top of the unit had a layer of dust and debris. The left and right corners underneath the vents, contained a fuzzy, white substance and many particles which were food. An observation on 1/9/2025 at 10:16 AM in resident room [ROOM NUMBER] revealed an A/C filter had a thick layer of dust and dirt which had accumulated on its surface. The filter had a grayish, brown coating. The holes in the grate were completely covered with dust and dirt. No light was visible through the filter. When the air filter was lifted from the compartment, a clump of dust, dirt and debris fell on to the floor. An observation on 1/9/2025 at 10:23 AM in resident room [ROOM NUMBER] revealed an A/C filter had a thick layer of dust and dirt which had accumulated on its surface. The filter had a grayish, brown coating. The holes in the grate were completely covered with dust and dirt. No light was visible through the filter. When the air filter was lifted from the compartment, a clump of dust, dirt and debris fell on to the floor. An observation on 1/9/2025 at 10:29 AM in resident room [ROOM NUMBER] revealed an A/C filter had a thick layer of dust and dirt which had accumulated on its surface. The filter had a grayish, brown coating. An observation on 1/9/2025 at 10:35 AM in resident room [ROOM NUMBER] revealed an A/C filter had a thick layer of dust and dirt which had accumulated on its surface. The filter had a grayish, brown coating. The holes in the grate were completely covered with dust and dirt. No light was visible through the filter. When the air filter was lifted from the compartment, a clump of dust, dirt and debris fell on to the floor. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 1/9/2025 at 10:35 AM in resident room [ROOM NUMBER] revealed an A/C filter had a thick layer of dust and dirt which had accumulated on its surface. The filter had a grayish, brown coating. An observation on 1/9/2025 at 10:35 AM in resident room [ROOM NUMBER] revealed an A/C filter had a thick layer of dust and dirt which had accumulated on its surface. The filter had a grayish, brown coating. When the air filter was lifted from the compartment, a clump of dust, dirt and debris fell on to the floor. An observation on 1/9/2025 at 10:35 AM in resident room [ROOM NUMBER] revealed an A/C filter had a thick layer of dust and dirt which had accumulated on its surface. The filter had a grayish, brown coating. In an interview on 1/9/2025 at 3:07 PM with M S, they said they were responsible to develop the schedule for and to complete the routine maintenance. They identified negative outcomes for residents and poorly functioning A/C units, and they could get sick. They said the filters were cleaned and changed each month . They said, I am a one-man department. It is just me. I do the best I can. They said they were informed about the condition of the A/C filters, and it did not meet their expectations. In an interview on 1/9/2025 at 3:13 PM with DON, they said the maintenance department was responsible for completing the routine maintenance on the A/C units. They said the ADM was responsible to ensure the routine maintenance was completed. They identified risk for residents as serious respiratory issues, difficulty breathing, Pneumonia, and other illness. They said the condition of the A/C units did not meet their expectations. In an interview on 1/9/2025 at 3:26 PM with ADM, they said the maintenance department was responsible for scheduling and completing the routine maintenance on the A/C units. They said the ADM and DON were responsible to ensure the routine maintenance was completed. They identified risk for residents as respiratory illness. When asked if the condition of the A/C units met their expectations, the response was, No. A Record Review of the facility's Maintenance/Housekeeping, Policies and Procedures, Wall A/C Unit Filter Inspection - Patient/Resident Areas (Monthly) forms, Revision date 7/26/2017. There were four forms, one for each hallway. The forms were divided into three columns; Room#/Location, Insp. Int., and Date. The first column, Room#/Location, is blank on all four forms. There was no indication of the specific rooms inspected monthly. A Record Review of the facility's Position Description for Maintenance Director, dated 09/08/2009 reflected: Summary Description: The Maintenance director is responsible for directing the overall operation of the requirements and as directed by the Administrator or designee, to ensure that a successful maintenance program is maintained at all times. (May be used along or along with Maintenance Assistant and/or transportation job description.) (continued on next page)

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	01/09/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.4. Ensures the plant and equipment are properly maintained for patient/resident safety, comfort, and convenience. .8. Inspects the facility, on a regular basis, to ensure that the grounds, facility, and equipment are maintained in accordance with established policies and procedures and all hazardous areas are properly identified. .10. Establishes an effective preventive maintenance program of cleaning, painting, maintaining facility equipment, etc., as necessary/approved. .12. Maintains the heating and cooling units/systems in proper working condition, as specified by the manufacturer. Prior to the onset of seasonal changes, inspects the systems for loose wires, broken lines, leaks, etc., and pre-start unit/system to ensure proper working order. 50042