

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/27/2025
NAME OF PROVIDER OR SUPPLIER  Trinity Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE  1600 Texas St Fort Worth, TX 76102	

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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44140</p> <p>Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for one of one kitchen reviewed for food and nutrition services.</p> <p>Cook I failed to wear a hair restraint while in the facility's kitchen on 03/25/25.</p> <p>These failures could place residents at risk for food contamination and foodborne illness.</p> <p>Findings included:</p> <p>Observation on 03/25/25 at 7:00 AM revealed [NAME] I not wearing a hairnet while in the kitchen. [NAME] I was observed to be walking around the kitchen where food was being cooked. [NAME] I's hair was down with the length of her hair reaching her neck area.</p> <p>Interview on 03/25/25 at 7:15 AM with [NAME] I revealed the first thing the staff were required to do upon entering the kitchen was to put on a hairnet restraint. She stated she had arrived at her shift a quarter before six and noticed salads were not prepped, and she got overwhelmed and began to prep the salads. She stated she got busy and forgot to put on a hairnet. She stated the potential risk of not wearing a hairnet could be hair falling inside the food.</p> <p>Interview on 03/25/235 at 10:58 AM with the Nutrition Services Manager revealed all staff must wear a hairnet upon entry of the kitchen. She stated hairnets and beard nets were located at each entrance of the kitchen. She stated the risk of not wearing a hairnet would be contamination and hair falling on the food.</p> <p>Record review of the facility's Uniform Dining Services policy, revised November 2024, reflected: Hair . must be pulled up and contained in a hair net.</p> <p>Record review of the Federal Food Code 2022 reflected: 2-402.11 Effectiveness. (Hair Restraints) 1. Code of Federal Regulations, Title 21, Sections 110.10 Personnel. (b) (1) Wearing outer garments suitable to the operation . (4) Removing all unsecured jewelry . (6) Wearing, where appropriate, in an effective manner, hair nets, head bands, caps, beard covers, or other effective hair restraints . (8) Confining .eating food, chewing gum, drinking beverages or using tobacco and (9) Taking other necessary precautions</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>43791</p> <p>Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 5 of 19 residents (Residents #11, #18, #19, #33 and #94) reviewed for infection control.</p> <p>MA A failed to sanitize a reusable blood pressure cuff between uses on Residents #11, #18, #19, #33 and #94.</p> <p>This failure could place residents at risk of cross contamination of infections from other residents.</p> <p>Findings included:</p> <p>Observation of medication administration in the East Tower by MA A on 03/26/25 from 7:01 AM to 8:10 AM revealed she did not sanitize her re-useable blood pressure cuff between blood pressure checks for Residents #11, #18, #19, #33 and #94.</p> <p>Record review of Resident #94's EHR revealed she was on Enhanced Barrier Precautions due to having an open wound.</p> <p>Interview on 03/26/25 at 8:10 AM with MA A revealed she did not usually check resident blood pressures. She stated the nurses normally did it because she was the only medication aide for the entire facility. She stated she was checking blood pressures due to her nurse being behind schedule. She stated she knew the cuff should be sanitized between each resident. MA A stated the risk to residents if the blood pressure cuff was not sanitized was that it could expose the residents to germs from other residents.</p> <p>Interviews on 03/27/25 from 11:00 AM to 11:41 AM with RN B, CNA C, CNA D, CNA E, CNA F, CNA G and RN H revealed they had been in-serviced on 03/26/25 by the ADON about sanitizing cuffs between resident use. They all stated the cuff had to be sanitized between residents to avoid cross contamination from one resident to another.</p> <p>Interview on 03/27/25 at 11:48 AM with the ADON revealed MA A notified him that she had not sanitized the blood pressure cuff between resident uses, so he provided an in-service training to all nurses and CNAs. He stated the cuff had to be sanitized with disinfecting wipes and left to dry for one minute to avoid cross contamination between residents.</p> <p>Interview on 03/27/25 at 11:55 AM with the DON revealed any equipment that was shared between multiple residents had to be sanitized between uses to avoid cross contamination between residents.</p> <p>Record review of the facility's Infection Control Standard Precautions policy, dated March 2022, reflected:</p> <p>.3. Resident-Care Equipment</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>.b. Ensure that reusable equipment is not used for the care of another resident until it has been appropriately cleaned, disinfected, and reprocessed .</p>		