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	07/09/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 3 of 18 residents (Resident#1, Resident #3, and Resident #4) reviewed for dignity. The facility failed to ensure catheter bag was covered and not visible Resident#1, Resident #3, and Resident #4. This failure placed residents at risk of embarrassment and diminished quality of life. Findings included: Record review of Resident#1's admission Record updated 7/9/25 revealed, Resident #1 was a [AGE] year-old female admitted to the facility on [DATE]. She had diagnosis of nontraumatic intracerebral hemorrhage (stroke), acute respiratory failure (difficulty breathing), dysphagia following cerebral infarction (difficulty swallowing after stroke).Record review of Resident#1's care plan updated 7/8/25 revealed, IN INTERVENTION: The resident requires SKIN inspection per facility protocol. Observe for redness, open areas, scratches, cuts, bruises and report changes to the Nurse. Record review of Resident#1's MDS dated [DATE] revealed, Resident #1 has a stage 2 pressure ulcer that was present upon admission. Resident#1 is receiving Ulcer/Injury treatment: pressure reducing device for bed; pressure ulcer/injury care; applications of ointments/medications.[JM1] In an observation 7/8/25 at 12:02 pm Resident #1 revealed her catheter bag was half full of a pale-yellow liquid visible from the hallway. There was not a cover on the catheter bag to disguise or cover the fact Resident #1 had a catheter bag. In an interview 7/8/25 at 12:02 pm Resident #1 revealed she has no modesty or dignity while at the facility. She said the staff does not care about her, they show no empathy, treat her like a child or like she is not even human. She said she did not know why she had a catheter because she could go to the restroom with assistance. Resident #1 said she was a nurse for many years, and she knows when things are wrong. Record review of Resident#3's admission Record updated 7/9/25 revealed, Resident #3 was an [AGE] year-old female with a diagnosis of Type II Diabetes (elevated blood sugar), Chronic Kidney Disease, Stage 3, and Pain in unspecified toes. Record review of Resident#3's care plan updated 7/8/25 revealed, Problem #1 The resident has an arterial ulcer to right heel. Intervention 1: Evaluate wound for: Size, Depth, Margins: peri-wound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene. Document progress in wound healing on an ongoing basis. Notify physician as indicated. Intervention 2: Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Problem #2: The resident has potential/actual impairment to skin integrity r/t immobility, foley catheter, history of wounds and bowel incontinence. Intervention#1: Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration etc. to MD. Intervention #2 Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Problem #3: The resident has an ADL self-care performance deficit r/t had surgical procedure of right hip, previous right shoulder replacement, chronic pain, OA of right shoulder, and weakness. Intervention: SKIN INSPECTION: The resident requires SKIN inspection per facility protocol Observe for redness, open areas, scratches, cuts, bruises and report changes to the Nurse. Record review of Resident#3's MDS dated [DATE] revealed, Section M- Skin Conditions revealed, Determination of Pressure Ulcer/Injury risk Formal assessment instrument/tool and Clinical Assessment. Yes, this resident is at risk of developing pressure ulcers/injuries. No, this resident does not have one or more unhealed pressure ulcers/injuries. Other Ulcers, Wounds, and Skin Problems: E: surgical wounds Skin and Ulcer/injury treatments: E: Pressure ulcer/injury care; F: Surgical wound care; H: Applications of ointments/medications. In an observation 7/8/25 at 3:17 pm Resident #3's catheter bag was half full of a pale-yellow liquid visible from the hallway. There was not a cover on the catheter bag to disguise or cover the fact Resident #3 had a catheter bag. In an interview on 7/9/25 at 3:54PM the ADON revealed a catheter bag should have a cover over it or not be visible to the public. They should have privacy bags/covers. The ADON said it is the CNA and nurses' responsibility to ensure all catheter bags are covered. The ADON stated it is the responsibility of all staff members to ensure each resident's dignity is intact to prevent embarrassment or quality of life. Record review of Resident#4's admission Record updated 7/9/25 revealed, Resident #4 was an [AGE] year-old male with no listed diagnosis. Record review of Resident#4's care plan updated 7/8/25 revealed, Problem: The resident has potential/actual impairment to skin integrity of the (specify location) r/t

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. (continued on next page)

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure residents received services in the facility with reasonable accommodation of each resident's needs for three (Resident #1, Resident #2, and Resident #17) of 18 residents reviewed for resident call system in that: The facility failed to ensure call lights were within reach for Resident #1, Resident#2, and Resident #17.This failure could have placed residents at risk of being unable to obtain assistance when needed Findings included:Record review of Resident#1's admission Record updated 7/9/25 revealed, Resident #1 was a [AGE] year-old female admitted to the facility on [DATE]. She had diagnosis of nontraumatic intracerebral hemorrhage (stroke), acute respiratory failure (difficulty breathing), dysphagia following cerebral infarction (difficulty swallowing after stroke).Record review of Resident#1's care plan updated 7/8/25 revealed, Problem: The resident has an ADL self-care performance deficit r/t CVA with hemiplegia of left side and weakness. Intervention revealed Resident #1 required 1 person assist with bathing, dressing, bed repositioning, and eating.Record review of Resident#1's MDS dated [DATE] revealed, Resident #1 was dependent on oral hygiene, toileting, upper and lower body dressing, and putting on/off footwear.In an observation and interview on 7/8/25 at 12:02 pm Resident #1 revealed she did not know where the call light was. She was looking on the wall but the plug for the call light was behind her head on her left side. She reached for the wall but was unable to locate the call light on her own. The call light itself was observed on the floor under her bed. She further stated when she needed assistance she yells out for help because she did not know where the call light was located. She stated last night she yelled for help for a long time before someone finally came to assist her.In an interview on 7/8/25 at 2:08 PM the DON stated the facility does not have a policy regarding call lights.Record review of Resident#2's admission Record updated 6/6/25 revealed, Resident #2 was a [AGE] year-old female with a diagnosis of unspecified dementia (memory loss); essential hypertension (elevated blood pressure); sarcopenia (age related muscle loss).Record review of Resident#2's care plan updated 7/8/25 revealed, Intervention for fall risk; Be sure Resident#2's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Intervention for ADL self-care encourage Resident #2 to use bell to call for assistance.Record review of Resident#2's MDS dated [DATE] revealed, supervision or touching assistance for transfers and not applicable or not attempted for walking 10 feet.In an observation 7/8/25 at 3:25 pm Resident #2 the call light was on the floor behind the bed where Resident #2 could not locate without assistance. In an interview on 7/8/25 at 3:25 pm Resident #2 said the staff always put the call light where she cannot reach it. She said she has asked them multiple times to leave it where she can push it when she needs help, but they never do as she asked.Record review of Resident#17's admission Record updated 7/9/25 revealed, Resident #17 was an [AGE] year-old female with diagnosis of unspecified dementia (memory loss) hyperlipidemia (elevated cholesterol), essential tremor (rhythmic shaking)Record review of Resident#17's care plan updated 7/8/25 revealed, an ADL self-care performance.deficit r/t dementia, parkinsonism, tremors, gait with Intervention: Encourage the resident to use bell to call for assistance. High risk for falls intervention; Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.In an observation 7/9/25 at 10:10 am Resident #17 the call light was on the floor behind the bed where Resident #17 could not locate without assistance. In an observation on 7/9/25 at 10:17 am RN A came into Resident #17's room. RN A located the call button tangled up off the left-hand side of bed, not within reach of resident. RN A untangled the call button. In an interview on 7/9/25 at 3:54 pm ADON stated the expectation for a call light is that a call light should be placed where a resident can reach the button in case care is needed. The ADON stated it is all staff's responsibility to place call light within resident's reach. The ADON stated if a call light is not within reach, then a resident would have to yell out if they can, to notify staff care is needed, but staff should be verifying call light placement prior to leaving the room.In an interview on 7/9/25 at 4:05 pm RN B stated the expectation for a call light is that a call light should be placed where a resident can reach the button in case care is needed. RN B stated it is all staff's responsibility to place call light within resident's reach. RN B stated if a call light is not within reach, then a resident would have to yell out if they can, to notify staff care is needed, but staff should be verifying call light placement prior to leaving the room.In an interview on 7/9/25 at 4:15 pm CNA C stated the expectation for a call light is that a call light should be placed where a resident can reach the button in case care is always

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure maintain medical records on each resident that are- Complete and accurately documented, for 3 (Resident #1, Resident #9, and Resident #10) of 5 residents reviewed for assessments in that: -The facility did not ensure Resident #1, Resident #9, and Resident #10's wound assessments accurately reflected current wound locations, measurements, or wound typeThis failure could place residents needing wound care at risk of not receiving proper care, treatments, and interventions.Findings included:Record review of Resident#1's admission Record updated 7/9/25 revealed, Resident #1 was a [AGE] year-old female admitted to the facility on [DATE]. She had diagnosis of nontraumatic intracerebral hemorrhage (stroke), acute respiratory failure (difficulty breathing), dysphagia following cerebral infarction (difficulty swallowing after stroke).Record review of Resident#1's care plan updated 7/8/25 revealed, IN INTERVENTION: The resident requires SKIN inspection per facility protocol. Observe for redness, open areas, scratches, cuts, bruises and report changes to the Nurse.Record review of Resident#1's MDS dated [DATE] revealed, Resident #1 has a stage 2 pressure ulcer that was present upon admission. Resident#1 is receiving Ulcer/Injury treatment: pressure reducing device for bed; pressure ulcer/injury care; applications of ointments/medications.Record review of Weekly Skin Observation dated 6/11/25 for Resident#1 revealed, Location 14 abdomen, peg tube site; location 38 left knee (front) scar; location 53 Sacrum, Pressure, Measurements 1x0.5x0.1, Stage II; Other IC/Sub q/implanted port; neck trach removed 0.5x0.4x0.1.Record review of Weekly Wound Progress dated 6/12/25 for Resident#1 revealed, Wound#1 Pressure ulcer to Sacrum 100% Epithelial, Stage II to Sacrum measuring 1x0.5x0.1.Record review of Weekly Skin Observation dated 6/18/25 for Resident#1 revealed, location 14 abdomen peg tube; location 31 right buttock pressure depth 0; location 34 left thigh (front) blister; Anterior neck surgical incision.Record review of Weekly Wound Progress dated 6/19/25 for Resident#1 revealed, pressure ulcer 100% epithelial, stage II, sacrum, 1x0.5x0.Record review of Weekly Skin Observation dated 6/25/25 for Resident#1 revealed, document is marked yes for Does resident have any observed skin issues? The rest of the document is blank.Record review of Weekly Wound Progress dated 6/26/25 for Resident#1 revealed, pressure ulcer 100% epithelial, stage II, sacrum, 2x2x0.Record review of Weekly Skin Observation dated 7/2/25 for Resident#1 revealed, document is marked yes for Does resident have any observed skin issues? Then in notes it stated, wound to sacrum area.Record review of Weekly Wound Progress dated 7/3/25 for Resident#1 revealed, pressure ulcer 50% granulation 50% epithelial, stage II, sacrum, 2x2x0.Record review of Resident#9's admission Record updated 7/9/25 revealed, Resident #9 was a [AGE] year old male with HEMIPLEGIA (complete or severe paralysis to one side of the body) AND HEMIPARESIS (weakness on one side) FOLLOWING CEREBRAL INFARCTION affecting the right dominant side; Hepatic encephalopathy (serious brain condition caused by liver dysfunction, leading to the accumulation of toxins in the blood that affect brain function.).Record review of Resident#9's care plan updated 4/18/25 revealed, Weekly skin assessments started 12/9/21. Monitor/document/report PRN: Edema (swelling caused by too much fluid trapped in skin tissue), Bruising/discoloration of skin. Provide skin care to keep clean and prevent skin breakdown.Record review of Resident#9's MDS updated 5/13/25 revealed, Skin and Ulcer/Injury Treatments: Pressure reducing device for bed; Applications of ointments/medications other than to feet; Application of dressings to feet (with or without topical medications).Record review of Weekly Skin Observation dated 6/16/25 for Resident#9 revealed, wound to left heel (location 50), pressure without measurements; left shin open area without location # or measurements; left forearm skin tear without location # or measurements.Record review of Weekly Wound Progress dated 6/19/25 for Resident#9 revealed, 1 wound to Sacrum with measurements 4.5 X 4 X 0.1 with 100% granulation for deep tissue wound. Record review of Weekly Skin Observation dated 6/23/25 for Resident#9 revealed, under notes section left heel wound, scabs to BLE (bilateral lower extremities), skin tear both arms. There was no site location # or measurements. Record review of Weekly Wound Progress dated 6/26/25 for Resident#9 revealed 1 wound pressure ulcer to Sacrum with measurements 4 X 2.8 X 0.1 with 100% granulation for deep tissue wound. Record review of Weekly Skin Observation dated 6/30/25 for Resident#9 revealed, under notes section left heel wound, scabs on BLE (bilateral lower extremities), scabs on arms.Record review of Weekly Wound Progress dated 7/3/25 for Resident#9 revealed, 1 wound pressure ulcer to Sacrum with measurements 3.5 X 2.5 X 0.1 with 100% granulation for stage II ulcer Record review of Weekly Skin Observation dated 7/7/25 for