STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675546	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065 Based on interviews and record reviews, the facility failed to ensure residents had a right to be free from neglect for 1 (Resident #1) of 6 residents reviewed for neglect. The facility failed to ensure CNA A reported that she observed signs and symptoms of dizziness from Resident #1 before taking her to the shower room on [DATE]. CNA A did not report to anyone what she observed and continued to take Resident #1 to the shower room. While CNA A's back was turned in the shower room to grab something, Resident #1 got up from a shower bench unassisted, fell , and sustained a nondisplaced right inferior pubic ramus fracture and right parietal scalp hematoma with underlying acute traumatic subarachnoid hemorrhage. Resident #1 was sent to the ER and placed on hospice for comfort care. On [DATE], Resident #1 passed away. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 3:56 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of not having change in conditions assessed, falls, injury, decreased quality of life, and/or death. Findings included: Record review of Resident #1's Admission Record, dated [DATE], revealed an [AGE] year-old female who was admitted to the facility on [DATE] and had diagnoses including unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), age-related osteoporosis (a condition in which bones become weak and brittle) without current pathological fracture, and unspecified low back pain. Record review of Resident #1's Quarterly MDS Assessment, dated [DATE], revealed a 3 BIMS score, which indicated she had severe cognitive impairment. Resident #1 also required partial/moderate assistance with showering/bathing herself and supervision or touching assistance with tub-shower transfers. The MDS reflected Resident #1 had no falls since admission. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Care Plan, dated [DATE], revealed Resident #1 was at risk for falls related to confusion, incontinence, and being unaware of safety needs. Resident #1 also had an ADL care performance deficit and required extensive assistance by one staff with showers and supervision assistance by one staff to move between surfaces. Record review of the facility's Incident List, dated [DATE], revealed Resident #1 had a witnessed fall on [DATE] at 6:30 a.m. Record review of the facility's Admission/Discharge Report, from [DATE] through [DATE], revealed Resident #1 discharged to an acute care hospital on [DATE]. Record review of Resident #1's Fall Risk Evaluation, created by RN B on [DATE] at 7:36 a.m., revealed she was categorized as low risk for falls, had no falls in the past three months, had no cognition changes in the last 90 days, displayed cognitive behaviors, had adequate vision, was independent and continent with ambulation and elimination, ambulated without problem and with a device, had a steady balance, no drop in systolic blood pressure (pressure in the arteries when the heart contracts) while lying, sitting, and 1 and 3 minutes after standing, had ,d+[DATE] health diseases that placed her at risk for falls, took ,d+[DATE] high risk medications within the last seven days, and had no changes in medication and dosage in the past five days. Record review of the facility's Incident List, dated [DATE], revealed Resident #1 had a witnessed fall on [DATE] at 6:30 a.m. Record review of the facility's Admission/Discharge Report, from [DATE] through [DATE], revealed Resident #1 discharged to an acute care hospital on [DATE]. Record review of Resident #1's Progress Notes revealed the following: -A note created by RN B on [DATE] at 7:35 a.m., [CNA A] reported to nurse that [Resident #1] had a fall in the shower. Nurse assessed resident and resident is noted to have a hematoma (A pool of mostly clotted blood that forms in an organ, tissue, or body space) to back of the right side of her head. Ice pack applied to head, vitals stable. Resident assisted into a wheelchair by staff. AROM WNL for resident. CNA stated that resident was noted to have some increase confusion while in the shower and became startled and hopped up out of the chair and fell to the floor. [Family member] made aware of incident. ADON and NP made aware. Neuro checks started. -A note created by RN B on [DATE] 8:34 p.m., [Resident #1] sent to [hospital] for evaluation per family request. -A note created by RN B on [DATE] at 8:40 p.m., [Resident #1] admitted to [hospital]. Record review of Resident #1's Pain Summary, dated [DATE], revealed she reported experiencing , d+[DATE] pain on [DATE] at 7:30 a.m. and ,d+[DATE] pain on [DATE] at 8:57 a.m. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Neurological Evaluation Flow Sheet, started by RN B on [DATE] at 6:30 a.m. , revealed monitoring was completed from [DATE] at 6:30 a.m. through [DATE] at 10:30 a.m., there were no changes in condition documented, and the last monitoring check documented on [DATE] at 11:30 a.m. indicated Resident #1 went to the hospital. Record review of Resident #1's Hospital Record, from [DATE] through [DATE], revealed she arrived at the hospital emergency department on [DATE] at 11:42 a.m. Resident #1's chief complaint was a fall and hip and rib pain. Resident #1 was presented to the hospital's ER with her family after a fall. Resident #1's family reported Resident #1 was transferring from a chair the morning of [DATE] when she fell backwards and struck her head and had since been complaining of head, ribcage, and pelvic pain. Resident #1's physical exam at the hospital revealed her head was with a contusion (a bruise) and she exhibited decreased range of motion and tenderness to her right hip. Resident #1's x-rays found she had a nondisplaced right inferior pubic ramus (group of bones that park up part of pelvis) fracture and right parietal scalp hematoma (typically appears as a bump on the head) that underlying was an acute traumatic subarachnoid hemorrhage (the accumulation of blood in the space between the arachnoid membrane and the [NAME] mater around the brain referred to as the subarachnoid space). Extensive conversation between Resident #1's family, Neurosurgery and SICU attending regarding how best to proceed moving forward resulted in Resident #1's family felt that she suffered and had significantly deteriorated over the past two days and decided to pursue comfort care only. Hospice was consulted and Resident #1 was transitioned to inpatient hospice the following day ([DATE]). Resident #1 was discharged to an inpatient hospice medical center on [DATE] with no resolved hospital problems. On [DATE], Resident #1 expired at the inpatient hospice medical center. During an interview on [DATE] at 8:25 a.m., CNA D revealed if she observed a resident had s/s of a change in condition, she would inform a nurse and document what she observed. CNA D stated CNAs were responsible for showering residents. CNA D also stated staff were required to never turn their back on a resident during a shower and to have all shower supplies prepared before taking a resident to the shower room. During an interview on [DATE] at 8:29 a.m., CNA E revealed if she observed a resident had s/s of a change in condition, she would notify a nurse. CNA E stated CNAs were responsible for showering residents. CNA E also stated staff were required to never turn their back on a resident during a shower and to have all shower supplies prepared before taking a resident to the shower room. During an interview on [DATE] at 8:38 a.m., LVN F revealed if a CNA observed a resident had s/s of a change in condition, CNAs were required to notify a nurse. LVN F stated CNAs were responsible for showering residents. LVN F also stated staff were required to never turn their back on a resident during a shower and to have all shower supplies prepared before taking a resident to the shower room. During an interview on [DATE] at 8:45 a.m., LVN G revealed if a CNA observed a resident had s/s of a change in condition, CNAs were required to report the incident to a nurse. LVN G stated CNAs and assigned hospice staff showered residents. LVN G also stated staff were required to never turn their back on a resident during shower and to have all shower supplies prepared before taking a resident to the shower room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:04 a.m., CNA H revealed if a CNA observed a resident had s/s of a change in condition, CNAs were required to report to the nurse. CNA H stated CNAs showered residents. CNA H also stated staff were required to never turn their back on a resident during shower and to have all shower supplies prepared before taking a resident to the shower room. During an interview on [DATE] at 9:23 a.m., CNA I revealed CNAs showered residents. CNA I stated staff were required to never turn their back on a resident during shower and to have all shower supplies prepared before taking a resident to the shower room. CNA I also stated if a CNA observed a resident had s/s of a change in condition, CNAs required to notify a nurse. During an interview on [DATE] at 10:26 a.m., the FAM revealed Resident #1 was on hospice due to a brain injury and hematoma sustained because of the fall she had on [DATE]. The FAM stated they requested Resident #1 be sent to the hospital. The FAM also stated the hospital x-rays and CT scans found Resident #1 had a recent pelvic fracture and brain bleed. The FAM stated Resident #1 was transferred to the trauma center. The FAM also stated he notified staff on [DATE] about Resident #1's hematoma and dehydration found at the hospital. During an interview on [DATE] at 10:48 a.m., the NP revealed the facility staff informed her that Resident #1 fell during a shower and sustained a hematoma (a pocket of blood) to the head. The NP also stated Resident #1 was not on any anticoagulant medication. NP explained the facility's protocol was to conduct neurological checks and vital sign checks for 72 hours if the resident was not taking any anticoagulant medication at the time of their fall. NP went on the explain there were no changes in Resident #1's condition and no abnormal vitals during the monitoring. NP explained Resident #1 denied any changes in condition or pain, even with the FAM present. NP went on to explain the FAM had her reevaluate Resident #1 when they arrived at the facility three hours after the fall, in which she complained of hip pain. The NP explained she informed the FAM that the facility could get a mobile x-ray to evaluate Resident #1's hip. NP went on to explain the FAM still wanted Resident #1 to go to the hospital. NP stated Resident #1 never had any past falls at the facility. NP also stated a hematoma was a great bodily injury, but she was not sure if Resident #1 sustained it due to her fall or that it was a precondition at her admission to the facility. During an interview on [DATE] at 11:12 a.m., the DON stated Resident #1 had no history of falls at the facility. DON stated Resident #1 was ambulatory and had no s/s of injury from previous falls. The DON stated CNA A showered Resident # 1 on [DATE]. DON stated CNA A told her that she had her back turned-on Resident #1 because she was moving another shower chair when Resident #1 got up unassisted and fell . DON also stated an Agency Hospice CNA was present who might have witnessed Resident #1's fall in the shower room. DON stated she made two attempts to contact the Agency Hospice CNA and was waiting for a returned call. DON also stated she was in-servicing staff on performing showers on residents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 12:08 p.m., CNA A revealed Resident #1 used a walker. CNA A stated CNAs showered residents. CNA A explained on [DATE], she observed Resident #1 walking without her walker on [DATE] at 6:30 a.m. CNA A stated she noticed Resident #1 was dizzy and might have been dizzy from walking without a walker. CNA A explained she knew Resident #1 was dizzy because Resident #1's eyes looked dizzy, and Resident #1 looked like she was going to fall when she was walking. CNA A stated she reeducated Resident #1 that she could not walk without her walker, helped Resident #1 back to her room, grabbed Resident #1's walker and new clothes, and thought she should shower Resident #1 because Resident #1 was awake. CNA A also stated she did not report that she observed Resident #1's dizziness to a nurse because RN B did not report to work on time. CNA A explained she did not immediately notify a nurse of Resident #1's dizziness because there was no nurse to report to. CNA A went on to explain the previous shift nurse left and RN B had not arrived yet when she observed Resident #1's dizziness. CNA A stated she did not look for another nurse because she was going to shower Resident #1. CNA A stated residents' health and safety could be affected if CNAs did not notify a nurse that a resident was showing s/s of dizziness. CNA A explained the nurses must know everything anytime a CNA observed a change in condition and CNAs must immediately notify a nurse whenever they observed a change in condition. CNA A explained she took Resident #1 to the shower room and helped Resident #1 into a small chair because Resident #1 could not get into the bigger shower chair. CNA A went on to explain she instructed Resident #1 to wait for her and had Resident #1's clothes off from the wrist down . CNA A stated as she looked the other way to prepare the shower, Resident #1 stood up within seconds, held onto the bigger chair, fell , and the bigger chair fell over her. CNA A stated a male witnessed Resident #1's fall incident. CNA A explained she notified RN B when RN B came into work, asked RN B to come to the shower room, RN B came to the shower room and saw Resident #1 on the ground and bleeding. CNA A stated her and RN B picked up Resident #1 and she observed Resident #1 had blood on her hand and hair. She stated RN B assessed Resident #1 and notified the DON, she brought ice and cleaned the blood from Resident #1's face and hand, and then informed RN B that she observed Resident #1 was dizzy before she took Resident #1 to the shower room. CNA A also stated RN B instructed her not to shower Resident #1. During an interview on [DATE] at 1:30 p.m., RN B revealed on [DATE], CNA A came to her and told her that Resident #1 fell . RN B explained she went into the shower room and observed Resident #1 was on the floor and had blood on her head. RN B stated she got gauze, assessed Resident #1's vitals and neuros, determined everything was okay and that ROM was normal, initiated neurological checks, applied ice to the injured area, placed Resident #1 in a wheelchair, and notified the DON, ADON, FAM and NP . RN B also stated CNA A told her that Resident #1 was sitting on a shower bench in the shower room, grabbed another shower chair, and fell . RN B stated CNA A told her that Resident #1 was confused before she brought Resident #1 to the shower room and stated she believed Resident #1 was confused because she was walking without her walker, which was abnormal for her. RN B also stated CNA A did not report to her that Resident #1 was confused before she took Resident #1 to the shower room. RN B stated she did not ask CNA A why CNA A did not inform her about observing confusion from Resident #1 because she was in middle of assessing and treating Resident #1. RN B stated Resident #1's family visited the facility (could not recall what time) and wanted Resident #1 sent out to the hospital. RN B also stated she did not think to ask CNA A about Resident #1's confusion prior to taking her to the shower room. RN B stated CNAs were supposed to immediately report to the nurse any change in condition . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:53 p.m., the DON revealed she conducted in-services on abuse, neglect, and ADL care related to showers. DON stated there were no in-services initiated on change in condition. DON also stated CNA A was suspended pending investigation until she found out what happened and CNA A was given the right training and reeducation before returning to work. DON stated CNA A told her that she helped Resident #1, knew it was Resident #1's shower day. The DON stated Resident #1 was ambulatory, CNA A gathered Resident #1's supplies, took Resident #1 to the shower room, sat Resident #1 on the shower bench that was against the wall, went to grab an extra shower chair, and noticed Resident #1 fell . DON also stated CNA A told her that Resident #1 seemed off before taking her to the shower room and that Resident #1 was like that sometimes. DON stated CNA A told her that Resident #1 was stable with a walker when walking to the shower room when she asked how Resident #1 was walking. DON also stated when she asked why CNA A believed Resident #1 was off before taking her to the shower room, CNA A told her that Resident #1 was off because Resident #1 was walking without her walker and believed it was abnormal behavior. DON stated CNA A mentioned Resident #1's confusion. DON also stated she asked if Resident #1's confusion was new and CNA A told her that Resident #1's confusion was not new because it sometimes happened. DON stated CNA A did not mention anything about Resident #1 showing s/s of dizziness. DON also stated CNA A did not mention reporting Resident #1's dizziness to a nurse before taking Resident #1 to the shower and did not provide an explanation to her as to why she did not tell a nurse before taking Resident #1 to the shower room when she observed abnormal behavior. DON stated she expected CNAs to notify a charge nurse whenever they suspected or observed s/s of a change in condition. DON also stated residents' health or safety could be affected if CNAs did not notify a nurse of a resident's change in condition. DON explained residents' diagnoses or change in condition could go overlooked if CNAs did not notify nurses about residents' change in condition. During an interview on [DATE] at 2:23 p.m., the ADM revealed she was notified that Resident #1 fell in the shower room, hit her head, and went to the hospital. ADM stated when investigating the incident, CNA A told staff that the shower room was not situated before she brought Resident #1 into the shower room, sat Resident #1 onto a shower bench, and grabbed a shower chair. ADM stated she was taught that shower tools were prepared before bringing a resident into the shower room. ADM also stated she could not recall if CNA A told staff that Resident #1 seemed off before taking Resident #1 to the shower room. ADM stated she recalled CNA A stating Resident #1 seemed off in the shower room. ADM explained CNA A described that Resident #1 was off because Resident #1 was acting differently and did not elaborate more than that to staff. ADM stated she was not sure if CNA A told RN B that she observed Resident #1 was off before taking Resident #1 to the shower room. ADM also stated residents' health and safety could be affected if staff were not reporting incidents within required timeframes and not notifying of residents' changes in condition. During an interview on [DATE] at 3:01 p.m., the DON revealed she checked with HR and did not find anything about CNA A completing training on notifying nurse of changes in condition expectation, training, or requirement. Record review of a voicemail from Resident #1's FAM on [DATE] at 10:46 a.m. revealed Resident #1 passed away in the morning of [DATE] and the death was caused by the brain bleed due to the damage it did from Resident #1's physical and mental state. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 8:38 a.m., CNA A revealed she could not remember if she were given training on how to shower residents. CNA A explained she was trained by an experienced CNA when she first began her employment. CNA A stated she was taught to have everything ready before bringing residents into the shower room and showering residents. CNA A also stated she was supposed to ask another CNA to grab whatever she forgot in the shower room when she was about to shower a resident and forgot something. CNA A stated she did not ask another CNA to grab the shower chair when she was in the shower room with Resident #1 because the other CNA was outside the shower room, she did not think it was necessary, and she was confident because there was another CNA from hospice in the shower room with her. CNA A also stated she did not ask the hospice CNA to grab the shower chair or monitor Resident #1 while she grabbed a shower chair because the hospice CNA was busy bathing the other resident in the shower room and was not able to help her at the same time. CNA A stated she turned her back on Resident #1 because there were two shower chairs in the shower room and she was trying to grab a shower chair. CNA A explained she left Resident #1 for one second. CNA A stated CNAs could not have their backs turned on a memory care resident in the shower room. CNA A also stated she did not think Resident #1 would stand up unassisted. CNA A stated the other CNA who was supposed to work on the shift did not arrive yet. CNA A explained there were three CNAs who were assigned to work on the day Resident #1 fell . CNA A stated RN B told her that she could bathe residents. CNA A stated RN B arrived at the facility at the time when Resident #1 fell . CNA A also stated RN B was not there when she took Resident #1 to the shower room. CNA A stated she was required to shower residents. CNA A also stated residents' health and safety could be affected if a CNA had their back turned on a resident and a resident got up unassisted and fell . During an interview on [DATE] at 9:09 a.m., the DON revealed the facility did not have any ADL policies specific to CNAs showering residents. DON stated the facility followed the ADA's recommendations and reasonably accommodate what they could do as a facility for the residents. During an interview on [DATE] at 9:17 a.m., RN B revealed CNA A showered Resident #1. RN B stated CNA A was assigned to care for the residents in the memory care unit who could walk, which included giving residents showers. RN B also stated she was given in-services on the fall protocol two weeks ago by the ADON. RN B stated the in-services did not address ADL care related to showers. RN B also stated CNAs were expected to press the call light for help if they forget to bring something in the shower room and about to shower resident in the shower room. RN B stated CNAs should get all shower equipment together before taking a resident to the shower room. RN B also stated she could not recall when she had clocked in on [DATE]. RN B stated when she arrived, CNA A was already in the shower room with Resident #1. RN B also stated CNA A did not receive her responsibilities from her before she arrived at the facility. RN B also stated CNA A had been told that she was required to provide care to residents who walked, which included Resident #1. RN B stated residents' health and safety could be affected if a CNA had their back turned and a resident got up unassisted and fell because residents were already in the shower room and residents could end up hurting themselves. RN B also stated CNAs should be keeping their eyes on residents at all times. During an interview on [DATE] at 9:47 a.m., the DON revealed the facility tried to reach out to the Agency Hospice CNA who was in the shower room with CNA A on [DATE]. DON explained she contacted the hospice company the Agency Hospice CNA worked for to see if they could reach him. DON stated she was informed that the agency hospice the CNA was on vacation. An attempt to call the Agency Hospice CNA was made on [DATE] at 9:53 a.m. A voicemail and call back number were left for the aide. The Agency Hospice CNA did not return the call. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:20 a.m., the DON revealed the facility did not have a specific training check off list for CNAs giving showers. An attempt to call CNA C was made on [DATE] at 10:28 a.m. A voicemail and call back number were left for the aide. During an interview on [DATE] at 10:39 a.m., CNA J revealed she was given orientation training on who and when to report a change in condition to. CNA J stated she did not receive an in-service on who and when to report a change in condition . CNA J also stated if she observed a change in condition, she was trained to ensure resident safety and report to a nurse. CNA J stated if her charge nurse were unavailable, she would find another nurse. CNA J also stated she was not given orientation training and recent in-services on ADL care related to how to shower residents. CNA J stated CNAs were required to have everything in place before taking a resident to the shower room. CNA J also stated if she forgot something and was about to give a resident a shower in the shower room, she would ask another CNA to grab what she forgot. CNA J stated CNAs were required to never turn their backs on a resident. During an interview on [DATE] at 10:46 a.m., CNA K revealed she was given orientation training on who and when to report a change in condition to and ADL care related to how to shower residents. CNA K stated she was in-serviced on falls yesterday ([DATE]) by the ADON. CNA K also stated she was not given a recent in-service on ADL care related to how to give showers. CNA K stated CNAs were required to have everything in place before taking a resident to the shower room. CNA K also stated if she forgot something and was about to give a resident a shower in the shower room, she would ask another CNA to grab what she forgot. CNA K stated CNAs were required to never turn their backs on a resident. CNA K also stated if she observed a change in condition, she was trained to report to a nurse. CNA K stated if the charge nurse were unavailable, she would find another nurse. During an interview on [DATE] at 10:52 a.m., CNA L revealed she was given orientation training on who and when to report change in condition to. CNA L stated she was not given recent in-services on who and when to report change in condition. CNA L also stated if she observed a change in condition, she was trained to report to a nurse. CNA L stated if the charge nurse she reported to was not on duty yet, she would find another supervisor. CNA L also stated she was not given orientation training on ADL care related to how to give showers. CNA L stated she was given a recent in-service on ADL care related to how to give showers. CNA L also stated CNAs were required to have everything in place before taking a resident to the shower room. CNA L stated if she forgot something and was about to give a resident a shower in the shower room, she would pull the emergency call light, cover up the resident and get the resident out of the shower room or ask another CNA to get what she forgot. CNA L also stated CNAs were required to never turn their backs on or leave a resident. (continued on next page)

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	675546	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	1000 E Main St Round Rock, TX 78664

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 11:38 a.m., the DON revealed she tried to give CNA A easier residents so she did not have to help with ADLs. DON defined easier as residents who were more independent with ADL care. DON stated she did not know who assigned CNA A to give Resident #1 a shower. DON stated RN B was drawing blood possibly during the time CNA A observed dizziness. DON also stated she in-serviced staff on showers and discussed how to prepare all shower items before taking a resident to the shower room on [DATE]. DON stated newly employed CNAs were paired with an experienced CNA who demonstrated to them how to perform duties. DON also stated she also discussed reporting change in condition during the in-service initiated on [DATE]. DON stated if CNAs noticed anything different or abnormal, CNAs were required and trained to notify a nurse or supervisor. DON also stated CNAs were expected to prepare all shower items before taking resident to shower room. DON stated CNAs could use the shower call light if they forgot something and were about to shower residents in the shower room. DON also stated CNAs were not allowed to have their backs turned on residents in the memory care unit while in the shower room. DON stated she added a reporting change in condition in-service. DON also stated CNAs were taught to find a nurse and notify them of any change in condition observed. DON stated the in-servicing was ongoing. DON stated Resident #1 did not have any dizzy behaviors prior to the fall. DON also stated she did not believe Resident #1's medication contributed to the dizziness observed by CNA A. Record review of the facility staff timesheets, dated [DATE], revealed staff worked in the memory care unit during the following shifts: -RN B [DATE] 6:22 a.m. - [DATE] 10:19 p.m. -CNA C [DATE] 6:53 a.m. - [DATE] 2:39 p.m. and [DATE] 3:24 p.m. - [DATE] 6:48 p.m. -CNA A [DATE] 6:12 a.m. - [DATE] 2:08 p.m. Record review of CNA A's proficiencies upon hire and annually and clinical proficiencies required upon hire and annually revealed no documented evidence of training given and completed related to falls, abuse, neglect, and change in condition. Record review of the facility's orientation, [DATE], revealed staff were trained on resident abuse/neglect and mistreatment, resident rights, customer satisfaction, medical records, dietary service, emergency preparedness, infection control, physical environment, and Nurse/CNA orientation checklists that covered hand hygiene, incontinent care, transfers, infection control, and vitals. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's self-report, received by the State Agency on [DATE], revealed on [DATE] at 6:30 a.m., Resident #1 was in the shower room with CNA A. CNA A sat Resident #1 on a shower bench to prepare the shower stall. When Resident #1 fell when she got up unassisted. The ADM first learned of the incident on [DATE] at approximately 7:00 a.m. RN B immediately assessed Resident #1. The NP reassessed Resident #1 on [DATE] around 9:00 a.m. There was a hematoma noted to Resident #1's right back area of her head. Ice was applied and neurological monitoring was started. Upon assessment, Resident #1 denied headaches or dizziness and did not vomit. Resident #1 did report right hip and groin pain. The facility staff notified Resident #1's family, physician, and the ADON who notified the ADM and DON, and Regional Nurse. Resident #1's family was present during the NP's visit and requested Resident #1 be sent to the hospital. The facility staff sent Resident #1 to the hospital for further evaluation. X-rays were completed in the hospital and noted Resident #1 had a brain bleed. On [DATE] at 5:30 a.m., Resident #1's family spoke with the facility staff and reported Resident #1's hospital scans revealed she had a brain bleed, old rib fractures they attributed to a fall prior to admission, six vertebrae fractures that were osteoporosis related and a broken pubic bone that was unknown if it was acute with the fall or not. Resident #1 was placed on hospice in the hospital on [DATE] and possibly had a stroke that could have caused the fall. CNA A was suspended until further investigation was completed. In-services on abuse and neglect, falls, and reporting were conducted. Record review of the facility's in-services revealed on [DATE], staff were educated on shower safety and taught to gather all supplies, ensure the shower room was ready prior to taking residents into the shower room, and to immediately report any suspicions of abuse/neglect to the ADM. Attached to the in-service was a copy of the State Agency's reporting guidelines and the facility's Assessing Falls and Their Causes policy and procedure revised in [DATE]. Record review of the facility's Abuse Prevention Program policy and procedure, revised [DATE], revealed the following, Our residents have the right to be free from abuse, neglect, misappropriation of resident property and

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interviews and record reviews, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 2 (Residents #1 and #2) of 6 reviewed for neglect and injuries of unknown origin. 1. The facility failed to report to SA within the required time frame of Resident #1's fall that resulted in a brain bleed and broken public bone. On [DATE], Resident #1's family reported to staff that Resident #1 sustained a brain bleed and broken pubic bone from her fall on [DATE]. 2. The facility failed to report to SA within the required time frame of Resident #2's injury of unknown source. On [DATE] at 1:30 a.m., staff observed Resident #2 had a hematoma to the left forehead, a skin tear to the left lower extremity and a swollen left wrist. This failure could place residents at risk of abuse, neglect, pain, and diminished quality of life. Findings included: 1. Record review of Resident #1's Admission Record, dated [DATE], revealed an [AGE] year-old female who was admitted to the facility on [DATE] and had diagnoses including unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), age-related osteoporosis (a condition in which bones become weak and brittle) without current pathological fracture, and unspecified low back pain. Record review of Resident #1's Quarterly MDS Assessment, dated [DATE], revealed a 3 BIMS score, which indicated she had severe cognitive impairment. Resident #1 also required partial/moderate assistance with showering/bathing herself and supervision or touching assistance with tub-shower transfers. Resident #1 had no falls since admission. Record review of Resident #1's Care Plan, dated [DATE], revealed Resident #1 at risk for falls related confusion, incontinence, unaware of safety needs. Resident #1 also had an ADL care performance deficit and required extensive assistance by one staff with showers and supervision assistance by one staff to move between surfaces. Record review of Resident #1's Progress Notes revealed the following: -A note created by RN B on [DATE] at 7:35 a.m., (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[CNA A] reported to nurse that [Resident #1] had a fall in the shower. Nurse assessed resident and resident is noted to have a hematoma to back of the right side of her. Ice pack applied to head, vitals stable. Resident assisted into a wheelchair by staff. AROM WNL for resident. CNA stated that resident was noted to have some increase confusion while in the shower and became startled and hopped up out of the chair and fell to the floor. Son made aware of incident. ADON and NP made aware. Neuro checks started. -A note created by RN B on [DATE] 8:34 p.m., [Resident #1] sent to [hospital] for evaluation per family request. -A note created by RN B on [DATE] at 8:40 p.m., [Resident #1] admitted to [hospital]. Record review of Resident #1's Hospital Record, from [DATE] through [DATE], revealed she arrived at the hospital emergency department on [DATE] at 11:42 a.m. Resident #1's chief complaint was fall and hip and rib pain. Resident #1 was presented to the hospital's ER with her family after a fall. Resident #1's family reported Resident #1 was transferring from a chair the morning of [DATE] when she fell backwards and struck her head and had since been complaining of head, ribcage, and pelvic pain. Resident #1's physical exam at the hospital revealed her head was with a contusion (a bruise) and she exhibited decreased range of motion and tenderness to her right hip. Resident #1's x-rays found she had a nondisplaced right inferior pubic ramus fracture and right parietal scalp hematoma that underlying was an acute traumatic subarachnoid hemorrhage (the accumulation of blood in the space between the arachnoid membrane and the [NAME] mater around the brain referred to as the subarachnoid space). Extensive conversation between Resident #1's family, Neurosurgery and SICU attending regarding how best to proceed moving forward resulted in Resident #1's family felt that she suffered and had significantly deteriorated over the past two days and decided to pursue comfort care only. Hospice was consulted and Resident #1 was transitioned to inpatient hospice the following day ([DATE]). Resident #1 was discharged to an inpatient hospice medical center on [DATE] with no resolved hospital problems. On [DATE], Resident #1 expired at the inpatient hospice medical center. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's self-report, received by the SA on [DATE] at 8:11 a.m., revealed on [DATE] at 6:30 a.m., Resident #1 was in the shower room with CNA A. CNA A sat Resident #1 on a shower bench to prepare the shower stall. When Resident #1 fell when she got up unassisted. The ADM first learned of the incident on [DATE] at approximately 7:00 a.m. RN B immediately assess Resident #1. NP reassessed Resident #1 on [DATE] around 9:00 a.m. There was a hematoma noted to Resident #1's right back of head. Ice was applied and neurological monitoring was started. Upon assessment, Resident #1 denied headaches or dizziness and did not vomit. Resident #1 did report right hip and groin pain. The facility staff notified Resident #1's family, physician, ADON who notified the ADM and DON, and Regional Nurse. Resident #1's family was present during NP's visit and requested Resident #1 be sent to the hospital. The facility staff sent Resident #1 to the hospital for further evaluation. X-rays were completed in the hospital and noted Resident #1 had a brain bleed. On [DATE] at 5:30 a.m., Resident #1's family spoke with the facility staff and reported Resident #1's hospital scans revealed she had a brain bleed, old rib fractures they attribute to were sustained due to a fall prior to admission, six vertebrae fractures that were osteoporosis related and a broken pubic bone that was unknown if it was acute with the fall or not, Resident #1 was placed on hospice in the hospital on [DATE] and possibly had a stroke that could have caused the fall. CNA A was suspended until further investigation was completed. In-services on abuse and neglect, falls, and reporting were conducted. Record review of the facility's self-report email to SA revealed the facility staff submitted Resident #1's report on [DATE] at 9:18 a.m. 2. Record review of Resident #2's Admission Record, dated [DATE], revealed an [AGE] year-old female who was admitted to the facility on [DATE] and had diagnoses including unspecified dementia, unspecified fracture of the lower end of the left radius (one of two bones in your forearm), chronic pain syndrome, and restlessness and agitation. Record review of Resident #2's Comprehensive MDS Assessment, dated [DATE], revealed a 4 BIMS score, which indicated she had severe cognitive impairment. The MDS reflected Resident #2 had no falls since admission. Record review of Resident #2's Care Plan, dated [DATE], revealed she was at high risk for falls related to impaired cognitions. Resident #1 also had an ADL care performance deficit. Record review of Resident #2's Progress Notes revealed the following: -A note created by LVN O on [DATE] at 3:43 a.m., Resident found lying in bed upon assessment discovered resident with a knot on left side of her head golf-ball size. Nurse did head to toe assessment and found resident left wrist to be sore, swollen, and painful to touch. Notified on call who ordered resident sent to ER for evaluation and treatment. Transported by ambulance to [hospital]. Accompany by EMT. Notified RP and ADON. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's self-report, received by the SA on [DATE] at 3:14 p.m., revealed on [DATE] at 1:30 a.m., Resident #2 fell in her room, there were no witnesses, Resident #2 crawled back in bed by herself, and LVN O noticed a hematoma on Resident #2's head when she turned on the lights during rounds and that Resident #2's left wrist was slightly swollen and sore. LVN O conducted a head-to-toe assessment, took vital signs, found neuros were within normal limits, Resident #2 had a hematoma to the left forehead, a skin tear to the left lower extremity and a swollen left wrist that ended up being fractured. Resident #2 told the staff she thought she fell and would be physically able to get herself up. LVN O applied ice to Resident #2's wrist and forehead before sending her to the hospital on [DATE] at 3:43 a.m. Cat scans were done at the hospital and came back within normal limits. A wrist splint and sling were applied to Resident #2's fractured left wrist. Safe surveys were performed and found all residents feel safe and do not have a problem asking staff for help. Resident #2's roommate was bedbound and no other residents were up wandering at that time. No injuries on other residents observed. Staff confirmed wrist fracture as investigative findings. During an interview on [DATE] at 9:46 a.m., the DON revealed the facility followed the SA's provider letter for reporting timeframes and guidelines. The DON stated her and the ADM reported alleged violations to SA. During an interview on [DATE] at 10:26 a.m., Resident #1's FAM revealed they notified the facility staff on [DATE] about Resident #1's hematoma found at the hospital due to her fall on [DATE]. During an interview on [DATE] at 11:12 a.m., the DON revealed a brain bleed constituted as a serious bodily injury . DON stated facility staff followed reporting guidelines for reporting to SA within 2 or 24 hours. DON also stated she reported to SA within 2 hours of Resident #1's FAM's notification to them of Resident #1's brain bleed. DON stated she was unable to determine at the time of the interview as to what time on [DATE] that LVN O made and reported her observation of Resident #2's swollen wrist and hematoma. DON also stated Resident #2 went to the hospital on [DATE] for injury of unknown origin and returned later that day. DON stated the facility staff notified her on [DATE] before sending Resident #2 to the hospital because of the swollen wrist and bump on her head. DON also stated she did not know why she did not notify SA within 2 hours of being notified of Resident #2's suspected injury of unknown origin and Resident #1's fall that resulted in great bodily injury. The residents' health and safety could be affected if staff were not reporting within required timeframes . During an interview on [DATE] at 2:23 p.m., the ADM revealed she was not aware that injury of unknown origin was to be reported within 2 hours. The ADM stated the residents' health and safety could be affected if staff were not reporting within required timeframes, especially for abuse incidents. During an interview on [DATE] at 3:01 p.m., the DON revealed she was notified of Resident #2's incident on [DATE] at 3:02 a.m. Record review of the facility's admission/transfer/discharge report, [DATE]-[DATE], revealed Resident #1 was discharged to the hospital on [DATE]. Resident #2 was not listed on the report. Record review of the facility's incident log, [DATE]-[DATE], revealed Resident #1's witnessed fall occurred on [DATE] at 6:30 a.m. and Resident #2's unwitnessed fall occurred on [DATE] at 3:14 a.m. Record review of the facility's Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigating policy and procedure, revised [DATE], revealed the following, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility. 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. 4. Verbal/written notices to agencies are submitted via special carrier, fax, e-mail, or by telephone. Record review of the facility's State Agency's Provider Letter, issued [DATE], revealed a nurse facility must report to the State Agency the following types of incidents, in accordance with applicable state and federal requirements: Neglect. Timeframes for reporting neglect incidents that result in serious bodily injury and injuries of unknown source are immediately, but not later than two hours after the incident occurs or is suspected. Timeframes for reporting an injury that does not result in serious bodily injury and involve neglect are immediately but not later than 24 hours after the incident occurs or is suspected. State Agency rules define neglect as, The failure to provide goods or services, including medical services that are necessary to avoid physical or emotional harm, pain, or mental illness. Federal Agency defines neglect as, The failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. To determine whether neglect may have occurred, a nurse facility must decide if an injury, emotional harm, pain or death of a resident was due to the facility's failure to provide goods or services to a resident. An injury is defined as an injury of unknown source when both of the following conditions are met: -The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and -The injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one point in time or the incidence of injuries over time. Record review of the facility's Abuse Prevention Program policy and procedure, revised [DATE], revealed the following, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. As part of the resident abuse prevention, the administration will: 7. Investigate and report any allegations of abuse within time frames as required by federal requirements.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, interviews and record reviews, the facility failed to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable, physical, mental and psychosocial well-being for 1 (CNA A) of 9 CNAs reviewed for competent nursing care. The facility failed to ensure CNA A was proficient in reporting residents' change in condition and resident shower safety. CNA A did not report that she observed Resident #1 having s/s of dizziness and did not have all shower supplies prepared before taking Resident #1 to the shower room. CNA A took Resident #1 to the shower room, turned her back to grab something, Resident #1 got up from the shower bench unassisted and fell in the shower room. Resident #1 was sent to the ER, found to have sustained a nondisplaced right inferior pubic ramus fracture and right parietal scalp hematoma with underlying acute traumatic subarachnoid hemorrhage, and placed on hospice for comfort care. On [DATE], Resident #1 passed away. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 3:56 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of not having change in conditions assessed, falls, injury, decreased quality of life, and/or death. Findings included: Record review of Resident #1's Admission Record, dated [DATE], revealed an [AGE] year-old female who was admitted to the facility on [DATE] and had diagnoses including unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), age-related osteoporosis (a condition in which bones become weak and brittle) without current pathological fracture, and unspecified low back pain. Record review of Resident #1's Quarterly MDS Assessment, dated [DATE], revealed a 3 BIMS score, which indicated she had severe cognitive impairment. Resident #1 also required partial/moderate assistance with showering/bathing herself and supervision or touching assistance with tub-shower transfers. Resident #1 had no falls since admission. Record review of Resident #1's Care Plan, dated [DATE], revealed Resident #1 at risk for falls related confusion, incontinence, unaware of safety needs. Resident #1 also had an ADL care performance deficit and required extensive assistance by one staff with showers and supervision assistance by one staff to move between surfaces. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Fall Risk Evaluation, created by RN B on [DATE] at 7:36 a.m., revealed she was categorized as low risk for falls, had no falls in the past three months, had no cognition changes in the last 90 days, displayed cognitive behaviors, had adequate vision, was independent and continent with ambulation and elimination, ambulated without problem and with a device, had steady balance, no drop in systolic blood pressure while lying, sitting, and 1 and 3 minutes after standing, had ,d+[DATE] health diseases that placed her at risk for falls, took ,d+[DATE] high risk medications within the last seven days, and had no changes in medication and dosage in the past five days. Record review of Resident #1's Pain Summary, dated [DATE], revealed she reported experiencing , d+[DATE] pain on [DATE] at 7:30 a.m. and ,d+[DATE] pain on [DATE] at 8:57 a.m. Record review of Resident #1's Neurological Evaluation Flow Sheet, started by RN B on [DATE] at 6:30 a.m. , revealed monitoring was completed from [DATE] at 6:30 a.m. through [DATE] at 10:30 a.m., there were no changes in condition documented, and the last monitoring check documented on [DATE] at 11:30 a.m. indicated Resident #1 went to the hospital. Record review of Resident #1's Progress Notes revealed the following: -A note created by RN B on [DATE] at 7:35 a.m., [CNA A] reported to nurse that [Resident #1] had a fall in the shower. Nurse assessed resident and resident is noted to have a hematoma to back of the right side of her. Ice pack applied to head, vitals stable. Resident assisted into a wheelchair by staff. AROM WNL for resident. CNA stated that resident was noted to have some increase confusion while in the shower and became startled and hopped up out of the chair and fell to the floor. Son made aware of incident. ADON and NP made aware. Neuro checks started. -A note created by RN B on [DATE] 8:34 p.m., [Resident #1] sent to [hospital] for evaluation per family request. -A note created by RN B on [DATE] at 8:40 p.m., [Resident #1] admitted to [hospital]. During an interview on [DATE] at 8:25 a.m., CNA D revealed if she noticed a resident had a change in condition, she would inform a nurse and document her observations. CNA D stated she would also never turn her back on a resident in the shower room during a shower. CNA D also stated she would have all the shower supplies prepared before taking residents to the shower room. During an interview on [DATE] at 8:29 a.m., CNA E revealed if she noticed a resident had a change in condition, she would notify a nurse. CNA E stated she would also never turn her back on a resident in the shower room during a shower. CNA E also stated she would have all the shower supplies prepared before taking residents to the shower room. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	1000 E Main St Round Rock, TX 78664

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 8:38 a.m., LVN F revealed if a CNA noticed a resident had a change in condition, CNAs were expected to report the incident to a nurse. LVN F stated CNAs were to never turn their back on a resident in the shower room during a shower. LVN F also stated CNAs were required to have all shower supplies prepared before taking residents to the shower room. During an interview on [DATE] at 8:45 a.m., LVN G revealed if a CNA noticed a resident had a change in condition, CNAs were expected to report the incident to a nurse. LVN G stated CNAs were to never turn their back on a resident in the shower room during a shower. LVN G also stated CNAs were required to have all shower supplies prepared before taking residents to the shower room. During an interview on [DATE] at 9:04 a.m., CNA H revealed if he noticed a resident had a change in condition, he would report the incident to a nurse. CNA H stated he would also never turn his back on a resident in the shower room during a shower. CNA H also stated he would have all the shower supplies prepared before taking residents to the shower room. During an interview on [DATE] at 9:23 a.m., CNA I revealed if she noticed a resident had a change in condition, she would help the resident and notify a nurse. CNA I stated she would also never turn her back on a resident in the shower room during a shower. CNA I also stated she would have all the shower supplies prepared before taking residents to the shower room. During an interview on [DATE] at 10:26 a.m., FAM revealed Resident #1 was placed on hospice care due to a brain injury and hematoma sustained due to her fall at the facility. FAM stated they requested the facility staff to transfer Resident #1 to the hospital. FAM also stated Resident #1 was then transferred to the trauma center. FAM stated he notified the facility staff on [DATE] about Resident #1's hematoma found at the hospital. During an interview on [DATE] at 10:48 a.m., NP revealed the facility staff informed her that Resident #1 fell during a shower and sustained a hematoma, which she defined was a pocket of blood to her head. NP stated Resident #1 was not taking any anticoagulants, which she defined as blood thinning medication. NP also stated FAM wanted Resident #1 to go to the hospital. NP stated Resident #1 did not have any falls at the facility in the past. NP also stated a hematoma was a great bodily injury, but she was not sure if the hematoma Resident #1 sustained was due to her fall or a precondition. During an interview on [DATE] at 11:12 a.m., DON revealed CNA A showered Resident #1. DON stated a brain bleed constituted as a serious bodily injury. DON also stated Resident #1 had no history of falls at the facility, was ambulatory, and had no s/s of injury from past falls. DON stated CNA A told staff that she had her back turned-on Resident #1 because she was moving another shower chair when Resident #1 got up unassisted and fell . DON also stated Agency Hospice CNA was in the shower room and may have witnessed Resident #1's fall, she made two attempts to contact Agency Hospice CNA, and still waiting for Agency Hospice CNA to return her calls. DON stated she was in-servicing staff on performing showers on residents. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 12:08 p.m., CNA A revealed Resident #1 used a walker, was on the right side of the hallway, and in the memory care unit. CNA A stated CNAs showered residents. CNA A also stated on [DATE] at 6:30 a.m., she observed Resident #1 was walking without a walker, helped walk Resident #1 back to her room, grabbed Resident #1's walker and new clothes from her room, and thought to shower Resident #1 because Resident #1 was awake. CNA A also stated she observed Resident #1 had s/s of dizziness and thought that might have been why she was walking without a walker. CNA A stated she knew Resident #1 was dizzy because Resident #1's eyes looked like she was dizzy and when walking looked like she was going to fall. CNA A also stated the nurse must know everything anytime a CNA observed a change in condition. CNA A stated a CNA must immediately notify a nurse whenever they observe a change in condition. CNA A also stated she did not report dizziness to the nurse because there was no nurse at the time because the nurse did not report to work on time. CNA A stated she did not look for another nurse because she was going to shower Resident #1. CNA A stated she notified RN B that Resident #1 was dizzy when RN B started her work shift, which was during the time she took Resident #1 to the shower room. CNA A stated residents' health and safety could be affected if CNA did not notify a nurse that residents were showing s/s of dizziness. CNA A stated there was a bigger chair in the room, Resident #1 could not sit on the bigger chair, she put Resident #1 in the small shower chair, she instructed Resident #1 to wait for her, and had Resident #1's clothes off from the wrist down. CNA A also stated as she looked away from Resident #1, Resident #1 stood up within seconds, held the bigger chair, fell down, and the bigger chair fell over her. CNA A stated a male had saw the incident in the shower room. CNA A also stated she notified RN B, she asked RN B to come, RN B came to the shower room, and saw Resident #1 on the ground and bleeding on her hand and hair, helped her pick up Resident #1, and assessed Resident #1 and notified the DON. CNA A stated she was not working at the facility at the time of the interview because the facility staff did not want to give her work hours or put her on the schedule and she was suspended pending an investigation. During an interview on [DATE] at 1:30 p.m., RN B revealed CNA A came to her and stated Resident #1 fell in the shower room. RN B stated she went into the shower room and observed Resident #1 on the floor and had blood on her head. RN B also stated CNA A told her that Resident #1 was sitting on shower bench, grabbed a shower chair, and fell in the shower room. RN B stated CNA A told her that Resident #1 was confused before she brought Resident #1 to the shower room and that she believed Resident #1 was confused because she was walking without her walker, which was abnormal behavior for her. RN B also stated CNA A did not tell her that Resident #1 was confused before taking her to the shower room. RN B stated she did not ask CNA A why CNA A did not inform her about Resident #1's confusion because she was in middle of assessing and treating Resident #1 after the fall. RN B also stated a CNA was supposed to immediately report to the nurse if they observe any change in condition. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:53 p.m., DON revealed she conducted in-services on abuse, neglect, and ADL care related to showers with the staff after Resident #1's fall. DON stated she did not initiate in-services on change in condition. DON also stated she did not initiate change in condition in-services because she did not believe Resident #1 had a change in condition at the time. DON explained CNA A told her that on [DATE], she knew it was Resident #1's shower day, Resident #1 was ambulatory, and helped Resident #1. DON also stated CNA A told her that she gathered Resident #1's shower supplies, took Resident #1 to the shower room, sat Resident #1 on the shower bench that was against the wall, went to grab an extra shower chair, and noticed Resident #1 fell . DON stated CNA A also told her that Resident #1 seemed off before taking her to shower room and that Resident #1 acted in that manner sometimes. DON also stated CNA A told her that Resident #1 was stable with a walker when walking to the shower room when she asked how Resident #1 was walking. DON stated CNA A told her that Resident #1 was off because Resident #1 was walking without her walker and believed it was abnormal behavior when she asked CNA A why CNA A believed Resident #1 was off before taking her to the shower room. DON also stated CNA A mentioned Resident #1 had some confusion. DON stated she asked CNA A if Resident #1's confusion was new and CNA A told her that it was not new because it sometimes happened with Resident #1. DON stated CNA A did not mention anything to her about Resident #1 showing s/s of dizziness. DON also stated CNA A also did not mention anything about reporting to a nurse before taking Resident #1 to the shower room and did not provide her with an explanation as to why she did not tell a nurse before taking Resident #1 to the shower room when she observed Resident #1's behavior. DON stated she expected CNAs to notify a charge nurse whenever they suspected or observed s/s of change in condition. DON also stated residents' health or safety could be affected if CNAs did not notify a nurse of a change in condition. DON explained residents' diagnoses or change in condition could go overlooked if CNAs did not notify a nurse. DON stated CNA A was suspended pending investigation until they found out what happened and CNA A had right training and reeducation before returning to work. During an interview on [DATE] at 2:23 p.m., ADM revealed she was notified that Resident #1 fell in the shower room, hit her head, and went to the hospital. ADM stated when investigating the incident, CNA A told staff that the shower room was not situated before bringing Resident #1 into the shower room, sat Resident #1 on a shower bench, and went to grab a shower chair in the shower room. ADM also stated staff were taught that shower supplies were prepared before bringing any resident to the shower room. ADM stated she could not recall if CNA A told staff that Resident #1 seemed off before taking Resident #1 to the shower room. ADM also stated she recalled CNA A stating Resident #1 seemed off in the shower room. ADM stated CNA A described Resident #1 was acting differently and did not describe how Resident #1 was acting differently to the staff. ADM also stated she was not sure if CNA A told a nurse before taking Resident #1 to the shower room about Resident #1 seeming off. ADM stated residents' health and safety could be affected if staff were not notifying residents' changes in condition. During an interview on [DATE] at 3:01 p.m., DON revealed she checked with HR and did not find any expectation, training, or requirement related to CNAs notifying nurses of s/s of change in condition. A voicemail from Resident #1's FAM on [DATE] at 10:46 a.m. revealed Resident #1 passed away in the morning of [DATE] and the death was caused by the brain bleed due to the damage it did from Resident #1's physical and mental state. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 8:38 a.m., CNA A revealed she could not remember if she were given training on how to shower residents. CNA A explained when she started as a CNA, she was trained by an experienced CNA. CNA A stated she was taught to have all shower supplies ready before bringing residents in the shower room to shower them. CNA A also stated CNAs were supposed to ask another CNA to grab whatever they forgot in the shower room if they are about to shower a resident and forget something. CNA A explained she did not ask another CNA to grab the shower chair when she was in the shower room with Resident #1 and needed it because the other CNA was outside the shower room, she did not think it was necessary to ask, and she was confident because there was an Agency Hospice CNA in the shower room with her. CNA A went on to explain she did not ask the Agency Hospice CNA to help her grab the shower chair or monitor Resident #1 while she grabbed the shower chair because the Agency Hospice CNA was busy bathing another resident and she believed he was unable to help her at the same time. CNA A stated she turned her back on Resident #1 because she was grabbing one of the two shower chairs in the shower room. CNA A also stated she left Resident #1 for one second. CNA A also stated CNAs could not have their back turned on a memory care resident in the shower room. CNA A explained she left Resident #1 for one second because she did not think Resident #1 would stand up unassisted from the shower bench. CNA A stated she was required to shower residents. CNA A stated RN B was not there when she took Resident #1 to the shower room. CNA A stated residents' health and safety could be affected if a CNA had their back turned and a resident got up unassisted and fell . During an interview on [DATE] at 9:09 a.m., DON revealed the facility did not have a policy on ADL care related to showering residents. DON explained the facility followed ADA's recommendations and reasonably accommodate what they can do as a facility for the residents. DON stated CNA A's training orientation was completed in 2010. During an interview on [DATE] at 9:17 a.m., RN B revealed she was given in-services on fall protocol a two weeks ago by the ADON. RN B also stated she was not given an in-service on ADL care related to showering residents. RN B also stated CNAs should get all the shower equipment together before taking a resident to the shower room. RN B stated she expected CNAs to press the call light for help if they forgot to get something and were about to shower a resident in the shower room. RN B stated she could not recall when she had clocked into work on [DATE]. RN B also stated when she arrived to work her shift, CNA A was already in the shower room with Resident #1 and already providing care to Resident #1. RN B stated CNA A did not receive responsibilities from her before she arrived to work her shift. RN B explained CNA A had been told since beginning to provide care to residents who could walk, which included Resident #1. RN B stated CNAs should be keeping eyes on residents at all times. RN B stated residents' health and safety could be affected if a CNA had their back turned on a resident and the resident got up unassisted and fell because the resident was already in the shower room and the resident could end up hurting themselves. During an interview on [DATE] at 9:47 a.m., DON revealed the facility tried to contact the Agency Hospice CNA, who was in the shower room with CNA A on [DATE]. DON explained she contacted the Hospice Company to see if they could reach the Agency Hospice CNA and was notified that he was on vacation. An attempt to call Agency Hospice CNA was made on [DATE] at 9:53 a.m. Left voicemail and call back number. Agency Hospice CNA did not return the call. During an interview on [DATE] at 10:20 a.m., DON revealed the facility did not have a specific training check off list for CNAs giving showers. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An attempt to call CNA C was made on [DATE] at 10:28 a.m. Left voicemail and call back number. During an interview on [DATE] at 10:39 a.m., CNA J revealed she was given orientation training on who and when to report change in condition. CNA J stated she did not receive an in-service on who and when to report a change in condition. CNA J also stated if she observed a change in condition, she was trained to ensure resident safety and report to a nurse. CNA J stated if her charge nurse were unavailable, she would find another nurse. CNA J also stated she was not given orientation training and recent in-services on ADL care related to how to shower residents. CNA J stated CNAs were required to have everything in place before taking a resident to the shower room. CNA J also stated if she forgot something and was about to give a resident a shower in the shower room, she would ask another CNA to grab what she forgot. CNA J stated CNAs were required to never turn their backs on a resident. During an interview on [DATE] at 10:46 a.m., CNA K revealed she was given orientation training on who and when to report change in condition and ADL care related to how to shower residents. CNA K stated she was in-serviced on falls yesterday ([DATE]) by the ADON. CNA K also stated she was not given a recent in-service on ADL care related to how to give showers. CNA K stated CNAs were required to have everything in place before taking a resident to the shower room. CNA K also stated if she forgot something and was about to give a resident a shower in the shower room, she would ask another CNA to grab what she forgot. CNA K stated CNAs were required to never turn their backs on a resident. CNA K also stated if she observed a change in condition, she was trained to report to a nurse. CNA K stated if the charge nurse were unavailable, she would find another nurse. During an interview on [DATE] at 10:52 a.m., CNA L revealed she was given orientation training on who and when to report change in condition. CNA L stated she was not given recent in-services on who and when to report change in condition. CNA L also stated if she observed a change in condition, she was trained to report to a nurse. CNA L stated if the charge nurse she reported to was not on duty yet, she would find another supervisor. CNA L also stated she was not given orientation training on ADL care related to how to give showers. CNA L stated she was given a recent in-service on ADL care related to how to give showers. CNA L also stated CNAs were required to have everything in place before taking a resident to the shower room. CNA L stated if she forgot something and was about to give a resident a shower in the shower room, she would pull the emergency call light, cover up the resident and get the resident out of the shower room or ask another CNA to get what she forgot. CNA L also stated CNAs were required to never turn their backs on or leave a resident. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 11:38 a.m., DON revealed she tried to give CNA A easier residents so she did not have to help with ADLs. DON defined easier as residents who were more independent with ADL care. DON stated she did not know who assigned CNA A to give Resident #1 a shower. DON explained RN B was drawing blood possibly during the time CNA A observed Resident #1's dizziness. DON also stated she in-serviced staff on showers and discussed how to prepare all shower items before taking a resident to the shower room on [DATE]. DON stated newly employed CNAs were paired with an experienced CNA who demonstrated to them how to perform job duties. DON also stated she also discussed reporting residents' change in condition during the in-service initiated on [DATE]. DON stated if CNAs noticed anything different or abnormal, CNAs were required and trained to notify a nurse or supervisor. DON also stated CNAs were expected to prepare all shower items before taking resident to shower room. DON stated CNAs could use shower call light if they forgot something and were about to shower residents in the shower room. DON also stated CNAs were not allowed to have their backs turned on residents in the memory care unit while in the shower room. DON stated she added a reporting change in condition in-service. DON also stated CNAs were taught to find a nurse and notify them of any change in condition observed. DON stated the in-servicing was ongoing. DON stated she did not observe any dizzy behaviors prior to Resident #1's fall. DON also stated she did not believe Resident #1's medication contributed to the dizziness observed by CNA A. Record review of the facility staff timesheets, dated [DATE], revealed staff worked in the memory care unit during the following shifts: -RN B [DATE] 6:22 a.m. - [DATE] 10:19 p.m. -CNA C [DATE] 6:53 a.m. - [DATE] 2:39 p.m. and [DATE] 3:24 p.m. - [DATE] 6:48 p.m. -CNA A [DATE] 6:12 a.m. - [DATE] 2:08 p.m. Record review of CNA A's proficiencies upon hire and annually and clinical proficiencies required upon hire and annually revealed no training given and completed related to falls, abuse, neglect, and change in condition. Record review of the facility's orientation, [DATE], revealed staff were trained on resident abuse/neglect and mistreatment, resident rights, customer satisfaction, medical records, dietary service, emergency preparedness, infection control, physical environment, and Nurse/CNA orientation checklists that covered hand hygiene, incontinent care, transfers, infection control, and vitals. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Hospital Record, from [DATE] through [DATE], revealed she arrived at the hospital emergency department on [DATE] at 11:42 a.m. Resident #1's chief complaint was fall and hip and rib pain. Resident #1 was presented to the hospital's ER with her family after a fall. Resident #1's family reported Resident #1 was transferring from a chair the morning of [DATE] when she fell backwards and struck her head and had since been complaining of head, ribcage, and pelvic pain. Resident #1's physical exam at the hospital revealed her head was with a contusion (a bruise) and she exhibited decreased range of motion and tenderness to her right hip. Resident #1's x-rays found she had a nondisplaced right inferior pubic ramus fracture and right parietal scalp hematoma that underlying was an acute traumatic subarachnoid hemorrhage (the accumulation of blood in the space between the arachnoid membrane and the [NAME] mater around the brain referred to as the subarachnoid space). Extensive conversation between Resident #1's family, Neurosurgery and SICU attending regarding how best to proceed moving forward resulted in Resident #1's family felt that she suffered and had significantly deteriorated over the past two days and decided to pursue comfort care only. Hospice was consulted and Resident #1 was transitioned to inpatient hospice the following day ([DATE]). Resident #1 was discharged to an inpatient hospice medical center on [DATE] with no resolved hospital problems. On [DATE], Resident #1 expired at the inpatient hospice medical center. Record review of the facility's self-report, received by the State Agency on [DATE], revealed on [DATE] at 6:30 a.m., Resident #1 was in the shower room with CNA A. CNA A sat Resident #1 on a shower bench to prepare the shower stall. When Resident #1 fell when she got up unassisted. The ADM first learned of the incident on [DATE] at approximately 7:00 a.m. RN B immediately assess Resident #1. NP reassessed Resident #1 on [DATE] around 9:00 a.m. There was a hematoma noted to Resident #1's right back of head. Ice was applied and neurological monitoring was started. Upon assessment, Resident #1 denied headaches or dizziness and did not vomit. Resident #1 did report right hip and groin pain. The facility staff notified Resident #1's family, physician, ADON who notified the ADM and DON, and Regional Nurse. Resident #1's family was present during NP's visit and requested Resident #1 be sent to the hospital. The facility staff sent Resident #1 to the hospital for further evaluation. X-rays were completed in the hospital and noted Resident #1 had a brain bleed. On [DATE] at 5:30 a.m., Resident #1's family spoke with the facility staff and reported Resident #1's hospital scans revealed she had a brain bleed, old rib fractures they attribute to were sustained due to a fall prior to admission, six vertebrae fractures that were osteoporosis related and a broken pubic bone that was unknown if it was acute with the fall or not, Resident #1 was placed on hospice in the hospital on [DATE] and possibly had a stroke that could have caused the fall. CNA A was suspended until further investigation was completed. In-services on abuse and neglect, falls, and reporting were conducted. Record review of the facility's Incident List, dated [DATE], revealed Resident #1 had a witnessed fall on [DATE] at 6:30 a.m. Record review of the facility's Admission/Discharge Report, from [DATE] through [DATE], revealed Resident #1 discharged to an acute care hospital on [DATE]. Record review of the facility's in-services revealed on [DATE], staff were educated on shower safety and taught to gather all supplies, ensure the shower room was ready prior to taking residents into the shower room, and to immediately report any suspicions of abuse/neglect to the ADM. Attached to the in-service was a copy of the State Agency's reporting guidelines and the facility's Assessing Falls and Their Causes policy and procedure revised in [DATE]. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's Change in a Resident's Condition or Status policy and procedure, revised February 2021, revealed the following, Our community promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). 1. The nurse will notify the resident's attending physician or physician on call when there has been a(an): a. accident or incident involving the resident. b. discovery of injuries of an unknown source. c. adverse reaction to medication. d. significant change in the resident's physical/emotional/mental condition. e. need to alter the resident's medical treatment significantly. f. refusal of treatment or medications two (2) or more consecutive times). g. need to transfer the resident to a hospital/treatment center. h. discharge without proper medical authority; and/or i. specific instruction to notify the physician of changes in the resident's condition. 2. A significant change of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting). b. impacts more than one area of the resident's health status. c. requires interdisciplinary review and/or revision to the care plan; and d. ultimately is based on the judgment of the clinical team and the guidelines outlined in the Resident Assessment Instrument. 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. The policy did not indicate CNA's responsibilities for who, what, when where and how to notify if they observe a resident had a change in condition or status. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675546	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	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)
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's ADL's Supporting policy and procedure, revised [DATE], revealed the following, Residents will provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 2. Appropriate care and services will be provided for residents who are unabl [TRUNCATED]