STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675238	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Terrace	1600 Texas Street 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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review the facility failed to provide pharmaceutical services to ensure accurate acquiring, receiving, dispensing, and administering of all medications for 1 of 3 residents (Resident #2) reviewed for medication administration. The facility failed to administrator Resident#2's Brimonidine Tartrate Ophthalmic Solution 0.2 % (Brimonidine Tartrate) as ordered from 05/15/26 to 05/27/26. The facility documented Resident #2's Brimonidine Tartrate Ophthalmic Solution 0.2 % (Brimonidine Tartrate) was administered when the medication had not been delivered to the facility from 05/15/26 at 7:00 P.M, 05/16/25 at 10:00 A.M. and 7:00 P.M till 5/19/26 was documented as administered. On 5/23/26 at 7:00 P.M till 06/25/26 was documented as administered. This failure placed residents at risk of complications related to routine medications not available in the facility. Findings included:Record review of Resident #2's face sheet dated 05/29/26, reflected Resident #2 was a [AGE] year-old male, was initially admitted on [DATE] and readmitted on [DATE]. Resident #2 was diagnosed with Hypertension (High Blood Pressure Condition), Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD) (bilateral. Refers to a condition where both eyes show early or suspicious signs of glaucoma but with minimal risk of progression, requiring careful monitoring rather than immediate treatment.) Record review of Resident #2's MDS dated [DATE] reflected, Resident #2 had a BIMS of 13 which indicated intact cognition. Record review of Resident #2's order summary, dated 05/29/26, reflected Brimonidine Tartrate Ophthalmic Solution 0.2 % (Brimonidine Tartrate) Instill 1 drop in both eyes two times a day related to open angle with borderline findings, low risk, bilateral, initiated on 01/20/26. Record review of Resident #2's progress notes, dated 05/29/26, reflected from 5/15/26 to 5/2726. Resident #2 was out of Brimonidine Tartrate Ophthalmic Solution 0.2%. Record review of Resident #2's May MAR dated 05/29/26 reflected on 5/15/26 at 10 am the eye drops were not available. MAR reflected on 5/15/26 LVN F administered eye drops until 10 am on 5/19/26. On 5/19/26 at 7 P.M, MA D documented until 05/22/26 at 10:00 A.M., that medication was not available. From 5/22/26 to 5/25/26 at 7:00 P.M., LVN C documented he administered eye drops. From 5/22/26 to 5/25/26 until 10:00 A.M., MA E documented eye drops were not available from 5/25/26 to 5/27/26 MA D documented at 10 am and 7:00 P.M., the eye drops were not available. During an interview on 5/27/26 at 10:00 A.M., Resident #2 stated that he had not had one of his eye drops for several days. Resident #2 stated the facility was working on getting eye drops for him. Resident #2 stated that he did not believe his vision had changed, but he was waiting. During an interview on 05/27/26 at 10:30 A.M, MA D stated she ordered the eye drops on 5/11/26 and they should have come in two days later. MA D stated she reordered again and turned in a daily list of medications that needed to be reordered and gave it to ADON J. MA D stated on Tuesday 5/26/26 she spoke directly to the DON about Resident #2's eye drops.During an interview on 05/28/26 at 8:25 A.M., the DON stated the pharmacy would not refill the drops because it was too soon. The DON stated on Tuesday, on 05/26/26 she started to reach out to the pharmacy called and emailed, the medication was too soon to fill on 05/24/26. The DON stated the medication was supposed to be delivered this evening, The DON stated since Resident #2 received eye drops (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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	twice a day in both eyes, the bottle was only good for a 15-day supply, not a 30-day supply. The DON stated she also needed to speak with LVN C about signing off on medication that was not there. The DON stated nurse management was responsible for following up on orders.During an interview on 05/28/26 at 2:50 P.M, LVN C stated on 05/23/26 to 05/25/26 he was without a medication aide and had to pass medication aide medications. LVN C stated he needed to make sure the medication was present before he documented that the medication was given. LVN C stated the resident was prescribed medication for a reason to prevent the medication from loss of effectiveness. Attempted telephone interview with the pharmacy on 05/28/26 at 3:30 P.M. and the line was busy.Attempted telephone interview with MA E on 05/28/26 at 3:35 P.M and the number was disconnected. Attempted telephone interview with MA F 05/28/26 at 3:48 P.M, and number was not available. Attempted telephone interview with an ophthalmologist on 05/28/26 at 3:45 P.M and left a voice message. During an observation on 5/29/26 at 10:15 A.M., Brimonidine Tartrate Ophthalmic Solution 0.2% was not on the medication cart.During an interview on 05/29/26 at 11:19 A.M., ADON H and ADON I stated, the DON in-serviced staff about checking the carts at night and making sure they order within the week before the eye drops run out. ADON H stated she notified the doctor on 05/28/26 and did an eye assessment, and no concerns were found. ADON H stated staff cannot document that medication was given if the medication was not on the medication cart. ADON H stated resident could be assed incorrectly because of the medication not being administered correctly.Record review of facility in-service, Topic: Correctly documenting, medication administration, 05/28/26, reflected, .documentation that a medication was administered when it was not physically received by the resident is unacceptable, and is not permitted.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure that drugs and biologicals were stored in locked compartments and permit only authorized personnel to have access to the keys, for 1 (medication cart #1) of 2 medication carts observed for medication storage. On 05/27/2026 at 3:24 P.M., MA D failed to ensure medications were secured or attended to by authorized staff when MA D did not lock medication cart #1. These failures place residents at risk of access to medications or drug diversion.Findings Included:During an observation on 05/27/2026 at 3:24 P.M., medication cart #1 red panel was outwards to indicate the cart was unlocked. The medication cart was observed midway down the hallway with drawers facing outward and unlocked. Observation revealed three visitors and a housekeeper walked by the open medication cart. Observation revealed MA D was not in view of the medication cart. During an interview on 05/27/2026 at 3:32 P.M., MA D stated she ran around the corner real quickly and didn't know she left the cart open. MA D stated the medication court was supposed to be locked so residents cannot get into it. During an interview on 05/28/26 at 10:00 A.M., RN G stated the medication cart had to be locked before staff could walk away. During an interview on 05/29/26 at 11:19 A.M., the ADON stated that when staff step away from the medication cart, they should lock the cart. The ADON stated the medication cart needed to be secured for the residents and visitors' safety. Record review of facility's Medication storage in the facility, revised 01/2018, reflected .B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, 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 disease and infections for 1 of 4 residents (Resident #17) reviewed for infection control.The facility failed to ensure CNA A performed hand hygiene in between glove changes while providing toileting care for Resident #17.These failures could place residents at risk of infections.Findings included:Review of Resident #17's quarterly MDS, dated [DATE], revealed the resident was an [AGE] year-old male admitted on [DATE] with diagnoses of cancer, renal failure and diabetes. The MDS also listed that Resident #17 was dependent on toileting. The MDS listed the resident's BIMS as 08, which indicated moderate cognitive impairment. Review of Resident #17's care plan, revised on 3/30/2026, revealed the resident had a history of UTI and was at risk of UTI due to incontinence. In an observation on 5/27/2026 at 9:15am, CNA A and CNA B were providing toileting care for Resident #17 before they transferred him from bed to wheelchair for his shower. Both CNAs washed hands before providing care to the resident. CNA A wiped Resident#17's bottom which was noted to have stools. CNA A removed her soiled gloves and proceeded to change gloves without performing hand hygiene. CNA B was observed to hand sanitize after she removed her soiled gloves before she put on a new pair of gloves. Both CNAs washed hands after they provided toileting care to the resident. In an interview on 5/27/2026 at 9:35am, CNA B stated she noticed CNA A did not perform hand hygiene after she removed her soiled gloves. She stated she whispered to CNA A to wash her hands. She stated she was not sure if CNA A heard her but CNA A did not wash her hands. She stated that put the resident at risk for infection. She stated the last in-service on hand hygiene was provided last month. In an interview on 5/27/2026 at 10:41am, CNA A stated she realized she did not sanitize her hands after she removed the soiled gloves. She stated she got nervous and she just kept going. She stated the risk of not performing hand hygiene in between glove change included infection. She stated she was provided in-service on hand hygiene last month. In an interview on 5/29/2026 at 9:35am, the Infection Preventionist stated he provided in-services regarding hand hygiene and infection control. He stated his expectation from his staff regarding hand washing was they need to wash hands before patient care, in between glove change, and after providing resident care. He stated he was made aware of the incident on 5/27/2026. He stated the risk of not performing hand hygiene in between glove change included infection. He stated he provided in-services on infection control and hand hygiene monthly or as needed. He also performed spot checks randomly to make sure staff followed infection prevention protocols. Record review of facility's Handwashing/Hand hygiene policy, revised 02/2023, revealed the policy stated if hands are not visibly soiled, use an alcohol-based hand rub. for the following situations:. after contact with resident's intact skin, after removing gloves. The policy also stated the use of gloves does not replace handwashing/hand hygiene.