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	08/03/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44671 Based on interview, and record review the facility failed to develop and implement interventions the person-centered care plan to reflect the current condition for 1 (Residents # 1) of 5 residents reviewed for care plan interventions. The facility failed to update Resident # 1's care plan for diet interventions after her diet order was changed. This failure could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs. The Findings included: Review of Resident # 1's face sheet revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnosis that included Unspecified protein-calorie malnutrition (lack of proper nutrition or an inability to absorb nutrients from food) , hypertensive heart disease (heart conditions caused by high blood pressure), and vascular dementia (problems with reasoning, planning, judgement, memory and other thought processes caused by brain damage from impaired blood flow to the brain). Review of Resident # 1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 7 which indicated severe cognitive impairment. Review of Resident # 1's care plan not dated revealed a problem of Resident # 1 had nutritional problem r/t dysphagia (difficulty swallowing), malnutrition, and dementia (memory loss). There was no goal or intervention of a vegetarian diet. Review of Resident # 1's physician orders dated 08/03/2024 revealed an order with a start date of 07/27/2024 for a vegetarian diet. Interview with the MDS coordinator on 08/03/2024 at 2:55 PM stated that LVN F would have been responsible for updating the care plan on 07/29/2024 when it was known by the order that Resident # 1 was a vegetarian. The MDS coordinator stated she had updated Resident #1's care plan 08/03/2024 when the DON told her to review Resident #1's care plan. The MDS coordinator stated that care plans needed to be updated when the orders are changed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN F on 08/03/2024 at 3:56 PM stated he came into the facility around 6:00 PM on 07/29/2024. LVN F stated he had a request on his desk to update Resident # 1's diet to vegetarian. LVN F stated he updated Resident # 1's order but he did not go into the care plan to update it. LVN F stated he just got too busy with other facility duties which was the reason he did not update the care plan. LVN F stated he was aware care plans should be updated timely. Interview with ADM on 08/03/2024 at 4:20 PM stated the care plans should be updated when the orders are placed and should be updated timely. The ADM stated that the charge nurse was responsible for updating care plan. ADM stated not having a care plan updated the residents needs would not get met and may cause illness. Review of Policy Care Plan, Comprehensive Person-Centered Revised December 2016, revealed 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change.

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NAME OF PROVIDER OR SUPPLIER Trinity Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44671 Based on interviews and record review, the facility failed to provide food that accommodates residents allergies, intolerances, and preferences for 1 (Resident # 1) of 5 residents reviewed for food preferences. The staff did not accommodate Resident # 1's dietary preferences for a vegetarian diet. This failure could affect the residents that are provided daily meals by the facility, by placing them at risk for adverse effect from food, frustration, not enjoying meals, and weight loss. The Findings included: Review of Resident # 1's face sheet revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included Unspecified protein-calorie malnutrition (lack of proper nutrition or an inability to absorb nutrients from food) , hypertensive heart disease (heart conditions caused by high blood pressure), and vascular dementia (problems with reasoning, planning, judgement, memory and other thought processes caused by brain damage from impaired blood flow to the brain). Review of Resident # 1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 7 which indicated severe cognitive impairment. Review of Resident # 1's care plan not dated revealed a problem of Resident # 1 had nutritional problem r/t dysphagia (difficulty swallowing), malnutrition, and dementia (memory loss). There was no goal or intervention of a vegetarian diet. Review of Resident # 1's physician orders dated 08/03/2024 revealed an order with a start date of 07/27/2024 for vegetarian diet with puree texture and nectar thick consistency. Review of Resident # 1's progress note dated 08/01/2024 at 2:34 PM reflected the DON wrote Resident # 1's RP came to the facility today upset because Resident # 1 had received meat on her tray. CNA C was in the room feeding Resident # 1 her lunch at the time. Review of Resident # 1's RP grievance dated 07/29/2024 revealed [Resident # 1] had been on vegetarian diet but had been receiving meat on her tray. Review of Resident # 1 's RP grievance dated 08/01/2024 revealed [Resident # 1] received meat on her tray. Review of Resident # 1's printed lunch dietary ticket dated 08/01/2024 reflected in notes (no pureed meat) and give extra servings of pureed vegetables. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 08/03/2024 at 11:00 AM stated that Resident # 1's RP was upset because Resident # 1 was brought ground chicken and she was a vegetarian. The DON stated Resident # 1 was being fed by CNA C and the RP was in the room when the tray came. The DON stated that Dietary matched the resident's food preferences by the meal ticket. The DON stated that the charge nurses would double check the meal ticket and tray. The DON stated once the tray had been verified the CNA staff would deliver the tray to the resident's room. The DON stated the facility did not have a policy on verification of trays and that was just a process that the facility followed to ensure residents received the correct meal. The DON stated on 08/01/2024 Resident # 1's tray did not get verified by LVN A or RN D because both charge nurses were busy with other facility duties. Interview with Resident # 1's RP on 08/03/2024 at 11:15 AM stated on 08/01 when I was at the facility, I got upset and blew a fuse. Resident # 1's RP stated he told LVN A told that they had poisoned Resident # 1 by feeding her meat and she was a vegetarian. Resident # 1's RP stated CNA C had delivered the tray to the room. Resident # 1's RP stated the facility had called the police on him because he would not calm down. Resident # 1's RP stated he left the facility and came back to the facility on [DATE] (time not recalled) to get Resident #1's belongings and he also took Resident # 1 out of the facility to his home. RP stated he had taken Resident #1 out of the facility due to the police kicking him out. RP stated Resident # 1 would not be returning to the facility due to that incident. Interview with LVN A on 08/03/2024 at 1:15 PM stated during lunch time (exact time not recalled) CNA C brought the tray to Resident #1. LVN A stated he did not verify Resident # 1's tray because he was busy with assisting another resident. LVN A stated he was focused on the issue with the resident and he did not get to check Resident # 1's tray. LVN A stated Resident # 1 's RP was upset that meat was on Resident # 1's tray. The facility process that is followed to make sure residents receive the correct diet, the dietary staff review the special instructions on the bottom of the meal ticket, the charge nurse verifies the meal ticket, and the CNA assigned would deliver the tray to the room. Interview with the Kitchen Manager on 08/03/2024 at 1:43 PM stated LVN A brought to her attention that meat was on Resident # 1's plate. The Kitchen Manager stated that [NAME] B had messed up, and the special instructions of no meat was on the bottom of the meal ticket. The Kitchen Manager stated she discarded the tray and made a new tray for Resident #1. The Kitchen Manager was unable to state why LVN A did not check the tray before CNA C delivered to the room. Interview with [NAME] B on 08/03/2024 at 2:05 PM stated she looked at Resident # 1's meal ticket on 08/01/2024 and it did have no meat on the ticket. [NAME] B stated that she made the plate puree, and she did not know what had happened with Resident # 1 receiving the puree meat on the tray. [NAME] B stated that she was told by the Kitchen Manager that Resident # 1 should not get any meat. Interview with CNA C on 08/03/2024 at 3:30 PM stated she delivered the tray on 08/01/2024 and was going to feed Resident # 1 and Resident # 1's RP told her to leave the tray and that he was going to feed Resident # 1. CNA C stated she never looked at the tray and she did not believe LVN A looked at the tray because he was busy with another resident. CNA C stated that Resident # 1 and Resident # 1's RP stated to her that she was vegetarian. CNA C stated she would not have given Resident # 1 any meat. CNA C stated that someone (no name given) dropped the ball that day and Resident #1's RP did not give her a chance because he had taken over. CNA C stated LVN A and RN D were busy with other facility issues, and she could not tell why the tray was not physically checked prior to her bringing to Resident # 1. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN D on 08/03/2024 at 3:42 PM stated as far as she understands it was the charge nurse of the resident who would verify the meal tray. RN D stated at around lunch time (exact time unknown) she was busy with sending out a resident to the hospital. RN D stated LVN A was busy with a resident and LVN A never checked Resident # 1 's tray from her understanding. Interview with the ADM on 08/03/2024 at 4:20 PM stated she did not know Resident # 1 had received the wrong diet until Resident # 1's RP had became upset on 08/01/2024. The ADM stated it was expected for residents to receive their food preference choices. Review of Policy Tray Service dated 2018, revealed The facility believes that accurate tray service and adequate portion sizes are essential to the residents' well being and safety. The facility will ensure that diets are served accurately and in the correct portions and that resident's preferences are met.