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	06/18/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 2 of 16 (Resident #1 and Resident #2) residents reviewed for accommodation of needs. 1. The facility failed to provide a working communication system, which was easily at reach at the bedside, which would allow Resident #1 to call for assistance. From 06/10/25 until 06/18/25, Resident #1 did not have a working communication system in her room. 2. The facility failed to provide a working communication system for Resident #2 on 06/18/25 when her call light was broken. These failures could place residents at risk of not having a means of directly contacting caregivers in an emergency, a delay in assistance, a decreased quality of life and a loss of dignity. Findings included: 1. Record review of Resident #1's face sheet, printed on 06/18/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included nontraumatic intracerebral hemorrhage (stroke) and acute respiratory failure with hypoxia (lungs not functioning properly lead to low oxygen levels). Record review of Resident #1's admission MDS assessment, dated 06/12/25, was In Progress. Record review of Resident #1's care plan, initiated on 06/11/25, reflected the resident had an ADL self-care performance deficit. The goal was to maintain current level of functioning. Interventions included total assistance by staff for bathing, bed mobility, dressing, eating, and personal hygiene. The care plan reflected the resident had a communication problem. The goal was to make basic needs known on a daily basis. Interventions included anticipate and meet needs and speak on an adult level. The care plan did not address a call light. Record review of Resident #1's progress note, dated 06/16/25 at 9:01 AM, written by the APRN, reflected in part the resident had expressive dysphasia (difficulty speaking), hemiplegia (paralysis on one side of the body) of left nondominant side, and required a g-tube (a surgically placed tube into the stomach) for medications and nutrition. (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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 06/18/25 at 9:04 AM, revealed there was no call light or bell in Resident #1's room. Resident #1 was not in the room. During an interview on 06/18/25 at 10:00 AM, the DON stated if a call light was not working, maintenance was notified. The DON stated they had bells that were used if the call light was not working. She stated they used an electronic program for submitting maintenance requests. She stated the maintenance request system was linked to their electronic medical record system, so everyone had access to submit requests. The DON stated they did not have a Policy & Procedure for call lights or maintenance requests . During an observation and attempted interview on 06/18/25 at 10:59 AM, revealed Resident #1 was lying in bed with the head of the bed elevated. A visitor was at the bedside. Resident #1, spoke just above a whisper, was able to state she was comfortable, but not able to say how she contacted staff for assistance. During an interview on 06/18/25 at 11:00 AM, the visitor in the room stated she had not seen a call light in Resident #1's room on previous visits, and she had visited a few times. During a telephone interview on 06/18/25 at 12:30 PM, a FM stated there had not been a call light in the room when she visited Resident #1 on 06/15/25. During an interview on 06/18/25 at 11:03, LVN A stated there had not been a call light in Resident #1's room since the resident moved into the room on 06/10/25. LVN A stated a maintenance request for a call light was placed on 06/10/25 . She stated she would round more frequently on residents if they did not have a call light in the room to ensure their needs were met. She stated without a call light, residents needs or requests may not be met. During an interview on 06/18/25 at 11:13 AM, the DOM stated he had not received a maintenance request for a call light in Resident #1's room until 06/18/25. He stated he was not aware there was not a call light in the room. The DOM stated he had just received the requests for Resident #1 and Resident #2s call lights. During an interview on 06/18/25 at 11:17 AM , CNA B, stated she worked through and agency and was at the facility two or three times a week. She stated Resident #1 and Resident #2 were both on the hall where she was assigned to work. She stated as far as she knew, Resident #1 had a call light in her room. She stated a nurse had been working with the resident earlier, so she had not provided care to the resident yet. She stated she did not know Resident #2's call light was not working. She stated she made rounds on her residents every two hours. She stated without a call light, the residents would not be able to call for assistance to have their needs met. 2. Record review of Resident #2's face sheet, printed on 06/18/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included unspecified cerebral infarction (stroke), type 2 diabetes (a condition that affects the way the body processes blood sugar), arthritis (swelling and tenderness of the joints), and dementia . Record review of Resident #2's quarterly MDS assessment, dated 05/18/25, reflected a BIMS score of 3, which indicated severely impaired cognition. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's care plan, revised 06/06/25, reflected Resident #2 was at risk for falls related to debility with a goal the resident would remain free of falls. Interventions included the call light within reach and encourage the resident to use it for assistance as needed and, The resident needs prompt response to all requests for assistance. An observation on 06/18/25 at 9:14 AM revealed Resident #2 lying in bed with her eyes closed. The head of the bed was elevated. The resident's call light button cord was wrapped around the side rail on the left side of the resident's bed. The end of the call light cord was observed on the floor under the head of the bed. The call light was not plugged into the receptacle on the wall. A connector was plugged into the wall receptacle . During an observation and interview on 06/18/25 at 11:06 AM, LVN A entered Resident #2's room. LVN A told Resident #2 she was going to test the call light. LVN A pushed the button on the call light, but the light did not activate. LVN A looked under the bed and stated, It must have broken. She stated she did not know how long the call light had not been working. She stated Resident #2 used her call light frequently. Resident #2 stated the staff usually answered her light promptly. Resident #2 did not remember the last time she used her call light. During an interview on 06/18/25 at 12:23 PM, the DON stated she did not know how long Resident #1 had been without a call light in the room. She stated it did not meet her expectation that there was not a call light or a bell in the room. She stated if there was not a functioning call light, residents would not be able to notify staff when they needed help. The DON stated she did not know how long Resident #2's call light had been broken. She stated sometimes the cords got caught and broke when the bed positions were adjusted so they always kept extra call lights in stock . During an interview on 06/18/25 at 1:04 PM, the ADM stated it was her expectation every room had a functioning call light. She stated Resident #1 was close to the nursing station and observed frequently. The ADM stated without a functioning call light, residents were not able to let staff know if they needed something. Record review of the facility's Resident Rights Policy, revised December 2016, reflected in part, .f. communication with and access to people and services, both inside and outside the facility