

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675546	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Trinity Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 E Main St Round Rock, TX 78664	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39269</p> <p>Based on observations, interviews, and record reviews, the facility failed to treat residents with respect and dignity and care for them in a manner and in an environment that promoted maintenance or enhancement of their quality of life for 6 of 22 residents (Resident #s 1, 2, 3, 4, 5 &6) reviewed for resident rights.</p> <p>The facility failed to treat Resident #s1, 2, 3, 4, 5 & 6 with respect and dignity when they did not receive their lunch meal tray while the other residents seated with them in the dining room were already eating.</p> <p>This failure could place residents at risk for decreased quality of life, decreased self-esteem and increased anxiety.</p> <p>Findings:</p> <p>Review of Resident#1's undated face sheet revealed a [AGE] year-old female with admitted [DATE]. diagnoses included hemiplegia and hemiparesis (hemiplegia refers to complete paralysis while hemiparesis refers to partial weakness on one side of the body that can affect the arm, leg and face) following cerebral infraction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it)., iron deficiency anemia, facial weakness following cerebral infarction.</p> <p>Review of Resident #1's admission MDS assessment dated [DATE] revealed a BIMS score 05, indicating severe cognitive impairment.</p> <p>Review of Resident #1's Care Plan dated 01/23/2024 revealed the resident has an ADL self-care performance deficit related to CVA with right sided weakness, the resident has potential for impaired cognitive function related to dementia.</p> <p>(continued on next page)</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 04/26/2024 at about 12:15 pm, Resident #1 was noted sitting are a table with 3 other Residents in an auxiliary dining hall on unit C. It was observed the first lunch cart for unit C was in the dining hall, Resident #1 and another resident on the same table were not yet served their lunch trays while the other 2 residents were already served their lunch trays. At about 12:41 pm, the second batch of cart for unit C was brought to the dining area, the 3rd person on Resident #1's table was served her lunch tray while Resident #1 continued to wait. At about 12:52 pm, the first 2 Residents who were served lunch earlier on Resident #1's table were done eating and sitting while Resident #1 was still waiting on her lunch tray. When Survey team asked Resident # 1 if she had gotten her lunch tray, all 4 residents on the table replied, It will come, it is usually on the last food cart. At about 12:56 pm, Resident #1 received her lunch tray.</p> <p>During an interview on 04/26/2024 at about 2:21 pm, Resident #1 stated it usually took 35 minutes to get her lunch tray after her table mates have gotten their food. Resident #1 stated it made her to feel bad that her table mates always get their food her, they are done with eating before her tray is delivered. Resident #1 also stated, We all are supposed to get our tray the same time on the table. We are supposed to eat together, at one time.</p> <p>Review of Resident#2's undated face sheet revealed a [AGE] year-old male with admitted [DATE]. Diagnoses include expressive language disorder, dysphagia (medical term for difficulty swallowing), cognitive communication deficit, anxiety disorder.</p> <p>Review of Resident #2's Nursing Home Optional MDS assessment dated [DATE] revealed a BIMS score 00, staff interview indicating severe cognitive impairment.</p> <p>Review of Resident #2's Care Plan revised 05/04/2023 revealed the resident has an ADL self-care performance deficit related to cognitive deficit, muscle weakness and impaired cognition, communication problems related to expressive aphasia.</p> <p>During an observation on 04/26/2024 at 12:31 pm it was observed Resident #2 was at the same table with another male resident and the male resident received his lunch tray while Resident #2 sat and watch his table mate eat. It was also observed Resident #2 did not get his lunch tray until his table mate was done eating and left the table. It was observed Resident #2 received his lunch tray at about 1:01 pm</p> <p>Review of Resident#3's undated face sheet revealed a [AGE] year-old female with admitted [DATE] and readmitted d of 05/20/2020. Diagnoses included Alzheimer's disease, unspecified dementia, dysphagia (medical term for difficulty swallowing), generalized anxiety disorder.</p> <p>Review of Resident #3's Nursing Home Optional MDS assessment dated [DATE] revealed a BIMS score 000, staff interview indicating severe cognitive impairment.</p> <p>Review of Resident #3's Care Plan revised 11/20/2023 revealed the resident has an ADL self-care performance deficit related to dementia, the resident has impaired cognitive function/dementia or impaired thought processes related Dementia, Alzheimer's.</p> <p>Review of Resident #3's physician order dated 10/14/2022 reflected the following:</p> <p>Regular diet, pureed texture, nectar consistency.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident#4's undated face sheet revealed an [AGE] year-old female with admitted [DATE]. Diagnoses included unspecified dementia with other behavior disturbance, dysphagia (medical term for difficulty swallowing), deficiency of other specified B Group vitamins.</p> <p>Review of Resident #4's quarterly MDS assessment dated [DATE] revealed a BIMS score 06, indicating severe cognitive impairment.</p> <p>Review of Resident #4's Care Plan revised 04/22/2024 revealed the resident has an ADL self-care performance deficit related to advancing Dementia, the resident has impaired cognitive function/dementia or impaired thought processes advancing dementia, history of TIA.</p> <p>Observation on 04/26/2024 at about 12:57 pm in the auxiliary dining area on unit C, Resident #3 and Resident #4 were sitting at the same table during lunch. Observation revealed Resident #3 sitting without her lunch tray while Resident # 4 already had her lunch tray and was eating. Observation also revealed Resident #3 trying to reach into Resident #4's plate to eat while Resident #4 was attempting to keep her plate away from Resident #3 by moving her plate to the other side of the table. Resident #3 attempted several times to reach in Resident #4's plate and was licking her fingers with each attempt.</p> <p>During an interview on 04/26/2024 at 1:09:pm Resident #4 stated the Lady [Resident #3] was trying to grab her plate and she [Resident #4] felt sorry for [Resident #3] because she was hungry. Resident #4 stated she wanted to give Resident #3 some her [Resident #4's] drink but she knew better not to do so.</p> <p>During an interview on 04/26/2024 at about 1:24 pm CNA A stated Residents on unit C do not have particular seating arrangement. She also stated there are lot of Residents in the dining hall for lunch. She stated the food carts used to get to unit at the same time and the trays were served according to the residents at the same table. She stated it is not right for some residents to get their food tray while the others at the same table waited. She stated Resident #3 has been trying to grab other resident food that is why she is usually put on a table by herself. She also stated Resident #3's diet is pureed and nectar liquid, if she grab someone with regular diet tray and eat from it, she will choke on the food and drink.</p> <p>During an interview on 04/26/2024 at about 1:45 pm LVN B stated there was an ongoing construction in the main dining hall for about 4 weeks now so residents on unit C ate in the auxiliary dining hall. LVN B also stated there not enough space for residents in the auxiliary dining hall. LVN B stated the food carts were brought on unit C 1 at the time and there were total of 3 carts. LVN B stated there is dignity problem for some residents at a table to receive their meal tray and eat while the others at the same table are sitting and watching. LVN B stated she had discussed the issue with ADON C and ADON C went to the kitchen to address the issue. LVN B stated, Resident [#3] was always reaching out but there were not enough tables.</p> <p>During an interview on 04/26/2024 at about 3:01 pm CMA D stated the food carts on unit C was not usually brought to the unit the same time. CMA D also stated sometimes there is problem because some residents were sitting and waiting for their food while others were eating. She stated some of the residents would be asking for their food. CMA D stated Resident #1's tray is always on the last food cart brought to the dining hall.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/29/2024 at about 11:01 am the Dietary Manager (DM) stated residents are not eating in the main dining area due to construction which started at the end of March 2024. The DM stated there were 3 food carts for unit C out of 7 total food carts in the facility. The DM stated Cart #1, cart # 5 and cart #6 were usually sent to unit C. The DM stated she, the Administrator, the DON and 2 ADON discussed how the trays were to be put on the carts and which food cart to be delivered first. The DM stated food trays were supposed to be served according to seating chart and tables and residents were to be served according to tables. The DM stated all the residents at 1 table should be served before moving to the next table because it was not fair for some residents on a particular table to be served their food while other residents at the same table sit and wait. The DM stated that was a dignity problem and the residents might feel neglected. The DM stated they did not revisit the seating arrangement after the construction started in the main dining hall, the residents who used to eat in the main dining area get their trays first and it took a while for the second food cart to be delivered on unit C.</p> <p>During an interview on 04/29/2024 at about 11:31 am CNA E stated she have seen where some residents would get their meal tray and eat while others at the same table are waiting to get their food. CNA E stated it was not fair, residents at the same table should get their food about the same time and eat together.</p> <p>During an interview on 04/29/2024 at about 11:52 am RN F stated the main dining hall had been closed for about a month and a half. RN F stated some residents get their tray while others at the same table sit and wait for their food tray. RN F stated it was not right but that was the system at the facility, kitchen staff were not updated on the seating arrangement. RN F stated, The residents are not happy when someone on the table was eating, and they were sitting there. I wouldn't feel happy too if it was me. I have had residents ask about their trays and we had to let them know that it is coming on the other cart. I think the system here is the problem.</p> <p>Review of Resident#5's undated face sheet revealed a [AGE] year-old male with admitted [DATE]. Diagnoses included type 2 diabetes mellitus with diabetic amyotrophy (a rare condition in which the patients develop sever aching or burning in the thighs.), dysphagia (medical term for difficulty swallowing), other mixed anxiety, unspecified dementia.</p> <p>Review of Resident #5's Nursing Home Optional MDS assessment dated [DATE] revealed a BIMS score 15, indicating no cognitive impairment.</p> <p>Review of Resident #5's Care Plan revised 12/15/2023 revealed the resident has an ADL self-care performance deficit related to Parkinson's, resident has impaired cognitive function and impaired thought processes related to Dementia/Parkinson's, swallowing problems related to dysphagia (medical term for difficulty swallowing).</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 04/29/2024 at about 12:20 pm to 12:32 pm, cart # 1 was already delivered on unit C, some Residents had gotten their trays, some finished eating while other resident's trays were still on the food cart #1. Resident #3 was sitting against the wall next to a table where another female resident was being fed by CNA G. It was observed Resident #3 was sticking her left hand and fingers in her mouth. Resident #3 was sucking on her thumb and licking the side of her hand. Resident #3 was observed reaching her hand over towards the other female resident who was being fed by CNA G. It was observed Resident #3's food tray was delivered on cart #1 while she was sitting and waiting and not being fed. Resident #5 was also observed standing next to the nurse's station, around the dining area waiting for a place to sit and eat.</p> <p>During an interview on 04/29/2024 at about 12:22 pm ADON C stated the main dining hall in the facility was not being used so each unit was using its auxiliary dining area due to kitchen construction that had been ongoing for the last 3-4 weeks. ADON C stated there were 3 food carts for unit C and it took approximately 20 minutes apart for each food cart to be delivered to unit C. ADON C stated that were dignity problem for some residents at a table to be served their food while other residents at the same table sit and watch them eat. The ADON stated they (DM, ADONs, DON and Administrator) would have to revisit the seating arrangement which should have been done already. ADON C stated nursing was responsible to notify dietary of changes in Resident's seating in the dining area.</p> <p>During an interview on 04/29/2024 at 12:34 pm CNA G stated that they had only received cart #1 for unit C and that there were two other meal carts they were still waiting for unit C. CNA G stated she could not recall how long it had been since cart #1 was delivered on unit C but said it had been a while.</p> <p>During an observation on 04/29/2024 from 12:38 pm through 12:54 pm revealed cart # 2 and #3 for unit C was delivered 7 minutes apart. It was also observed staff were passing out tray from food cart # 2 and #3 while trays were still on food cart #1 that was not yet served. It was observed Resident #3's tray was still on food cart #1 while she was still waiting.</p> <p>During an interview on 04/29/2024 at about 12:43 pm Resident #4 stated he usually had breakfast in his room. Resident #4 stated he was waiting on his lunch tray, he usually had lunch in the dining hall on the unit. Resident #4 stated it made him upset having to wait for his food when other residents were eating or have already eaten. At about 1:02 pm Resident #4 express that he was hungry</p> <p>Review of Resident#6's undated face sheet revealed an [AGE] year-old male with admitted [DATE]. Diagnoses included unspecified dementia, unspecified severity with behavioral disturbance, other specified diabetes mellitus with diabetic neuropathy 9 most often damage the nerves in the feet and legs), cerebral infraction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it).</p> <p>Review of Resident #6's Nursing Home Optional MDS assessment dated [DATE] revealed a BIMS score 08, indicating moderate cognitive impairment.</p> <p>Review of Resident #6's Care Plan revised 02/20/2023 revealed the resident has an ADL self-care performance deficit related to weakness, CVA and dementia, the resident has impaired thought processes related to dementia.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 04/29/2024 at about 01:06 pm Resident # 6 was observed sitting in a chair in the dining room area by the door on unit C. Resident #7 was not sitting at table, He had been in the area for about 20 minutes. Resident #6 stated he had not eaten yet, a staff member interjected that there was not a table available for Resident #6. At 1:07 pm Resident #6 was served food at a table by himself. Resident #6 stated he was not bothered that he had to wait for his food, he usually got to the dining room earlier, but today he was late to arrive.</p> <p>During an interview on 04/29/2024 at about 1:13 pm the DON stated the facility was not using the main dining area due to construction being done in the kitchen for about 3-4 weeks. The DON stated there were 7 food carts in total for each meal. The DON stated unit C got cart #1, rotate to the other units and back to unit C and then unit A and back to unit C for cart #7 to give staff enough time to care for cart one at a time to prevent the food from sitting there. The DON stated it was her expectation for residents at the same table to be served their meal trays at the same time to prevent residents from sitting watching their mates eat. The DON stated the nurses and CNAs knew how the Residents sat at a table and knew how the trays came out of the kitchen. The DON stated it was not ok for a resident to be reaching out or grabbing another resident's food out of their plate, it could be the wrong diet, or the resident could be allergic to their table mate's food.</p> <p>During an observation on 04/29/2024 at about 1:15 pm it was observed Resident #3 was just being fed by CNA E, her food tray was on cart #1 which was deliver to unit C at or before 12:20 pm.</p> <p>During an interview on 04/29/2024 at about 2:27 pm the Administrator stated she expected resident trays to come out hot and enough time for staff to pass to each Resident. The Administrator stated trays were supposed to come out according to residents at a table. The Administrator stated, If the residents don't get their trays at the same time at a table, they may think that they are being left out. The charge nurses are to verify the diet and so I would say they have to ensure the trays are served according to the tables. It is in the policy for Residents at the table should be serve at the same time.</p> <p>Review of facility's policy titled Meal Service dated 2018 reflected: The facility believes that all residents should be always treated with dignity and respect. A respectful, positive dining experience is essential to the residents' quality of life and helps to identify residents' needs and improve their overall nutritional status. Residents will be properly groomed, and their needs attended to during the meal service.</p> <p>--A seating chart will be used to ensure that residents sit at a table that can accommodate their wheelchair or Geri-chair and to ensure that residents are seated with preferred table mates. A sample Seating Chart form is included in this section.</p> <p>---All residents at one table will be served at the same time prior to serving residents at other tables. Table service will be rotated so that the same table is not always served first or last. Residents who require dining assistance will not have their trays delivered until a staff member is available to assist with dining.</p> <p>Review of facility's policy titled Resident Rights dated December 2016 reflected the following:</p> <p>Team members shall treat all residents with kindness, respect, and dignity.</p> <p>(continued on next page)</p>		

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