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	08/30/2023

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45830 Based on observation, interview and record review, the facility failed to promote and facilitate resident self-determination through support of resident choice for one (Resident #1) of eight residents reviewed for self-determination. CNA L denied Resident #1 the right to attend a group therapy activity. This failure placed Resident #1 at risk of mental anguish. Findings included: A record review of Resident #1's face sheet dated 8/30/2023 reflected a [AGE] year-old female originally admitted on [DATE] with diagnoses of multiple sclerosis (autoimmune disease), anxiety disorder, type 2 diabetes (uncontrolled blood sugar), dysthymic disorder (persistent depressive disorder), major depressive disorder (depression), unspecified dementia (cognitive decline), and cauda equina syndrome (spinal cord disease). A record review of Resident #1's MDS assessment dated [DATE] reflected a BIMS score of 12, which indicated mildly impaired cognition. This assessment reflected Resident #1 received hospice care. A record review of Resident #1's care plan last revised on 8/27/2023 reflected she required a two-person mechanical lift for transfers. Resident #1's care plan reflected she was dependent on staff for meeting her needs related to immobility, was very social, loved to be out in activities settings, attended all special events, and liked to get involved by talking to everyone. Interventions reflected CNAs were to assist/escort Resident #1 to activity functions. During an observation and interview on 8/29/2023 at 10:04 a.m., Resident #1 was observed lying in her bed. Resident #1 stated staff did not offer to get her up for group therapy that day and she had asked to get out of bed two hours ago. Resident #1 stated she liked to get up as soon as she could in the mornings and said she usually woke up around 6:00 a.m. Resident #1 stated she wanted to go to the group therapy exercise. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 8/29/2023 at 10:11 a.m., CNA L entered Resident #1's room to answer her call light. Resident #1 told CNA L she wanted to get up for group therapy and CNA L replied, you don't do therapy because you're hospice. Resident #1's eyebrow then furrowed, she raised her voice and became visibly agitated. During an observation and interview on 8/29/2023 at 10:14 a.m., CNA M stated there was no reason why residents on hospice could not attend the therapy exercise. CNA M stated she knew Resident #1 wanted to join and said she was going to get a sling from laundry. Observed residents in the 400-hall dining room area tossing balloons back and forth between residents and therapy staff. An observation on 8/29/2023 at 10:15 a.m. revealed the balloon activity was complete and residents were dispersing from the 400-hall dining room area. During an interview on 8/29/2023 at 10:19 a.m., PTA O stated residents who attended the group therapy sessions were on therapy services and she did not think they had anyone on hospice on therapy services. PTA O stated she would have to ask the DOR whether hospice residents were allowed to join group therapy activities. PTA O stated hospice residents would not know the activity was going. An observation on 8/29/2023 at 10:25 a.m. revealed CNA L and CNA M were with Resident #1 in her room. Resident #1 had a mechanical lift sling underneath her as she sat in her wheelchair. During an interview on 8/29/2023 at 10:27 a.m., CNA L stated therapy staff got the residents up for group therapy and she did not see any hospice patients going to therapy activities. CNA L stated no one had instructed her not to allow residents on hospice to join group therapy activities but she was not sure whether or not they could join. When asked how Resident #1 or other residents on hospice might feel if they were told they could not join an activity, CNA L stated, I would feel bad. During an interview on 8/29/2023 at 11:04 a.m., PTA O stated that after checking with the DOR, anyone is welcome to join group therapy hospice or not. PTA O stated group therapy was not an activity and the WLED was not involved but said the WLED could coordinate with CNAs to get residents up for group therapy exercises. PTA O stated CNAs were responsible for getting residents up if they wanted to join. During an interview on 8/30/2023 at 9:06 a.m., the DON stated the facility's policy on resident rights was based off their cognition and included offering residents a choice with what they wanted to wear and encouraging them to be involved in their care. The DON stated not necessarily when asked if she expected staff to tell residents they could not join an activity because they were on hospice. The DON stated hospice and therapy were a different ball game and CNA L was probably trying to communicate to Resident #1 that in general, residents on hospice were not on therapy. The DON stated CNA L could have inquired first as to whether Resident #1 was allowed to join before telling her she could not join. The DON stated nurse management monitored staff and, if we're in the hallway and resident brings up a concern we talk to the aide. The DON stated if it were an agency aide, the facility did not use them anymore. The DON stated, we'd talk to that aide about residents' rights to choose and dignity. The DON stated staff were trained on resident rights upon hire, annually and as needed. The DON stated they could feel excluded if residents were denied the right to participate in a group activity. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/30/2023 at 9:49 a.m., the Administrator stated she expected staff to allow residents to attend therapy activities regardless of what their payer source was. The Administrator stated Resident #1 had probably seen the group therapy activity going on before when she was out in the common area. The Administrator stated she did not know why CNA L told Resident #1 she could not attend and stated CNAs should not be deciding which activities they should be attending. The Administrator stated being told she could not join when she wanted to join could make Resident #1 feels sad, upset, and she would wonder why she was being treated differently. A record review of the facility's policy on Resident Rights dated December 2016 reflected the following: Policy Statement Team members shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation 1. Federal and state laws guarantee basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity; e. self-determination; f. communication with and access to people and services, both inside and outside the facility; g. exercise his or her rights as a resident of the facility and as a resident or citizen of the United States; h. be supported by the facility in exercising his or her rights; jj. equal access to quality of care, regardless of source of payment. A record review of the facility's undated computer-based training log reflected CNA L was last trained on Resident Rights on 8/01/2023.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observation, interview, and record review the facility failed to ensure residents unable to conduct activities of daily living (ADLs) received the necessary services to maintain good grooming and personal hygiene for four of fifteen residents (Resident # 4, Resident #4, Resident #73, and Resident #109) reviewed for quality of life. The facility failed to ensure Resident#4's, Resident #52's, Resident #73's, and Resident #109's fingernails were trimmed and cleaned. These failures could place residents at risk for poor hygiene, dignity issues and decreased quality of life. Findings included: 1. Record review of Resident #4's face sheet, dated 08/30/2023, reflected an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis of partial or total body function on one side of the body, whereas hemiparesis was characterized by one-sided weakness, but without complete paralysis), muscle weakness (when full effort does not produce a normal muscle movement), and type 2 diabetes mellitus with diabetic chronic kidney disease (a disease that occurs when your blood glucose, also called blood sugar, is too high and poorly controlled diabetes can cause damage to blood vessels in your kidneys that filter waster from your body). Record review of Resident #4's Quarterly MDS Assessment, dated 06/30/2023, reflected Resident #4 had a BIMS score of 10 which indicated residents' cognition was moderately impaired. Resident did not reject care. Resident #4 assessed to require extensive assistance with one person assist with personal hygiene. Record review of Resident #4's Comprehensive Care Plan, completed date of 07/07/2023, reflected Resident #4 had an ADL self-care performance deficit related to cerebral vascular accident with right hemiparesis. Interventions: Bathing/showering: check nail length, trim, and clean on bath days and as needed. Report any changes to the nurse. Personal Hygiene: Resident #4 required extensive assistance by one staff with personal hygiene. Resident had diabetes mellitus. Observation/Interview on 08/28/2023 at 10:12 AM, Resident #4 was in bed watching television. Resident's fingernails on his forefinger and middle finger on the left hand was jagged and had blackish/brownish substance underneath the nails. Resident # 4 stated he wanted his nails cleaned and cut. He did not respond to any further questions concerning his nail care. 2. Record review of Resident #52's face sheet, dated 08/30/2023, reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included contracture of right and left shoulder, and left wrist (brain and nervous system disorders), autistic disorder (affects how people interact with others, communicate, learn, and behaviors), and seizures (a sudden , uncontrolled burst of electrical activity in the brain). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #52's Quarterly MDS assessment, dated 07/14/2023, reflected Resident #52 cognitive status was assessed by staff related to resident was rarely/ never understood. Resident #52 had poor short- and long-term memory recall. His decision-making ability was severely impaired. Resident did not reject care. had a BIMS score of 1 which indicated residents' cognition was severely impaired. Resident assessed to require total dependence with one person assist with personal hygiene. Record review of Resident #52's Comprehensive Care Plan, dated 08/25/2023, reflected Resident #52 had ADL self-care performance deficit related to contractures, and seizures. Intervention: Resident was totally dependent on one staff for personal hygiene. Bathing/Showering: check nail length, trim, and clean on bath days and as necessary. Report any changes to the nurse. Observation/ Interview on 08/28/2023 at 09:55 AM, Resident #52 was not interviewable. He was in bed with eyes opened. Residents fore finger, middle finger, and ring finger on his right hand was jagged and had blackish/ brownish substance underneath his nails. 3. Record review of Resident #73's face sheet, dated 08/30/2023, reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included type 2 diabetes mellitus with other circulatory complications (high blood sugar can damage blood vessels and the nerves that control your heart), muscle weakness (a lack of strength in the muscles), and chronic pain (pain that carries on for longer than 12 weeks despite medication or treatment). Record review of Resident #73's Quarterly MDS Assessment, dated 06/14/2023, reflected Resident #73 was rarely/never understood. (Resident #73 unable to complete cognitive questions). He was assessed to have poor short- and long-term memory recall. His decision-making ability was moderately impaired (decisions poor). Resident #73 did not reject care. He was also assessed to be total dependent with one staff assist for personal hygiene. Record review of Resident #73's Comprehensive Care Plan, with a completion date of 08/20/2023, reflected Resident #73 had an ADL self-care performance deficit related to debility, deconditioning and weakness. Intervention: Bathing/Showering check nail length, trim, and clean on bath day and as needed. Report any changes to the nurse. Personal Hygiene: Resident required assistance by one staff for personal hygiene. Resident had diabetes mellitus. Record review of Resident #73's Shower Record for the past 30 days from 08/30/2023 reflected resident did not reject care. Record review of Resident #73's Nurses notes from 08/01/2020 through 08/30/2023 reflected resident did not reject nail care. Observation/ Interview on 08/29/2023 at 11:05 AM , Resident #73 was sitting in his specialty wheelchair near the nurse's station on the 500 hall. Resident #73's fingernails on right and left hand were jagged. Resident # 73's fore finger, middle finger, and ring finger on both hands had blackish/brownish substance underneath the nails. Resident # 73 was not interviewable. Resident #73 mumbled when responded to questions. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Record review of Resident #109's face sheet, dated 08/30/2023, reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included unspecified lack of coordination (uncoordinated movement), muscle weakness (a lack of strength in the muscles), type 2 diabetes mellitus with other skin complications (high blood sugar can damage blood vessels and the nerves that control your heart, and skin problems looks like scaly patches may be oval or circular). Record review of Resident #109's Quarterly MDS Assessment, dated 07/11/2023, reflected Resident #109 was assessed to be rarely/never understood. He had poor short- and long-term memory recall. His decision-making ability is moderately impaired (his decisions are poor). Resident #109 did not reject care. Resident #109 required limited assistance with one staff person assist with personal hygiene. Record review of Resident #109's Comprehensive Care Plan, dated 08/17/2023, reflected Resident #109 had an ADL self-care performance deficit related to cognitive deficits, and muscle weakness. Intervention: Bathing/Showering: check nail length, trim, and clean on bath day and as needed. Report any changes to the nurse. Personal hygiene: required by staff with persona hygiene. (Did not specify by how many staff). Resident #109 had diabetes mellitus. Observation/Interview on 08/18/2023 at 11:15 AM, Resident #109 revealed his fingernails on right and left hand were jagged. Resident #109's fore finger, middle finger, and ring finger on his right hand had blackish/brownish substance underneath the nails. Resident was not interviewable. In an interview on 08/30/2023 at 9:50 AM, CNA H stated the nurses were responsible for diabetic nail care. She stated the CNAs were responsible for all other resident's nail care such as cleaning, trimming and filing the nails. She stated nail care was usually completed during showers or as needed. She stated nail care was to be completed daily if a resident's nails were dirty or needed to be trimmed. She stated if a resident had a blackish/brownish substance underneath their nails it could be any type of bacteria. CNA H stated there was a possibility a resident may eat with their hands and the blackish substance may transfer from residents' hands to the food. She stated the resident may become physically ill with some type of stomach problems such a vomiting or diarrhea. She stated it was a possibility a resident may need to be assessed at a hospital if it was severe. CNA H stated if a residents' nails were rough there was a possibility a resident may scratch themselves and develop a skin tear or could scratch their eyes. She stated there was a potential a resident may develop and infection in their eyes. She stated she had been in serviced to clean and trim residents' nails in the shower and/or as needed except for diabetic nails. She stated she did not recall when the last in-service on nail care was given by nurse supervisors. CNA H stated she had given care to Resident #52, Resident #4, Resident #73, and Resident #109 at times. She stated all these residents needed to be monitored closely for dirty nails. CNA H stated some of these residents were diabetic and the nurse would complete nail care on their nails. She stated she documented nail care on the shower record when she gave showers to residents and performed nail care in the shower. CNA H stated she thought the nurses documented nail care in the nurses' notes. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/30/2023 at 10:05 AM, LVN F stated it was the nurses and CNAs responsibility to trim, cut and clean residents' fingernails. She stated only the nurses can trim and clean residents with diagnosis of diabetes. LVN F stated if a resident's nails were jagged there was a possibility a resident my infect their skin if the resident scratched themselves and develop a skin tear. LVN F stated if there was a blackish substance underneath a resident's nails there was a possibility the substance was feces. She stated if a resident placed their finger in their mouth the feces could transfer from their fingers to their mouth. LVN F also stated if the resident swallowed the feces or other bacteria a resident may develop a stomach infection such as E coli (eating contaminated food) and the resident would require to be hospitalized . She stated the symptoms of a stomach infection may include the following: diarrhea, vomiting and/or loss of appetite. She also stated if a nurse trimmed or cleaned resident nails the nail care would be documented in the nurses notes and the CNAs would document it on the shower record. LVN F stated she was not the supervisor over the hall where Resident #52, Resident #4, Resident #109, and Resident #73 resided. In an interview on 08/30/2023 at 10:25 AM, RN C stated the CNAs were responsible for nail care unless a resident was a diabetic. She stated the CNAs usually trimmed, and cleaned nails during showers , however, the nails can be cleaned or trimmed by nurses or CNAs as needed. RN C stated the nursing staff was expected to clean and trim residents' nails immediately if there were blackish substance underneath the residents' nails and/ or if their nails needed to be trimmed. She stated if the nursing staff waited until shower the resident had potential of skin tears because of the residents scratching themselves. said it was a possibility the resident may get an infection from the skin tear. She stated the blackish substance possibly may be fecal matter underneath the residents' nails. She also stated a resident may become physically ill with an intestinal problem and may need to be admitted to the hospital. RN C stated she was the supervisor on the hall where Resident #52, Resident #4, Resident #109, and Resident #73 resided. She stated Resident #109 did have a tendency of getting feces on his hands. She also stated there were times Resident #109 would refuse care. She stated Resident #109 would require a nurse assist resident with nail care related to Resident #109 had a diagnosis of diabetes. She also stated if Resident #109 refused nail care it would be documented in the nurses' notes. In an interview on 08/30/2023 at 10:45 AM, CNA J stated the nurses was responsible to trim and clean all diabetics nails. She stated it was the CNA's responsibility to clean and trim all other residents' nails. She stated the CNAs usually did nail care when residents received a shower or as needed. CNA J stated if anyone observed a brownish and/or blackish substance underneath residents nails the staff was expected to clean the residents' nails or ask the appropriate nurse to complete the nail care. She stated the blackish/ brownish substance possibility could be feces or any type of bacteria underneath the residents' nails. CNA J stated if a resident swallowed the bacteria there was a possibility a resident may become very ill with stomach issues such as diarrhea or vomiting. She also stated a resident may become dehydrated and may require to be transfer to hospital for further medical assessment. CNA J stated if a residents' nails were long or rough a resident may scratch themselves or another resident and cause a skin tear or they could get their nails caught on something and pull the nail off and cause an infection on the finger. She stated she had not been given care to Resident #52, Resident #4, Resident #109, or Resident #73. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/30/2023 at 11:35 AM, The Administrator stated the residents' nail care was the CNAs responsibility. She stated if a resident was a diabetic it was the nurse's responsibility. The Administrator stated nail care was expected to be taken care of when nails were visibly dirty or needed to be trimmed. She stated if the blackish substance was a certain type of bacterial a resident may become physically ill such as vomiting or diarrhea. She stated it depended on what the blackish substance was underneath the nail. She stated it was the nurse supervisor's responsibility to monitor residents nail care. In an interview on 08/30/2023 at 11:50 AM, the Director of Nurses stated if a resident had dirty nails there was a possibility bacteria could be on their fingers and/or underneath the resident's nails. She stated it depended on the type of bacteria of what type an illness a resident could receive from the bacteria. The Director of Nurses stated a resident potentially could become ill with stomach issues or any type of infection. She also stated a resident had a potential to scratch themselves and may develop a skin concern such as a skin tear and may develop an infection if the residents' nails were not trimmed properly. She stated it was the nurse supervisor responsibility to monitor nursing staff to ensure residents were receiving proper nail care. She also stated nail care was expected to be completed on shower days or as needed. Record review of the facilities Policy on Activities of Daily Living (ADLs), Supporting dated, March 2018 reflected Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observation, interviews and record reviews the facility failed to ensure each resident received adequate supervision and assistant devices to prevent accidents for 1 or 2 residents (Resident # 25) reviewed for accidents and hazards, in that: supervision. The facility failed to ensure staff properly transferred Resident #25 from her bed to wheelchair and suffered pain on her right arm between the elbow and the wrist. This failure could result in residents experiencing accidents, injuries, unrelieved pain, and diminished quality of life. Findings included: Record review of Resident #25's face sheet, dated 08/30/2023, revealed Resident #25 was a [AGE] year-old-female who was admitted to the facility on [DATE] with the diagnoses which included unspecified osteoarthritis, unspecified site (progressive, degenerative joint disease, the most common form of arthritis, especially in older persons), age-related osteoporosis without current pathological fracture (a disorder characterized by reduced bone mass), muscle weakness (lack of muscle strength), muscle wasting and atrophy (the wasting- thinning or loss of muscle tissue), pain in right knee (inflammation from repeated pressure on the knee), and difficulty with walking (problems with the joints such as arthritis, bones, poor circulation and/ or even pain can make it difficult to walk properly). Record review of Resident #25's Annual MDS assessment, dated 07/19/2023, reflected Resident #25 had a BIMS score of ninety-nine, which indicated resident #25 was unable to complete the cognitive assessment. Resident had poor short- and long-term memory recall. Resident #25 was assessed to have moderately impaired decision-making ability (decisions poor; cues/supervision required). Resident did not reject care. Resident #25 required extensive assistance with one staff person assist with transfers, bed mobility, dressing, toileting, and personal hygiene. Record review of Resident #25's Comprehensive Care Plan, with a completed dated of 08/20/2023, reflected Resident #25 required ADL self-care performance deficit related to muscle weakness and arthritis. Intervention: Resident #25 required assistance by one staff to move between surfaces. She required assistance by one staff to turn and reposition with bed- mobility. Resident was at risk for falls related to gait/balance problems and unaware of safety needs. Record review of Resident #25's last Physician Orders reviewed, dated, 08/14/2023 reflected monitor for pain every shift. Record review of Resident #25's mediation administration record reflected she had a pain level of two (pain scale of 1 the lowest and 10 is the highest) on 08/28/2023 at 3:00 PM. She was given extra strength Tylenol. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #25's medication administration record reflected she had a pain level of two (pain scale of 1 being the lowest and 10 the highest) on 08/29/2023 at 7:00 AM. She was given extra strength Tylenol. Record Review of Resident #25's medication administration record reflected she did not have any pain on 08/29/2023 at 3:00 PM. Record Review of Resident #25's medication administration record reflected she did not have any pain on 08/30/2023 at 7:00 AM or 3:00 PM. Record Review of CNA K's Inservice Training for Agency Certified Nurses Aides dated 06/16/2023 reflected CNA K was in- serviced on transfers/ambulation: gait belt, mechanical lift and one and two person assist. Observation on 08/28/2023 at 10:30 AM Resident #25 was lying in bed and CNA K was standing beside Resident #25's bed. CNA K stated to Resident #25 she was in her room to assist her from her bed to her wheelchair. Resident #25 stated ok. CNA K put left hand around Resident #25's right arm between the wrist and the elbow. CNA K put her right hand around Resident #25's left arm between the wrist and the elbow. CNA K did not have a gait belt. CNA K began to pull on Resident #25's both arms and attempted to transfer Resident #25. Resident #25 began to state you are hurting my arms. Resident #25 also stated it would be easier to move me if my bed was lower. CNA K lowered Resident #25's bed and proceeded to place her hands round Resident # 25's arms between the wrist and elbow and pulled Resident #25 from the bed to the locked wheelchair. Observation/Interview on 08/28/2023 at 10:37 AM, Resident #25 stated she was in some pain, and she pointed to area on her right arm between her wrist and her elbow. The area on Resident #25's right arm did not have any redness or bruising. Resident #25 did not respond to any other questions or conversation. In an interview on 08/28/2023 at 10:45 AM, CNA K stated she did not use a gait belt when transferring Resident #25. She stated Resident #25 was not physically capable of transferring herself and did require one person assistance. CNA K stated using a gait belt was a requirement if a resident required assistance with transfers. She stated she was aware any information about residents' care was in the electronic medical record. CNA K stated she had given care to Resident #25 in the past and Resident #25 did require the use of a gait belt. She stated she made a mistake by not using a gait belt when transferring Resident #25. She stated she was in-serviced on transfers from this company approximately within the past 2-3 months. CNA K refused to answer any further questions concerning the transfer or resident #25 such as if the resident stated she was in pain after the transfer. Observation/Interview on 08/28/2023 at 11:30 AM, Resident #25 was sitting in wheelchair in hallway. Resident #25 did not have any red areas or bruises on both arms. Resident #25 stated her arm had been hurting and pointed to the area on her right arm between the elbow and wrist but was currently not hurting. Observation/ Interview on 08/ 28/2023 at 1:10 PM, Resident #25 was in her room. There were no red areas/ bruises to her right or left arms. Resident #25 did not respond to any questions. (continued on next page)

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	675546	A. Building B. Wing	08/30/2023

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation/ Interview on 08/28/2023 at 2: 30 PM, Resident #25 was in her room. There were no red areas / bruises to her right or left arms. Resident #25 stated she was in some pain and the nurse gave her some medicine. She did not specify where her pain was located. Observation/ Interview on 08/28/2023 at 3:50 PM, Resident #25 was in her room. She did not have any red areas/ bruises to her right or left arm. Resident #25 did not respond to conversation/ questions. Observation/Interview on 08/28/2023 at 11:30 AM, Resident #25 was sitting in wheelchair in hallway. Resident #25 did not have any red areas or bruises on both arms. Resident #25 stated her arm had been hurting and pointed to the area on her right arm between the elbow and wrist but was currently not hurting. Observation/ Interview on 08/ 28/2023 at 1:10 PM, Resident #25 was in her room. There were no red areas/ bruises to her right or left arms. Resident #25 did not respond to any questions. Observation/ Interview on 08/28/2023 at 2:30 PM, Resident #25 was in her room. There were no red areas / bruises to her right or left arms. Resident #25 stated she was in some pain and the nurse gave her some medicine. She did not specify where her pain was located. In an interview on 08/28/2023 at 3:09 PM the Director of Nurses stated if Resident #25 required extensive one staff person assistance the staff was expected to use a gait belt with transfers. She stated any agency staff would complete training with the facility by using a check off list of when a specific training was completed. She stated if CNA K placed her hands on Resident #25's arms when transferring her this was not a proper transfer. The Director of Nurses stated Resident #25 had a potential of having bruises or potential of any type of injury to her arm. She stated it was the nurse supervisor responsibility to monitor CNAs to ensure they were performing their ADL care properly. Observation/ Interview on 08/28/2023 at 3:50 PM, Resident #25 was in her room. She did not have any red areas/ bruises to her right or left arm. Resident #25 did not respond to conversation/ questions. Observation/Interview on 08/29/2023 at 8:00 AM, Resident #25 was in her room in bed. She did not have any red areas/ bruises on either of her arms. Resident #25 denied she was in pain. Observation/Interview on 08/29/2023 at 10:00 AM, Resident #25 was in the common area. She did not have any bruises/ red areas on either of her arms. Resident #25 denied being in pain. Observation/ Interview on 08/29/2023 at 11:30 AM, Resident #25 stated she was not in pain. Resident did not have any red areas/bruises on her left or right arms. Observation/Interview on 08/29/2023 at 2:30 PM, Resident #25 stated she was not in pain. Resident did not have any bruising or red areas on both of her arms. Observation/ Interview on 08/30/2023 at 8:30 AM, Resident #25 did not have any red areas or bruises on both of her arms. She stated she was not in pain. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/30/2023 at 9:50 AM, CNA H stated all staff received training on how to transfer residents properly. She stated if a resident required one-person extensive assistance with transfers, the staff needed to use a gait belt with transfer. CNA H stated if staff used their hands on a resident's arms to transfer from bed to a chair this transfer was not completed correctly. She stated there was a possibility a resident would receive bruises or red marks on their arms. CNA H stated all staff was trained on how to transfer properly when they were hired and during other trainings. She stated she had taken care of Resident #25 sometimes and she did require a gait belt for transfers. CNA H stated all residents information about their transfers and other care was in the electronic medical record and the CNA's had access to these records. In an interview on 08/30/2023 at 10:05 AM, LVN F stated the CNA's had access to the electronic medical record to view all residents ADL care including transfers. She stated if a resident was assessed to require extensive one person assistance with transfers the staff was required to use a gait belt with transfer. LVN F stated she was the nurse supervisor on half of the 500 hall and Resident #25 was not a resident on the half of 500 hall where she was a supervisor. She was not familiar with Resident #25 care. She stated if a CNA held onto a resident's arms during a transfer this was an improper transfer. LVN F stated if a resident required extensive one person assist with transfers the staff was required to use a gait belt. She stated a resident had potential of receiving bruises or a dislocated shoulder. LVN F stated all staff was trained on how to properly transfer residents using gait belts and mechanical lifts. She also stated they have a yearly clinic event on how to correctly transfer residents. She stated she was not certain the date the last time they had this clinic. In an interview on 08/30/2023 at 10:25 AM, RN C stated she was Resident #25's nurse supervisor. She stated Resident #25 did require a gait belt during all transfers. She stated if CNA K held Resident #25's arms during a transfer from bed to wheelchair the CNA did not perform the transfer correctly. She stated CNA K was expected to use gait belt. She stated an assessment was completed on Resident #25 on 08/29/2023 and she did not have injuries from the improper transfer by CAN K. She stated Resident #25 did have some pain as documented on the medication administration record. RN C stated all staff was required to be trained on how to complete proper transfers using a gait belt and a mechanical lift. She stated if a resident was not transferred properly, a resident had potential to sustain an injury such as bruises or a broken bone. In an interview on 08/30/2023 at 10:45 AM, CNA J stated she had not given care to Resident #25. She stated all CNA's had access to electronic medical record. She stated in the electronic medical record was the ADL care information for every resident including transfers. CNA J stated if a resident required extensive one person assist with transfers a gait was required to be used when transferring a resident. She stated if a resident was transferred by a staff holding onto residents' arms and did not use a gait belt there was a possibility a resident may have bruises, skin tear, broken bone and/ or dislocated shoulder. She stated the staff did receive training on transfers during an all-staff meeting. She did not recall the last time they had this meeting. She stated it was usually once a year and as needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/30/2023 at 11:35 AM, The Administrator stated if staff used their hands and placed on a resident's arms to transfer a resident from bed to a chair without using a gait belt, it was not considered a proper transfer. She stated if the resident required extensive one staff person assist the CNA was required to use a gait belt. She stated a resident had a potential to sustain an injury such as bruises or a fracture arm. She stated the facility had clinics and trained staff on how to transfer a resident properly when using a gait belt or mechanical lift. The administrator also stated the staff received training upon hire and as needed. She stated it was the Nurse Supervisor responsibility to monitor CNAs to ensure they are completing their tasks properly. The Administrator also stated the facility had an annual clinic where transfers was demonstrated by using gait belt and mechanical lifts. Observation/ Interview on 8/30/2023 at 12:50 PM Resident #25 stated she was not in pain. Resident #25 did not have any bruises or red areas on her left or right arms. In an interview on 08/30/2023 at 11:50 AM, the Director of Nurses stated she contacted the agency where CNA K was employed, and CNA K had been blocked from working at this facility. Record review of the Facilities Policy on Safe Lifting and Movement of Residents dated, July 2017, reflected In order to protect safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques, and devices to live, and move residents.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45830 Based on observation, interview and record review, the facility failed to sign and date all orders for one (Resident #1) of eight residents reviewed for physician services. The facility's Physician failed to sign Resident #1's verbal order for hospice care. The facility failed to include in Resident #1's chart a signed order for hospice care. These failures placed Resident #1 at risk of receiving unconfirmed hospice services. Findings included: A record review of Resident #1's face sheet dated 8/30/2023 reflected a [AGE] year-old female readmitted on [DATE] with diagnoses of multiple sclerosis (autoimmune disease), anxiety disorder, type 2 diabetes (uncontrolled blood sugar), dysthymic disorder (persistent depressive disorder), major depressive disorder (depression), unspecified dementia (cognitive decline), and cauda equina syndrome (spinal cord disease). A record review of Resident #1's MDS assessment dated [DATE] reflected a BIMS score of 12, which indicated mildly impaired cognition. This assessment reflected Resident #1 received hospice care. A record review of Resident #1's care plan last revised on 8/27/2023 reflected she received hospice services due to terminal illness of multiple sclerosis (autoimmune disease). A record review on of Resident #1's physician orders on 8/30/2023 reflected no orders for hospice care. Resident #1's last order review date reflected 8/14/2023 and next order review date 9/13/2023, respectively. A record review of Resident #1's Admission Assessment note dated 10/07/2022 authored by RN G reflected [Resident #1] is a readmission that arrived via stretcher. A record review of the facility's document titled Facility Notification Form dated 10/07/2022 reflected that starting on 10/07/2022, Resident #1 required routine home care. The notification reflected an unknown hospice representative as well as an unknown facility representative signed to acknowledge this on 10/07/2022. A record review of the facility's document titled [Name of hospice removed] Hospice reflected Resident #1 was being admitted to hospice for palliative care. This document reflected the Physician was Resident t#1's attending physician. This document reflected the name of the Hospice Physician's name accompanied by a date of 10/07/2022 and an undated signature from the nurse receiving the verbal order. There was no date or signature of the Hospice Physician receiving the order. A review of Resident #1's hospital discharge instructions dated 10/07/2022 reflected she was discharged to hospice. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #1's admit to hospice services order dated 10/07/2022 reflected missing signatures for both the Hospice Physician and Resident #1's (attending) Physician. A record review of Resident #1's nurses note dated 10/08/2022 authored by LVN P reflected Resident admitted to [name of hospice removed] Hospice yesterday. During an observation and interview on 8/29/2023 at 10:04 a.m., Resident #1 was observed lying in her bed. Resident #1 stated staff did not offer to get her up for group therapy that day and she had asked to get out of bed two hours ago. Resident #1 stated she liked to get up as soon as she could in the mornings and said she usually woke up around 6:00 a.m. Resident #1 stated she wanted to go to the group therapy exercise. During an interview on 8/30/2023 at 12:51 p.m., the DON stated she could not find Resident #1's order for hospice services. The DON stated she spoke with the Hospice RN who could see that the order came from the hospital but was unable to open the order itself. The DON stated Resident #1's hospice was looking for the order. During an interview on 8/30/2023 at 2:32 p.m., the RNC stated the facility's policy on physician orders was that we follow them for medications. The RNC stated yes that an order needed to be in place for residents to receive hospice services. The RNC stated the nurse completing the hospice admission was responsible for adding it as an admit order in the resident's chart. The RNC stated nurses were trained on admitting residents and obtaining hospice orders through orientation and nursing school. The RNC stated, in this case she was admitted on hospice. The RNC stated Resident #1's electronic chart contained a special directions tab which reflected she was on hospice so staff would have thought there was already an order in place and that was probably why it got overlooked. The RNC stated honestly when you're admitting someone, you're not looking for that. The RNC stated two nurses looked at discharge orders to ensure necessary orders were obtained but stated it was not normal practice that residents were admitted on hospice. RNC stated it was not in Resident #1's hospital discharge orders that she was on hospice, but it was in the body of her paperwork. RNC stated no the admitting nurse was not responsible for reading the full paperwork before admitting residents and that the expectation was for them to read the discharge orders and make sure they were in place. RNC stated she guessed form then on, when the facility found out there was hospice, they would go back and make sure there was an order. When asked why having a resident's hospice order on file was important, the RNC stated it had not affected anything, Resident #1 was getting services, and the facility was following her code status. During an interview on 8/30/2023 at 2:35 p.m., the DON stated hospice sent Resident #1's order to her and she had just placed it in Resident #1's chart. The DON stated the nurse who admitted Resident #1, RN G, no longer worked at the facility. The DON stated that by not having Resident #1's order for hospice care on file at the facility, she did not know that it would have any potential to affect Resident #1. During an interview on 8/30/2023 at 3:39 p.m., the RNC stated there was no policy on when orders needed to be signed by physicians. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #1's physician order on 8/30/2023 dated 10/07/2022 reflected Admit patient to [Hospice name removed] hospice for terminal diagnosis of multiple sclerosis. The order reflected ORIGINAL COPY Physician Please Sign and Return Within 48 Hrs. The order was signed by an unknown physician but not dated. A record review of the facility's policy titled Medication Orders dated November 2014 reflected the following: Purpose The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. Supervision by a Physician 2. A current list of orders must be maintained in the clinical record of each resident. 3. Orders must be written and maintained in chronological order. A record review of the facility's undated procedure titled Early Identification of End-of-Life Procedure reflected the following: Early identification of patients that are approaching end of life requires the following: 1) Assessment of the individual prior to admission to the nursing facility to determine if end of life precursors listed below are flagged. 4) If the patient opts for Hospice care: -Contact Physician to request an order for referral to hospice. Facilitate referral to hospice agency of patient's choice.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46735 Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 7 % based on 2 errors out of 32 opportunities, which involved 2 of 6 residents (Resident #15, and Resident #274) reviewed for medication errors. - MA N failed to apply medications as ordered to Resident #15 as by applying Lidocaine 4% patch to the resident's right knee instead of the back. - Facility failed to store and administer medications as ordered to Resident #274 by not ordering Linaclotide 290 mcg PO mg ER (medication for constipation). These failures could place residents at risk of not receiving the desired therapeutic effect of their medications and uncontrolled pain. Findings included: Resident #15 Record review of Resident #15's Face Sheet dated 06/28/23 revealed, a [AGE] year-old female that admitted to the facility on [DATE] with diagnoses which included: acute pain due to trauma and generalized anxiety disorder. Record Review of MAR on 08/23 Revealed: Lidocaine Patch 4 % Apply to Left Hip topically one time a day for pain and remove per schedule. Doses were given at 09:00 AM and removed at 09:00 PM Record Review of Physician order dated 08/29/23 Revealed: Lidocaine Patch 4 % Apply to Left Hip topically one time a day for pain and remove per schedule. Doses were given at 09:00 AM and removed at 09:00 PM Record Review of care plan dated 08/27/23 revealed Resident #15 was to be receive intervention from facility to administer analgesic medications as ordered by physician. Monitor/document side effects and effectiveness every shift. Record Review of MDS on 08/10/23 Revealed: Resident #15 BIMS score is uncalculatable having a diagnosis of Hip and Knee Replacement receiving pain management and experiencing frequent pain within the last 5 days. An observation on 08/29/23 at 09:33 AM revealed, MA N preparing for administration of medication to Resident #15. She opened 1 patch of Lidocaine 4 %.MA A walked over to Resident # 15's bed and removed a used Lidocaine 4 % patch located on Resident #15's lower back. MA A placed a new Lidocaine 4 % patch on Resident #15's lower back. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/29/23 at 10:10 AM, MA N said prior to administering medication to residents nursing staff are expected to check the medication to be administered against the order verifying the strength, formulation, and route of administration. She said she applied Resident #15's Lidocaine Patch to her lower back even though the order said to the left hip the facility has always done that with Resident #15. In an interview on 08/30/23 at 02:10 PM, LVN E said medication aides are to look at the order and administer pain patches the way the doctor prescribed. LVN E stated that Resident # 15 does have pain in lower back but if patches were to be put on that location that needed to be communicated to a nurse so they can notify the doctor to update the order. Resident #274 Record review of Resident #274's Face Sheet dated 08/29/23 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included: Prediabetes, Essential Primary Hypertension (Blood Pressure) and Anxiety. Record review of Resident #274's physician order dated 08/25/2023 revealed Linaclotide 290 mcg PO at 08:00 am for constipation. Record review of Resident #274's MAR dated 08/29/2023 revealed Linaclotide 290 mcg PO at 08:00 am for constipation with the following administration schedule: 08/26/2023: Not given 08/27/2023: Not given 08/28/2023: Not given 08/29/2023: Not given An observation on 08/29/23 at 10:00 AM revealed, MA N looked in medication cart and medication room for Linaclotide medication. MA N did not administer the Linaclotide medication to Resident #15. In an interview on 08/29/23 at 10:15 AM, MA N said medications are supposed to be administered 1 hour before and/or an hour after scheduled administration time. MA N said Resident #15 Linaclotide medication was out of stock. In an interview on 08/29/23 at 11:45 AM, RN D said medications that are out of stock are supposed to be communicated to the nurse. The facility was not able to get the medication approved for administering by upper management due to how expensive the medication was so that is why the medication was on hold. RN D said that the facility was able to find another alternative to give Resident # 274 for her constipation. Facility policy titled Medication and Preparation Administration, undated revealed: 1. Facility staff should observe the 6 rights and verify the right resident, right drug, right dose, right route, right time and right documentation. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medication are administered within 60 minutes before or after of scheduled time, except orders to be administered with meals.