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	01/23/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a safe, clean, comfortable, and homelike environment for 3 (Resident #16, Resident #17, and Resident # 26) of 20 residents reviewed for resident rights.The facility failed to ensure Resident #16, Resident #17, and Resident #26's bedrooms had no scratches or holes on the walls next to their beds.The facility failed to ensure that the walls and carpets in 2 of 3 (200 hall, 400 hall) hallways were in good condition. These failures could place residents at risk of decreased quality of life. Findings included:During an observation on 01/20/2026 at 9:25 AM revealed tattered floors, walls and stains in the carpets of the hallways on 200 hall and 500 hall. The carpets had a foul urine odor to it in the hallways of 200 hall and 400 hall.1. Record review of Resident #26's admission Face sheet, reflected a [AGE] year-old female, admitted to the facility on [DATE], with a diagnoses of hypertensive heart disease without heart failure (structural and functional changes in the heart, such as left ventricular hypertrophy (LVH) or diastolic dysfunction, caused by chronic high blood pressure), vascular dementia (common form of dementia caused by an impaired supply of blood to the brain, such as may be caused by a series of small strokes), Xerosis Cutis (abnormally dry, rough, and itchy skin caused by a lack of moisture in the epidermis, often resulting from a damaged skin barrier) and Anorexia (eating disorder that involves severe calorie restriction and, often, a very low body weight). Record review of Resident #26's Quarterly MDS Assessment, dated 12/09/2025, reflected, Resident #26 had a BIMS score of 3 indicating the Resident's cognition was severely impaired.Record review of Resident #26's Comprehensive Care Plan, dated initiated 11/18/2021, reflected Resident #26 had little interest in activities and enjoyed hanging out in her bedroom.During an observation on 01/20/2026 at 10:20 a.m., of Resident #26's bedroom revealed holes and scratches in the wall next to the head of her bed.During an interview on 01/20/2026 at 10:20 a.m., with Resident #26 revealed that the walls were ruined when she arrived at the facility. Resident #26 stated she did not like that the walls are messed up and stated that it did not make her feel at home.2. Record review of Resident #16's admission Face sheet, undated, reflected a [AGE] year-old female, admitted to the facility on [DATE], with a diagnosis of Quadriplegia (paralysis of all four limbs and the torso, typically caused by damage to the cervical spine (neck) from injuries, infections, or disorders). Record review of Resident #16's Quarterly MDS Assessment, dated 11/06/2025, reflected, Resident #16's had a BIMS score of 15 which indicated the resident's cognition was intact.Record review of Resident #16's Comprehensive Care Plan, dated initiated 09/22/2025, reflected Resident #16 was dependent on staff to meet emotional, physical and social needs.During an interview on 01/20/2026 at 11:30 a.m., Resident #16 stated that there were scratches and holes in the bedroom wall, when she had moved in on 08/22/2024. Resident #16 stated there were not any repairs made at the facility since she arrived. Resident #16 stated the room did not look homelike with the wall issues.3. Record review of Resident #17's admission Face sheet, undated, reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease (a progressive, irreversible lung disease-comprising chronic bronchitis and emphysema-that blocks airflow and makes breathing difficult) and Anxiety Disorder (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(persistent, excessive fear or worry that interferes with daily life).Record review of Resident #17's Quarterly MDS assessment dated [DATE] reflected, Resident #17 had a BIMS score of 15 which indicated the Resident's cognition was intact.Record review of Resident #17's Comprehensive Care Plan initiated 09/22/2025 reflected Resident #17 had little to no activity interest and preferred to stay in his bedroom.During an observation on 01/20/2026 at 11:30 a.m., Resident #17's and Resident #17's bedroom revealed walls with scratches and holes throughout the bedroom. During an interview on 01/20/2026 at 11:30 a.m., Resident #17 stated that there were holes next to his bed since he arrived. Resident #17 stated he did not know where it came from. Resident #17 stated the holes does did not make him feel good.During an interview on 01/22/2026 at 2:14 p.m., the MD stated they worked at the facility for 22 years where he had received training on resident rights which included residents have the right to make their own choices. MD revealed the policy regarding maintaining carpets and walls included when maintenance received a work order, they were to work on the repair. MD stated he would go around every three months to complete painting in the facility. MD stated he would complete rounds around the facility, which included checking residents' bedrooms, every day. MD also stated there were no current work orders for 500 halls where the identified residents reside. MD also stated the conditions of the bedrooms and hallways could negatively affect residents as the residents feel like their conditions of their home were worn down. During an interview on 01/23/2026 at 11:45 a.m., the DON stated she had received training on resident rights which included the right to make choices. The DON stated her expectation for residents' bedrooms would be for the rooms to be clean, and tidy, and decorated to the residents' preference. The DON stated that all staff were responsible for ensuring that the environment in the facility was clean and maintained. The DON stated that during Angel Rounds (every morning managers go around the facility and look at bedrooms), every room is accounted for and checked on by a manager at the facility. The DON stated that the bedrooms are monitored by the same managers every day. The DON stated that the conditions of the facility and bedrooms being torn and scratched could negatively impact residents by the facility did not feel homelike and comfortable. The DON stated to her that there were repairs scheduled regarding the carpets in the facility due to their conditions.During an interview on 01/23/2026 at 12:45 p.m., the ADM stated she was employed at the facility for four years. The ADM stated she had received training on resident rights which included residents have the right to speak up. The ADM stated her expectation for condition of resident's bedrooms was to ensure that the beds were made, and maintenance would repair reported issues that have been reported. The ADM stated that housekeeping was responsible for ensuring the facility was clean, whereas maintenance would be responsible for making sure the facility was repaired. The ADM stated things were often repaired daily at the facility. The ADM stated that if a resident had scratches and holes in their wall in their bedroom, which were not caused by them, it could negatively impact the resident by not having access to a nice environment. The ADM stated that there were current work orders in place which included replacing the carpet with laminate flooring.Record review of undated work order provided by the facility included the following:Supplies were ordered for the replacement of the carpets in the facility.

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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** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for 3 of ten residents (Resident #32, Resident #100, and Resident #113) reviewed for ADLs. The facility failed to ensure Resident #113's fingernails were trimmed and clean. The facility failed to ensure Resident #32's and Resident #100's facial hair was shaved. These failures could place residents at risk of not receiving care services, diminished quality of life, and decreased self-esteem.Findings included: 1. Record review of Resident #32's face sheet, dated 01/21/2026, revealed an [AGE] year-old female, admitted [DATE], diagnoses included chronic venous hypertension (condition of sustained high blood pressure in leg veins caused by damaged valves or, less commonly, venous obstruction, leading to blood pooling), major depressive disorder (severe mental health condition marked by persistent, overwhelming sadness, loss of interest (anhedonia), and fatigue lasting at least two weeks), and raynaud's syndrome with gangrene (a rare, severe complication, usually associated with secondary raynaud's rather than the primary form). Record Rreview of Resident #32's quarterly MDS record, dated 12/31/2025, revealed Resident #32 had a BIMS of 12 which indicated mild cognitive impairment. The MDS also revealed that Resident #32 required 1-person maximum assist for ADL care, including shaving. Record review of Resident #32's care plan, dated initiated on 03/04/2025, revealed Resident #32 had an ADL deficiency related to weakness, polyneuropathy and chronic pain. The care plan revealed Resident #32 required substantial/maximum assist with 1 person. During an observation and interview on 01/20/2026 at 10:00 a.m., revealed Resident #32 had chin hair on her face.An interview on 01/20/2026 at 10:00 AM with Resident #32 stated she plucked her chin hair because she had never been offered to be shaved at the facility and knew she had chin hair. Resident #32 stated she did not feel comfortable with her chin hair on her face. She stated that it would be helpful if she had the resources to complete her facial hair care.2. Record review of Resident #100's face sheet revealed a [AGE] year-old woman, admitted to the facility on [DATE], Resident #100 had diagnoses included of essential hypertension (high blood pressure without a single, identifiable cause), osteoporosis (common, often asymptomatic silent disease characterized by low bone mass and structural deterioration, making bones fragile and prone to fractures, particularly in the hip, spine, and wrist), and pain in right shoulder. Record review of Resident #100's quarterly MDS, dated [DATE], revealed Resident #100 had a BIMS of 7 which indicated severely cognitive impairment. The MDS also revealed that Resident #100 had required supervision or touching assistance for ADL care such as shaving. Record review of Resident #100's care plan, dated initiated on 11/15/2022, revealed Resident #100 had an ADL self-care deficit related to dementia and weakness. The care plan revealed Resident #100 required limited assistance with one person. During an observation and interview on 01/20/2026 at 11:05 a.m., revealed Resident #100 had facial hair on her face. Resident #100 stated that the facility had not offered to shave her face. She stated that she did not like to have facial hair.3. Record review of Resident #113's Face Sheet, dated 01/21/2026, reflected an [AGE] year-old male, admitted [DATE], with diagnoses that included dementia (the loss of cognitive functioning, thinking, remembering, and reasoning), obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs), heart disease (refers to a range of conditions that affect the heart), kidney disease (renal disease or nephropathy, occurs when the kidneys can no longer effectively do their job of removing excess waste and fluids from your body), cognitive communication deficit (a condition that affects how individuals think and communicate), and age-related physical debility (physical debility refers to the gradual decline in physical and sometimes cognitive functions such as weakness, fatigue, and diminished stamina, often coexisting with chronic diseases). Record review of Resident #113's quarterly MDS, dated [DATE], reflected a BIMS Score of 14, which indicated cognitively intact. Record review of Resident #113's (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Care Plan, dated 11/28/2025, reflected Resident #113 required supervision assistance with bed mobility, bathing, hygiene, toileting, dressing, grooming, eating, and all assisted daily living care needs. The goal was for Resident #113 to maintain current level of function with assistance in his ADL care needs. During an observation on 01/20/2026 at 11:32 a.m., Resident #113's fingernails on both of his hands were approximately one inch long from the fingernail bed. Observation revealed Resident #113's fingernails had untrimmed jagged edges including a crack at the tip of Resident #113's right middle finger. During an interview on 01/20/2026 at 11:33 a.m., Resident #113 stated long fingernails were bothering him. Resident #113 stated nursing staff had not asked him if he wanted his fingernails trimmed. Resident #113 stated his fingernail length had been bothering him, and he accidentally hit his fingernails when rolling his wheelchair wheels with his hands. Resident #113 stated he was afraid he would hurt himself by breaking a fingernail and it made him feel discouraged. Resident #113 stated staff had not trimmed his fingernails in a long time, but he did not have an exact time frame since it was long ago. During an observation on 01/21/2026 at 10:22 a.m., Resident #113's fingernails appeared trimmed and filed. During an interview on 01/21/2026 at 10:23 a.m., Resident #113 he liked the length of his fingernails now that the nursing staff trimmed his fingernails. Resident #113 stated his fingernails did not hurt him anymore since being trimmed. During an interview on 01/23/2026 at 10:42 a.m., CNA A stated she worked here at the facility for one year. CNA A stated she received training on ADL care and trimming resident's fingernails timely. CNA A stated ADL care and trimming resident's fingernails timely training included if residents had diabetes, then a charge nurse trimmed their fingernails and how to properly trim the resident's fingernails. CNA A stated resident's fingernails should be trimmed and cleaned on every shower day, which was three times a week. CNA A stated if resident's fingernails were not trimmed over a few months, it would be considered neglectful. The CNA A stated ADL care and trimming resident's fingernails timely were monitored by the DON and nursing staff. The CNA A stated she had not received complaints from residents that staff were not trimming their fingernails. CNA A stated it is the responsibility of nursing staff to ensure ADL care and trimming resident's fingernails is taking place. CNA A stated if ADL care and not trimming resident's fingernails was not taking place, it could affect and diminish the resident's quality of life by potentially causing infections, resident cutting themselves, or causing skin tears. CNA A stated it was ultimately the overall responsibility of the nurses and the DON and nursing staff to ensure ADL care and residents fingernails were trimmed timely. CNA A reported she received training regarding facial hair care which included how to shave the residents' faces, where to dispose of the used razors and to go with the grain of the hair while shaving. CNA A stated CNAs and LVN/RN were responsible for facial hair care for residents. CNA A stated residents should have their faces shaved or offered to be shaved during shower days. CNA A stated if the residents refused to be shaved, staff were to notify the charge nurse. CNA A stated all floor staff monitored that shaving was taken care of but it does not have its own documentation tab. CNA A stated it could negatively impact a resident if they were not offered to be shaved, specifically as a woman, by causing them to feel neglected, not received proper care and could affect their dignity. During an interview on 01/23/2026 at 10:56 a.m., LVN B stated he worked at the facility for ten years. The LVN B stated he received ADL care and trimming resident's fingernails timely training. LVN B stated ADL care and trimming resident's fingernails timely training included a nurse trimmed resident's fingernails with a diabetes diagnosis and for other residents CNAs trimmed residents' fingernails. LVN B stated he does not remember the last time that he received that training. LVN B stated it was the CNAs responsibility to ensure residents' fingernails were trimmed and cleaned during each bath or shower times during the week. LVN B stated ADL care and trimming resident's fingernails timely were monitored by CNAs and reported to charge nurses. LVN B stated he has not received complaints from residents that staff were not trimming their fingernails. The LVN B stated it was the responsibility of the charge nurse and nursing staff to ensure ADL care and trimming resident's fingernails is taking place. The LVN B stated if ADL care and not trimming resident's fingernails was not taking place, it (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	can affect and diminish the resident's quality of life by potentially having dirty fingernails, long fingernails, infection control, and residents can have a hard time putting on clothes. LVN B stated it's ultimately the overall responsibility of the DON to ensure ADL care and resident's fingernails are trimmed timely for all residents. LVN B stated he had received training regarding the cleanliness for residents. LVN B stated the charge nurse should look at the residents and ensure that they are properly cared for. LVN B stated all floor staff are responsible for facial hair care for the residents. LVN B also stated residents should be offered every shower day, or PRN, to be shaved. LVN B stated all employees monitor that the care is completed. LVN B stated they do not document if shaving had been offered. LVN B stated it could negatively impact a resident if they aren't being offered to be shaved, specifically for women, by feeling neglected and not taken care of.During an interview on 01/23/2026 at 11:38 a.m., the DON stated she worked here at the facility for five years. The DON stated she received ADL care and trimming for resident's fingernails training in nursing school and not at this facility as it is not usually what the facility goes over with DON's. The DON stated that ADL care and trimming resident's fingernails timely training for the nursing staff goes over, any residents' fingernails that are observed by nursing staff to be too long then nursing staff need to be trimmed resident's fingernails, there is no specific timeline, but it is done during shower days. DON stated residents who have diabetes diagnosis, fingernails need to be trimmed and cleaned by nurses. The DON stated ADL care and trimming of resident's fingernails are monitored by CNA's, nurses, and all staff members. The DON stated she has not received complaints from residents that staff are not trimming fingernails. DON stated if a resident's fingernails are not being offered to be trimmed by nursing staff, it can be an issue for the residents. The DON stated that if ADL care and not trimming resident's fingernails is not taking place, it can affect and diminish the resident's quality of life such as the resident's fingernails can be sharp or jagged, fingernails may collect dirt underneath, and if a resident uses a wheelchair, fingernails may hit the wheel when pushing it around themselves. The DON stated it's the responsibility of the DON to ensure ADL care and trimming resident's fingernails is taking place. The DON stated it's ultimately the overall responsibility of the nursing staff including the DON to ensure ADL care and resident's fingernails are trimmed for all residents. The DON stated her expectation for facial hair care would be to offer and complete during showers, which should be offered by the CNAs. The DON stated that showers are offered/provided 3 times a week, and residents should be offered during those times at least. The DON stated that CNAs complete the task, Nurses should check to ensure that it was completed, and all staff above them are also involved in ensuring that it was completed. The DON stated it could negatively affect a resident if they aren't offered to be shaved, specifically for females, by causing a dignity issues/concern. During an interview on 01/23/2026 at 12:22 p.m. with ADM, she stated the following: has worked here at the facility for almost four years. The ADM stated she has not received ADL care and trimming resident's fingernails training as it is not necessary since she does not provide ADL services to residents. The ADM stated it's the CNA's job to look at residents during baths to ensure ADL care and fingernails are being trimmed. The ADM stated ADL care and trimming resident's fingernails training goes over, from what is understood, that CNAs are not to trim resident's fingernails with diabetes diagnosis, but she does not know since she does not receive the ADL care training as a ADM. The ADM stated ADL care and trimming resident's fingernails are monitored by the charge nurses, ADON, DON, nursing staff, and the ADM. The ADM stated she has not received complaints from residents that staff are not trimming fingernails, and if a resident complains about not having fingernails being trimmed it will be an issue, but the nursing staff would take care of it. The ADM stated it's the responsibility of nursing staff to ensure ADL care and trimming resident's fingernails is taking place. The ADM stated if ADL care and not trimming resident's fingernails is not taking place, it can affect and diminish the resident's quality of life by resident's fingernails getting too long, fingernails harboring food or feces underneath fingernails, and residents may potentially scratch themselves. The ADM stated it's ultimately the overall responsibility of the charge nurses, ADON, DON, and the ADM to ensure ADL care and (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents fingernails are trimmed for all residents. The ADM stated it's her expectation for ADL care and fingernails being trimmed is taking place for residents and it's her expectation that nursing staff are asking residents if they need fingernails trimmed during bath times. The ADM stated that her expectation for facial hair care would be to provide it during their shower days, including their hair, nails and facial hair. The ADM stated that CNAs are responsible for facial hair care at least 3 times a week. The ADM stated that the charge nurse should monitor the shower list and ensure that facial hair care is completed. The ADM stated it could negatively affect a resident if they aren't offered to be shaved by the feeling of embarrassment if they had known there was facial hair. The ADM stated that it could result in seclusion ultimately.Record review of facility in-service education for ADL documentation, dated 06/18/2025, reflected to have been provided and completed by nursing staff, and not by CNA A and LVN B. ADL documentation in-service stated it was mandatory to be completed by staff by end of shift. Record review of facility in-service education for neglect, dated 12/02/2025, reflected to have been provided and completed by nursing staff, including CNA A and LVN B. The neglect in-service stated failure to provide necessary care, or services to avoid physical harm, pain, mental anguish, or emotional distress. The neglect in-service stated examples included failing to provide hygiene. Record review of Resident #113 point click care files, dated 01/23/2026, reflected there was no ADL documentation for fingernail trimming for the past three months in the ADL tasks checklist. Record review of Resident #113's nursing progress notes file, dated 01/23/2026, reflected no documentation of Resident #113 receiving ADL care for fingernail trimming in the past three months. Record review of ADLs supporting policy, dated 03/2018, reflected residents would be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Residents will be provided with care, treatment and services to ensure that their ADLs do not diminish unless the circumstances of their clinical conditions) demonstrate that diminishing ADLs are unavoidable. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the residents and in accordance with the care plan, including appropriate support and assistance with hygiene.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to establish a system of accurate reconciliation and determine that drug records were in order, and that an account of all controlled drugs were maintained and periodically reconciled for 3 of 6 medication carts (RN G's Medication Cart #1, RN H's medication cart #2, and RN I's Medication Cart #3) in the facility effecting 3 residents (Resident #5, Resident #55, and Resident #148) reviewed for pharmacy services.1. The facility failed to ensure RN G accurately reconciled Resident #5's narcotic medication log when she administered but did not sign for Resident #5's Lorazepam (controlled medication used for anxiety) 1 tablet and Acetaminophen/APAP (controlled medication used for pain) 1 tablets on 01/22/2026 at 8:48 a.m.2. The facility failed to ensure RN H accurately reconciled Resident #55's narcotic medication log on the medication cart 2 by omitting the count of Resident #55's morphine sulfate (controlled medication used for pain and shortness of breath) after this resident left the facility a 17 days earlier (01/05/2026) and medication was not returned to the resident, not turned in to DON for destruction, and not counted with other controlled medications on the medication cart 2.3. The facility failed to ensure RN I accurately reconciled Resident #148's narcotic medication log which revealed the controlled medication discrepancy for Resident #148's morphine sulfate (controlled medication used for pain and shortness of breath) with lesser amount (27ml) in the bottle than amount documented on the control medication log (28ml) for this medication.These failures could place residents at risk for loss of prescribed medications, potential for not receiving their prescribed medications, and risk of drug diversion.Findings included: During the medication cart #1's reconciliation and interview on 01/22/2026 at 08:46 a.m., RN G stated she administered the medications to Resident #5 but failed to document the administration of one Ativan Oral Tablet 0.5 MG (Lorazepam) and one Hydrocodone-Acetaminophen Oral Tablet 5-325 MG on Resident #5's narcotic record. RN G stated she was responsible for documenting the resident's narcotic record when narcotic medication was administered but she forgot to sign for Resident #5's controlled medications since she was very busy all morning. RN G stated that not documenting the narcotic medication was administered could cause a discrepancy or a medication error, since someone will not know the resident had already received the narcotic medication. Record review of Resident #5's face sheet, indicated Resident #5, [AGE] year-old male, admitted [DATE] with diagnoses which included Alzheimer's disease with late onset (the most common form of dementia with progressive memory loss, confusion, behavioral changes, and requires 24-hour care in advanced stages), schizoaffective disorder, bipolar type (a mental health condition characterized by symptoms of schizophrenia like hallucinations and delusions, co-occurring with mood episodes of mania and sometimes depression), and chronic pain. Record review of Resident #5's Significant change in status MDS assessment, dated 07/16/2025, did not reveal Resident #5's score. The MDS assessment indicated Resident #5 received scheduled opioid pain and antianxiety medication. Record review of Resident #5's comprehensive care plan, dated 10/24/2025, indicated Resident #5 had anti-anxiety medications related to anxiety and restlessness with intervention to administer antianxiety medication as ordered. Resident #5 had the risk for both acute and chronic pain related to diabetic neuropathy, mood changes and fluctuating behaviors. The care planned interventions were to anticipate the resident's need for pain relief and respond immediately to any complaint of pain with (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration of pain medications as ordered. Record review of Resident #5's order summary report, indicated he had an order for Ativan Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth in the morning for restlessness/anxiety with an order start date of 07/23/2025 and Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth two times a day for chronic pain with an order start date of 11/03/2025. Record review of Resident #5's medication administration record, dated 01/22/2026, indicated Resident #5 received Ativan Oral Tablet 0.5 MG (Lorazepam) one time a day and Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) two times a day including 01/22/26 when medications were not documented in controlled medication administration record. During the medication cart #2 reconciliation and interview on 01/22/2026 at 09:41 a.m., RN H stated she did not count controlled medications Morphine Sulfate (controlled medication for pain and shortness of breath) for Resident #55 because Resident #55 was discharged a while ago and left her medication at the facility. RN H stated she was responsible for counting all controlled medication on her cart in the beginning and at the end of her shift. She stated that all discontinued or discharged residents 'controlled medications should be taken to the DON for destruction. She stated until discontinued medications were properly discarded, they should be counted twice every shift with other controlled medications locked on the cart. RN H stated that omitting the controlled medication from the regular count could cause a discrepancy or risk of drug diversion. The Resident #55's bottle of Morphine Sulfate 20mg/ml was not opened, and top was sealed. Record review of Resident #55's face sheet, date 01/22/2026, indicated an [AGE] year-old female, admitted [DATE], diagnoses which included Alzheimer's disease with late onset (the most common form of dementia with progressive memory loss, confusion, behavioral changes, and requires 24-hour care in advanced stages), chronic kidney disease, and anxiety. Record review of Resident #55's None of the above (respite care -short term stay) MDS assessment, indicated Resident #55 had a BIMS score of 3, which indicated severe cognitive impairment. The MDS assessment indicated Resident #55 was in hospice care and did not have pain in the last five days of assessment. Record review of Resident #55's comprehensive care plan, dated 12/31/2025, indicated Resident #55 had acute/chronic pain. The care plan interventions included anticipating the resident's need for pain relief and responding immediately to any complaint of pain through PRN pain medication. Record review of Resident #55's order summary report, indicated Resident #55 had an order for Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML (Morphine Sulfate) Give 0.25 ml by mouth every 1 hour as needed for Pain/SOB with a start date of 06/20/2025. Record review of Resident #55's medication administration record, dated 01/01/2026-01/31/2026, indicated Resident #55 did not receive Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML (Morphine Sulfate) during her stay in this facility. During the medication cart #3 reconciliation on 01/22/2026 at 9:12 a.m., the discrepancy in Resident 148's controlled medication Morphine Sulfate Solution 100/5ml count was revealed with 27ml in (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Morphine Sulfate Solution bottle and 28ml documented on the controlled medication log. During an observation and interview on 01/22/2026 at 9:12 a.m., RN I stated she did not administer Morphine Sulfate Solution to Resident #148, and she did not count the controlled medications at the beginning of her shift today, 01/22/2026 at 6:00 a.m., as she came late and an unidentified nurse already counted her medication cart with the night nurse. RN, I stated that she had training on controlled medication storage, and she was responsible for medications on her cart including counting controlled medications at each shift change to make sure the count was correct. She stated if she did not follow the proper medication storage and controlled medication counting policy, it could lead to medication errors and drug diversion. RN, I stated that when a medication discrepancy was found, the DON should be notified immediately. Observation revealed she took the medication to the DON. During the interview on 1/23/2026 at 12:28 p.m., with RN K, she stated that she received training on proper controlled drug storage and counting at shift change annually and few months ago. She stated that each nurse or medication aide was responsible for counting the controlled medications on their carts. She stated that if controlled medications were not counted, it could cause residents would not get medications as prescribed and their conditions would be not properly treated. She stated a controlled drug discrepancy should be reported immediately to the ADON and the DON to start investigation. She stated she forgot to date the spillage on the controlled log for Resident #148 during her shift 3-4 months ago, with agency nurse. She stated she did not remember that nurse's name. Record review of Resident #148's face sheet, dated from 01/22/2026, indicated an [AGE] year-old female, who was admitted to the facility on [DATE], diagnoses included cerebral infarction (a type of stroke caused by a blocked blood vessel to the brain, leading to brain tissue death), type 2 diabetes mellitus (a chronic condition causing high blood sugar due to insulin resistance and insufficient insulin production), and major depression. Record review of Resident #148's quarterly MDS assessment, dated 11/18/2025, indicated Resident #148 BIMS' score of 6, indicating severe cognitive impairment. Record review of Resident #148's comprehensive care plan, dated 03/31/2022, indicated Resident #148 had chronic pain with interventions to monitor and evaluate the pain routinely to address pain management needs. Pain medications would be administered per physician orders. Pain medication effectiveness would be documented and reported as needed. Record review of Resident #148's order summary report, indicated Resident #148 had an order for Morphine Sulfate (Concentrate) Solution 20 MG/ML give 0.5 ml by mouth every 1 hour as needed for moderate pain and give 1 ml by mouth every 1 hour as needed for severe pain with a start date of 05/15/2025. Record review of the controlled log for Resident #148's medication Morphine Sulfate Solution 20 MG/ML, undated, revealed RN K documented a spillage of 1.5ml with an agency nurse on the controlled log and corrected count to 28.0ml without documenting the date of spillage on the controlled log. During an interview on 01/23/2026 at 12:11 p.m., the DON, stated, regarding the narcotic discrepancies found the day prior (01/22/2026), were submitted to the state for an investigation. She stated they started the investigation and in services. She stated that interviews with the residents revealed they all received their medications. She stated that she started interviewing nursing staff on (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	different shifts and those who worked with the cart the night prior. She denied any history of suspicious behavior from staff regarding medications or any history of narcotic discrepancies. The DON stated there was no harm or impact on the residents regarding the incorrect counts. She stated the ADON and herself were doing the random cart audit and MARs. She stated that each nurse or medication aides were responsible for their medication carts and counting controlled medication at shift change. She stated she had training on medication storage and controlled medication annually and staff get that training through computer modules annually. During an interview on 01/23/2026 at 2:21 p.m., the ADM stated she was not trained in medication administration and storage as she was not medically licensed. She stated the DON, ADON, charge nurses and medication aides were responsible for counting controlled medications at shift change and monitor for medications' discrepancies especially with controlled medication to prevent drug diversion. She stated the DON randomly audit medication carts and MARs. She stated if discrepancy is noted, nurse of CMA was responsible to notify ADON, DON or herself. She stated that if not monitored and properly counted, it would potentially harm affect residents. Record review of the facility's Drug Diversion policy, undated, revealed Drug diversion is the unauthorized taking, use, or distribution of prescription medications – especially controlled substances – for personal use or sale. Examples: falsifying or skipping narcotic waste documentation. Inventory red flags: narcotic count discrepancies. Missing medications. Prevention/Best Practices: count narcotics at shift change. Chart after administration. Ensure accuracy and timeliness.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5%. There were 15 errors in 43 opportunities resulting in a 34.88% error rate, which involved 3 of 5 residents (Resident #70, Resident #109, and Resident #114) and 2 of 3 staff (MA C and MA D) observed during medication administration reviewed for medication errors.MA D failed to administer Spironolactone 25 mg (treating high blood pressure) ordered by physician for Resident #70. MA C failed to administer Namenda 5 mg (treating moderate to severe dementia) as ordered by physician for Resident # 114.MA C administered Resident #109's 13 medications outside of the allotted time frame. These failures could place residents at risk of their medications not being administered according to Physician's orders, getting their medications late, or not receiving the intended therapeutic benefits of their medications.Findings included: During observation of the medication pass on 01/21/2026 at 7:44 a.m., MA D did not administer Spironolactone 25 mg one tablet ordered by physician for Resident # 70 to treat her hypertensive heart disease as this medication was not available on her cart. MA D went to check with charge nurse to see if there was a dose available in the emergency medication kit but returned without medication available to give to Resident #70. During an interview on 1/21/2026 at 7:47 a.m., MA D stated Spironolactone 25 mg was not administered as ordered including one dose yesterday, 1/20/2026. She stated that whoever worked on the medication cart was responsible for reordering resident #70's medications. She stated that she was trained on medication administration annually. She stated she knew the 5 rights of medication,: with right time and right medication. She stated that not providing Resident #70 with ordered medication, especially if it was important medication like blood pressure, could make Resident #70's blood pressure go high and cause harm to her health. She stated that medication aides and nurses were responsible for reordering medications. She stated that usually she makes sure to reorder medications when there were 5 or less pills left in the blister packs. She stated she was off for a week and did not work on this cart, so she did not know what happened. She stated that she told the nurse and the medication was reordered. Record review of Resident #70's MAR, dated January 2026, revealed Spironolactone 25 mg was scheduled for one time a day at 8:00 a.m. and 2 doses were missed on 1/20/2026 and 1/21/2026. Record review of Resident #70's order summary report, dated, indicated Resident #70 had an order for Spironolactone Oral Tablet 25 MG (Spironolactone). Give 1 tablet by mouth one time a day related to HYPERTENSIVE HEART DISEASE WITH HEART FAILURE with a start date of 12/20/2025. Record review of Resident #70 's face sheet, dated from 01/22/2026, indicated an [AGE] year-old female, admitted [DATE], diagnoses included hypertensive heart disease with heart failure (a serious, often chronic, condition where long-term high blood pressure causes the heart muscle to thicken and weaken), chronic systolic (congestive) heart failure (a long-term condition where the heart's left ventricle becomes weakened and enlarged, unable to contract with enough force to pump sufficient blood), and permanent atrial fibrillation (the heart remains in an irregular rhythm continuously, and efforts to restore a normal rhythm). Record review of Resident #70's quarterly MDS assessment, dated 01/13/2026, indicated Resident #70's BIMS score of 3, indicating severe cognitive impairment. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #70's comprehensive care plan, dated revised 11/11/2025, indicated Resident #70 had cardiac disease related to heart failure with interventions of her cardiac medications as ordered. During an observation of the medication pass on 01/21/2026 at 9:11 a.m., MA C did not administer Namenda 5mg ordered by physician for Resident #114 to treat her moderate to severe dementia as this medication was not available on MA C's medication cart. During the observation, the medication was reordered, but Resident #114 still missed her morning dose of this medication scheduled for 9:00 a.m. Record review of Resident #114 's face sheet, dated from 01/22/2026, indicated a [AGE] year-old female, admitted [DATE], diagnoses included unspecified dementia - moderate with mood disturbance (a general term for a decline in mental ability, such as memory, reasoning, and communication, severe enough to interfere with daily life, resulting from damaged brain cells) and major depressive disorder. Record review of Resident #114's Significant change in status MDS assessment, dated 11/28/2025, indicated Resident #114's BIMS score of 3, indicating severe cognitive impairment. Record review of Resident #114's comprehensive care plan, dated revised 11/24/2025, indicated Resident #114 had impaired cognitive function, dementia, and impaired thought process related to dementia with interventions to administer medications as ordered. Record review of Resident #114's order summary report, indicated Resident #114 had an order for Namenda Oral Tablet 5 MG (Memantine HCl) Give 1 tablet by mouth two times a day for dementia with start date on 11/03/2025. During observation of the medication pass on 01/21/2026 at 9:38 a.m., MA C administered Resident #109's 13 medications scheduled for 8:00 a.m. in more than one hour allotted time frame. Record review of Resident #109's orders and MAR, dated January 2026, revealed orders and scheduled time for administration for Residents 109's 13 medications was 8:00 a.m. and these medications were administered at 9:38 a.m. - one hour outside of medication administration policy: a. Bystolic Oral Tablet 2.5 MG (Nebivolol HCl) Give 1 tablet by mouth one time a day for blood pressure with start date on 02/28/2025. b. Calcitriol Oral Capsule 0.25 MCG (Calcitriol) Give 1 capsule by mouth in the morning for Vitamin D Supplement with start date on 03/01/2025. a. Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium) Give 2 capsule by mouth in the morning for Bipolar with start date on 09/10/2025. b. Zoloft Oral Tablet 50 MG (Sertraline HCl) Give 50 mg by mouth one time a day related to bipolar disorder, and major depression with start date on 11/05/2025. c. Eliquis Oral Tablet 2.5 MG (Apixaban) Give 1 tablet by mouth two times a day for DVT prevention with start date on 04/15/2025. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Fluticasone Propionate Nasal Suspension 1 spray in both nostrils two times a day for Nasal Allergies with start date on 03/27/2025 e. GlycoLax Powder (Polyethylene Glycol 3350) Give 17 gram by mouth every morning and at bedtime with start date on 08/22/2025. f. NIFEdipine ER Oral Tablet Extended Release 24 Hour 30 MG (Nifedipine) Give 30 mg by mouth every 12 hours for high blood pressure with start date on 02/28/2025. g. Lokelma Oral Packet 5 GM (Sodium Zirconium Cyclosilicate). Give 1 packet by mouth in the morning every Mon, Wed, Thu, Fri for Hyperkalemia with start date on 10/16/2025. a. Senna Oral Tablet 8.6 MG (Sennosides). Give 1 tablet by mouth every morning and at bedtime for constipation with start date on 06/25/2025. b. Acetaminophen Tablet 500 MG. Give 2 tablet by mouth three times a day for chronic pain with start date on 03/05/2025. c. Hydralazine HCl Oral Tablet 50 MG. Give 1 tablet by mouth three times a day for blood pressure with start date on 07/28/2025. d. Sodium Bicarbonate Oral Tablet 650 MG. Give 2 tablets by mouth four times a day for Antacid Give 1 tablet by mouth with start date on 08/30/2025. Record review of Resident #109's face sheet, dated 01/22/2026, indicated an [AGE] year-old male, admitted [DATE], diagnoses included Type 2 diabetes mellitus (a chronic metabolic condition where the body develops insulin resistance, causing high blood sugar levels because cells cannot effectively use insulin), bipolar disorder (a mental health condition causing extreme shifts in mood, energy, and activity levels, ranging from manic highs to depressive lows), and hypertensive heart disease without heart failure (structural and functional changes in the heart caused by chronic high blood pressure). Record review of Resident #109's quarterly MDS assessment, dated 12/11/2025, indicated Resident #109 BIMS' score of 12, indicating moderate cognitive impairment. Record review of Resident #109's comprehensive care plan, dated 07/29/2025, indicated Resident #109 had electrolyte imbalance related to hypokalemia with interventions to provide supplement per physician orders. Resident#109 has allergic rhinitis (the inflammation of the nasal tissues, causing symptoms like a runny or stuffy nose, sneezing, and mucus in the throat) with interventions to administer medication for allergies per physician orders. Resident #109 has behavior problems, outbursts and agitation secondary to bipolar disorder with interventions to administer medications as ordered. Resident #109 has cardiac disease related to atherosclerosis (a condition in which plaque builds up inside your arteries), high blood pressure with interventions to administer anti-hypertensive medications as ordered. Resident #109 has anticoagulant therapy related to DVT prophylaxes with intervention to administer anticoagulants (medications that prevent or reduce blood clot formation to lower the risk of stroke, heart attack, and embolism) medications as ordered by physicians. During an interview on 1/21/2026 at 9:41 a.m., MA C stated Namenda was not administered to Resident # 114 as ordered MA D stated that she was not sure why medication was not available on the cart and in the facility. MA C stated that she looked in Resident # 114'a cubby in the medication (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room and asked the charge nurse to check the emergency medication kit and this medication was not available there either. MA C stated she went to ask the charge nurse to reorder this medication when she realized it was not available during the med pass, and it was reordered. She stated that potential risk for Resident #114's if she missed her Namenda 5 mg dose could be decline in her memory or other health issues depending on medication. She stated that she had training on medication administration sometimes in the last year. She stated the right time for administering medication was one hour before and one hour after ordered time. She stated if it was outside of that time window, the medication administration was late, and it would be a medication error. She stated that she was busy and got behind with her medication administration today. She stated that late administration could be potentially harmful to residents especially if this medication was blood pressure or seizure medication. During an interview on 01/23/2026 at 12:11 p.m., the DON, she stated that she had medication administration training last January 2025. She was aware about right time was one of the significant characteristics of medication administration. She stated that medication aides and charge nurses were responsible for timely reordering of medication electronically through point click care medical record system they use. She stated that Spironolactone for Resident #70 was reordered and was already delivered to the facility. She stated that Namenda was available at the facility in the emergency medication kit and was not sure why MA C was not able to find it. She stated the ADON and herself were doing the random cart audit and MARs. She stated if medication was not administered to residents as ordered or administered late, it could affect the residents' health conditions the medications were supposed to treat. She stated medication errors were reported to health care providers and families and staff in service was provided on 1/22/2026. During an interview on 01/23/2026 at 2:21 p.m., the ADM, stated she was not trained in medication administration and storage as she was not medically licensed. She stated that DON, ADON, charge nurses, and medication aides were responsible for reordering medications and monitoring proper medication administration. She stated the DON randomly audits med carts and MARs along with the pharmacist's audits every month. She stated if medication error occurred like late medication administration, wrong medication administration, or medication omission, nurses or med aides were responsible to notify ADON, DON or herself. She stated that if medications administration was not performed properly, it would potentially harmfully affect residents. Record review of facility's staff in-services revealed 6 rights of medication administration, dated 6/27/2025, signed by MA C and MA D,. included information on right time for medication administration. Record review of the facility's Medication Administration policy, undated, revealed, Facility staff should take all measures required by Facility Policy, Applicable Law, and the State Operation Manual when administering medications. Medications are administered as prescribed in accordance with good nursing principles and practice. During medication administration, the facility staff should observe the 6 Rights. Medications are administered within 60 minutes before or after the scheduled time.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for one of one kitchen reviewed for sanitation. 1.The facility failed to ensure sanitation practices including cleaning the ice machine, cleaning the juice dispenser nozzle, cleaning the front of the convection oven, and cleaning the dish rack storage cart.2. The facility failed to label and date all food items in the kitchen.3. The facility failed to properly cover all food items to prevent contamination.These failures could place residents at risk of foodborne illness.Findings Included: During an observation on 1/20/26 at 9:22 a.m., revealed a container of spaghetti meat sauce and a container of winter vegetable blend on stovetop griddle uncovered. This should be covered to prevent cross contamination from a physical contaminant. During an observation on 1/20/26 at 9:23 a.m. revealed a bag of corn chips undated, unlabeled, and not closed securely. Further observation revealed a bag of oatmeal undated, unlabeled, and not closed securely under the steam table on a lower shelf in the kitchen. During an observation on 1/20/26 at 9:24 a.m. of reach in refrigerator revealed: -a tray of individually portioned pudding cups unlabeled and undated -a tray of individually portioned glasses of nectar thick tea unlabeled and undated -a pitcher of red juice unlabeled and undated -a pitcher of orange juice unlabeled and undated -a container of hot dogs with a date of 1/18/26 and unlabeled if this was the receipt date, opened date, or discard date, without a lid securing the container. -a container of lunch meat slices dated 1/18/26 and unlabeled if this was the receipt date, opened date, or discard date, without a lid securing the container. During an observation on 1/20/26 at 9:26 a.m. of ice scoop receptacle revealed brown, white, and black food debris and mineral deposit buildup(whitish chalk like residue) in the bottom of the container. During an observation on 1/20/26 at 9:27 a.m. of kitchen ice machine revealed, inside of the ice machine lid and inner upper plastic shield, was a white, black, and brown substance all over it. During an observation on 1/20/26 at 9:28 a.m. of a pitcher of red juice in a tub of ice on a utility cart with a label dated 1/6/26, unlabeled if this was the preparation date or discard date. During an observation on 1/20/26 at 9:9:29 a.m. of pitcher of red juice in tub of ice on a utility cart with a label dated 1/13/26, unlabeled if this was the preparation date or discard date. During an observation on 1/20/26 at 9:30 a.m. of tray of individually bowled dry cereal dated 1/6/26 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unlabeled if this was the preparation date or discard date. During an observation on 1/20/26 at 9:32 a.m. of 5 separate large plastic storage bags with sandwiches, peanut butter crackers, cookies, and cheese snack crackers unlabeled and undated on utility cart. During an observation on 1/20/26 at 9:33 a.m. of juice dispenser nozzle revealed inside of juice dispenser nozzle was black, orange, red, slimy substance covering the inside of the dispenser nozzle. During an observation on 1/20/26 at 9:35 a.m. of lower steam table shelf revealed container of dry ring cereal, dated 10/29/24, unlabeled if this was preparation date or discard date. Further observation revealed a container of raisin flake dry cereal labeled pudding, dated 9/5/25. Observation of a container of rice puff dry cereal, dated 3/21/25, unlabeled if this was preparation date or discard date. During an observation on 1/20/26 at 9:42 a.m. of convection oven revealed front of convection oven with dried food debris and grease buildup on front bottom under doors. During an observation on 1/20/26 at 9:45 a.m. of dish rack storage cart with trash, food debris, and black substance. During an interview on 1/22/26 at 2:14 p.m., MS stated he had worked at the facility for 22 years. MS stated they received training regarding Abuse, Neglect, and Exploitation, Resident Rights but they were unsure of the exact date of the last training. MS stated a contract company comes every six months and cleaned the ice machine and he was responsible for changing the filters every three months. MS stated when the contract company comes, they clean the ice machine for mold and mineral build up. MS showed surveyor pictures on his phone from the last time the contract company came to the facility kitchen to clean the ice machine dated 10/13/25, showing no mold or substance build-up on the ice machine components. MS stated it could possibly negatively affect a resident if the ice machine was not cleaned properly depending on where the sludge buildup was located or if it encountered the ice. During an interview on 1/22/26 at 4:22 p.m., [NAME] stated they worked at the facility for one year. [NAME] stated they received training regarding Abuse, Neglect, and Exploitation, Resident Rights, Kitchen sanitation, and Food labeling and dating. [NAME] stated they received training monthly at meetings and as needed and when there were new hires. [NAME] stated DA was responsible for cleaning the juice machine dispenser nozzle and DA cleaned them daily. [NAME] state the service provider periodically and flushed the machine, but was unsure of the frequency. [NAME] stated MS cleaned the ice machine, and DA sends the ice scoop receptacle through the dish machine to clean it. [NAME] states it could negatively affect the residents if the juice dispenser nozzles and the ice machine were not properly cleaned because of cross contamination. [NAME] states anybody who handles food in the kitchen is responsible for labeling and dating the food. [NAME] states the food items are dated upon receipt, when opened or prepared with the preparation date and the discard date. [NAME] stated by not labeling and dating there would be no way for staff members to know the quality of the food, and it could be expired. During an interview on 1/22/26 at 4:31 p.m., DA stated they had worked at the facility for 3 years. DA stated they had been trained regarding Abuse, Neglect, and Exploitation, Resident Rights, Kitchen sanitation, and Food labeling and dating. DA stated they have received training bi-weekly and monthly (continued on next page)

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	675546	A. Building B. Wing	01/23/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at staff meetings. DA stated DA is responsible for cleaning the juice dispenser nozzle, and the DA cleans it daily it is left soaking in soapy water. DA takes the black cover to the dispenser off and cleans the inside of the nozzle. DA states MS is responsible for cleaning the ice machine, but they are unsure of how often. DA states that they are responsible for cleaning the ice scoop receptacle daily. DA stated it can negatively affect a resident if the juice dispenser nozzles and the ice machine are not cleaned properly because mold can build up and the residents can become sick. DA stated all dietary staff are responsible for labeling and dating food items. DA stated all items are dated upon receipt, at preparation with the prep date and the discard date. DA stated it can negatively affect the residents if food items are not labeled and dated properly because residents can get sick from consuming old food. During an interview on 1/22/26 at 4:40 p.m., DM stated they had worked at the facility for 2 1/2/ years. DM stated they had received training regarding Abuse, Neglect, and Exploitation, Resident Rights, Kitchen sanitation, and Food labeling and dating. DM stated they conduct training monthly. DM stated the drink DA is responsible for cleaning the juice dispenser nozzle and that it is cleaned nightly. DM stated MS is responsible for cleaning the ice machine and DA are responsible for cleaning the ice scoop receptacle. DM stated it could potentially negatively affect the residents if the juice dispenser nozzles and the ice machine are not cleaned because the residents could become sick. DM stated all dietary staff are responsible for labeling and dating food items. DM stated the process for food labeling and dating is that all items are dated upon receipt, items are dated upon opening or preparation with a preparation date and a discard date. DM stated it could negatively affect a resident if food items are not labeled and dated properly because expired foods could make a resident sick. During an interview on 1/23/26 at 11:39 a.m., DON stated they had worked at the facility for 5 years. DON stated they had received training regarding Abuse, Neglect, and Exploitation, and Resident Rights. DON stated they had not received any specific training regarding kitchen sanitation and food labeling /dating but stated they were aware that the food is supposed to be labeled and dated but was unsure of the timeframes. DON stated they were unsure of who was responsible for cleaning the juice machine dispenser nozzle, ice machine, and ice scoop receptacle. DON stated that there would be DM responsibilities regarding her staff. DON stated it could potentially negatively affect a resident if the juice dispenser nozzles and the ice machine are not cleaned properly because the residents could become sick. DON stated I would assume whatever dietary staff prepare the food items are responsible for labeling and dating of those items. DON stated she was unsure of the food labeling and dating process regarding timeframes. DON stated it could potentially negatively affect a resident if food items are not labeled and dated because if the food has not been labeled and has been in the facility for a little bit there could be a poor outcome if the resident receives the food. During an interview on 1/23/26 at 12:24 p.m., ADM stated they had worked at the facility for 4 years. ADM stated they had received training regarding Abuse, Neglect, and Exploitation, and Resident Rights. ADM stated she had not received training regarding kitchen sanitation or food labeling /dating, but she was aware that all food items are to be labeled and dated. ADM stated DA is responsible for cleaning the juice dispenser nozzle, but she was unaware of the frequency. ADM stated MS, DM, and a contract company were responsible for cleaning the ice machine. ADM stated she was unsure who was responsible for cleaning the ice scoop receptacle. ADM stated it was her expectation for the kitchen to be clean and for the staff to follow the cleaning schedule. ADM stated it could potentially negatively affect a resident if the juice dispenser nozzle or the ice machine were not cleaned because the residents could get an infection. ADM stated all kitchen staff and ultimately DM are responsible for food labeling and dating. ADM stated she was unsure of the process for food labeling and dating. ADM stated it was her expectation that the food items always be labeled and dated. ADM stated it (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	could potentially negatively affect the residents if food items are not labeled and dated by foodborne illness. Record review of daily cleaning schedule, dated 1/18/26-1/24/26, reflected under column of ice machine to be cleaned by maintenance. Further review reflected no column for juice machine or dispenser nozzle cleaning. Record review of weekly cleaning schedule, dated January 2026, reflected under column of ice machine to be cleaned by maintenance, with last cleaning date of 1/9/26 by MS and contract company cleaning dated 1/14/26. Further review reflected no column for juice machine or dispenser nozzle cleaning. Record review of kitchen in-service, dated 1/8/25, reflected topics discussed by the DM were to label & date every item with 12 staff signatures of attendance. Record review of kitchen in-service, dated 4/10/25, reflected the title was labeling & dating all food items with 9 staff signatures of attendance. Record review of facility food storage policy, dated 10/1/2018 and revised on 6/1/2019, reflected under heading policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to state, federal, and US Food Codes and HACCP guidelines. Under heading dry storage -To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated. -Use the first-in, first-out (FIFO) rotation method. Date packages and place new items behind existing supplies, so that older items are used first. Under heading refrigerators -Date, label, and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. Record review of facility general kitchen sanitation policy, dated 201,8 reflected under heading policy: The facility recognizes that food-borne illness has the potential to harm elderly and frail residents. All Nutrition & Foodservice employees will maintain clean, sanitary kitchen facilities in accordance with the state and US Food Codes to minimize the risk of infection and food borne illness. Under heading procedure -Clean and sanitize all food preparation areas, food-contact surfaces, dining facilities, and equipment. -Keep food-contact surfaces of all cooking equipment free of encrusted grease deposits and other accumulated soil. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Clean non-food-contact surfaces of equipment at intervals as necessary to keep them free of dust, dirt, and food particles and otherwise in a clean and sanitary condition.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide a safe and sanitary environment to prevent the development and transmission of communicable diseases and infections for 9 of 15 residents (Resident #18 and 8 residents in the dining room near nursing station C) reviewed for infection control.1. CNA E did not change gloves between dirty and clean peri-care tasks and did not sanitize her hands between glove changes during peri-care for Resident #18.2. CNA F and RN G did not sanitize their hands between passing meal trays for 8 residents in the dining room near nursing station C. These failures could place the residents at risk of infection transmission, sepsis, and hospitalization.Findings included: An observation on 01/22/2026 at 12:18 p.m. of peri-care for Resident #18, revealed CNA E did not change her gloves after cleaning dirty peri-care area with bowel movement and front peri-care area. CNA E changed her gloves without conducting hand hygiene. CNA E touched bedside table, blanket and pillow in Resident 18's environment while assisting Resident #18 with repositioning without changing her gloves. An observation of Resident #18's skin in the peri area appeared red without apparent skin break down. An interview with CNA E on 01/22/2026 at 12:21 p.m., she stated that she received hand hygiene in-service sometimes in the last year. She stated that she was supposed to sanitize her hands between gloves and change gloves between dirty and clean peri-care areas. She stated that potential risk to residents if not following hand hygiene could lead to cross contamination. Record review of Resident #18's face sheet, dated 1/22/2026, revealed a [AGE] year-old female, who was admitted to the facility on [DATE]. Her diagnoses included chronic diastolic congestive heart failure (when the heart muscle becomes stiff, preventing the left ventricle from filling properly with blood, leading to back up in the lungs/body, causing shortness of breath, fatigue, and swelling), aphasia (a language disorder caused by brain damage, most often from stroke, that impairs communication by making it difficult to speak and understand), and functional quadriplegia (complete immobility requiring total assistance with daily living). Record review of Resident #18's admission MDS assessment, dated 12/16/2025, revealed no BIMS score entered. Further review of Resident #18's assessment revealed she was frequently incontinent with bladder and bowel and required total assistance for her activities of daily living. Record review of Resident #18's Care Plan, dated 12/06/2025, reflected: Resident #18 had actual impairment to skin integrity of the right cheekbone/trauma and right upper posterior thigh/MASD. Is at risk related to incontinence, PEG tube, edema, contractures and needs assistance with ADLs. An observation on 1/20/2026 at 12:21 p.m. of staff passing lunch trays to the 8 residents in the dining room near nursing station C, revealed CNA F and RN G did not sanitize their hands while passing trays to some of the residents. CNA F touched her face and without sanitizing her hands, touched the lunch tray, and took it to the residents in the dining room. An interview on 01/20/2026 at 12.:24 p.m., CNA F stated she had hand hygiene training 4-6 months ago. She stated staff needed to wash or sanitize their hands between passing food trays between (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	each resident to prevent the spread of infection. She stated she should have washed her hands after she touched her face. She stated that she was distracted and had to move fast and forgotten to sanitize her hands. An interview on 01/20/2026 at 1:34 p.m., RN G, stated she had an in-service on hand hygiene not too long ago. She stated according to the facility's policy she was supposed to sanitize her hands between each resident's tray during meal tray pass. She stated not sanitizing her hands properly could lead to potential cross contamination. During an interview on 1/23/2026 at 12:05 p.m., the ADON, stated charge nurses should monitor how staff were conducting hand hygiene and following infection control measures, and the DON conducted oversight. The ADON further stated the policy on hand hygiene and providing peri-care, wound care, urinary catheter care was to conduct handwashing before and when they left the room with wound care, aides would wash when they come in and out. She stated when going in and coming back out, they sanitized their hands. She further stated there was an order in how you do things from the cleanest to the dirtiest, depending on if providing peri-care for male and female, who should be cleansed from front to back. She stated for wound care you cleanse the wound, remove gloves, wash hands or gel, put on clean gloves and apply the wound treatment. The ADON stated she was trained on infection control and hand hygiene many times, and the potential negative outcome for the residents when not practicing good hand hygiene was cross-contamination. During an interview on 01/23/2026 at 2:11 p.m., the DON, stated she and the Infection Preventionist were responsible for ensuring staff were conducting proper hand hygiene/following infection control measures when providing care for the residents. She stated she and ADONs conducted periodic audits and provided hand hygiene in-services to staff. She stated the policy on hand hygiene, providing peri-care, wound care, and foley catheter care was to conduct hand hygiene before going in the room, between dirty and clean area, between changing gloves and when coming out of the room. The DON stated training on infection control and hand hygiene was taught during annual skills training. The DON stated a potential negative outcome for the residents would be transmission of bacteria. During an interview on 1/23/2026 at 12:21 p.m., the ADM, stated she had hand hygiene training sometimes within the last year which covered the policy for conducting handwashing/hand hygiene when providing care/passing meal trays included all staff were to be using hand sanitizer between each meal pass unless something happened and they needed to wash their hands. She stated a negative outcome to the residents could be cross contamination. During an interview on 01/23/2026 at 2:30 p.m., the Infection Preventionist RN K stated she was responsible for ensuring staff were conducting proper hand hygiene and following infection control measures when providing care for the residents. She stated the policy on hand hygiene during providing peri-care and passing food trays should be washing or sanitizing hands before entering residents' room, between changing gloves, exiting resident' rooms and between each individual food tray. Infection Preventionist RN K stated she had the training on infection control and hand hygiene during the annual skills training. The DON stated a potential negative outcome for the residents would be cross contamination. Review of Handwashing/ Hand Hygiene Policy, dated 08/2019, reflected, This facility considers hand hygiene the primary means to prevent the spread of infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy interpretation and implementation 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 3. Use an alcohol=based hand rub or alternatively, soap and water for the following situations: h. Before moving from a contaminated body site to a clean body site during residence. m. Before/After removing gloves. o. Before and after assisting a resident with meals.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident has the right to secure and confidential personal and medical records for 1 of 15 residents (Resident #87) reviewed for Privacy and Confidentiality. The facility failed to ensure Resident #87's clinical records were protected from being viewed by unauthorized persons when LVN J left Resident #87's personal information visible on the computer's screen on unattended medication cart. This failure could place residents' personal information at risk of being exposed to unauthorized individuals. Findings included:Observation on 1/21/2026 at 4:24 p.m., revealed the computer screen on LVN J's medication cart on side C was open and unlocked, with Resident #87's MAR information displayed and visible to unauthorized individuals, including visitors or other residents not observed at that time near that cart.During an interview on 1/21/2026 at 4:26 p.m., with LVN J, she stated she was in-serviced on HIPAA a few months ago via computer module which included instructions on not discussing residents' private clinical information with unauthorized individuals and locking the computer screen when stepping away from the medication cart. She stated everybody who worked with charting computers was responsible for closing and locking them when not in attendance. She stated that leaving the screen unlocked with resident's clinical information displayed could be harmful for residents as anybody could see it. She stated she was at fault for not locking the computer.Record review of Resident's #87's face sheet, date 1/22/2026, revealed a [AGE] year-old female, admitted on [DATE]. Resident #87 had diagnoses which included hemiplegia affecting right dominant side (the paralysis of one side of the body), type 2 diabetes mellitus (a chronic condition causing high blood sugar due to insulin resistance and insufficient insulin production), and aphasia followed cerebral infarction (an acquired language disorder resulting from damage to brain areas responsible for speech).During an interview on 1/23/2026 at 12:05 p.m., with the ADON, she stated that nursing staff in this facility had HIPAA training annually and the facility's policy was not sharing the residents' information with unauthorized people and locking computers' screens when not in front of them. She stated that if the screen was not minimized, somebody could falsify information or use it inappropriately and harm residents.During an interview on 1/23/2026 at 12:11 p.m., with the DON, she stated the facility's policy was to minimize the charting computers' screens when stepping away. She stated that if the screen was not minimized, someone could have unauthorized access to private clinical information displayed on the screen. She stated HIPAA in-services were provided to all employees at hire and annually through computer modules which included instructions on locking the computer screens. She stated that she had the HIPAA in-service in January 2025. She stated the person who worked with residents' private clinical information should lock the screen before walking away. She stated the potential negative effect was unauthorized disclosure of residents' confidential information.During an interview on 1/23/2026 at 12:21 p.m., with the ADM, she stated she had HIPAA training sometimes within the last year which covered the importance of maintaining the residents' private information. She stated whoever used the computer was responsible for shutting it down to ensure the residents' information was not visible to visitors. She stated the potential risk for not shutting down the charting computers was a breach of residents' privacy. She stated that all staff completed HIPAA in-services at hire and annually through computer modules. She stated LVN J completed her annual training but could not provide documentation.Record review of facility's HIPAA in-services for the last six months dated 06/2025-12/2025, did not reveal HIPAA in-services completed by LVN J and documented before this incident.Record review of facility's HIPAA policy and staff education curriculum HIPAA and You, undated, revealed, HIPAA's Privacy Rule - Administrative Safeguards:Policies - Must be in place to safeguard information.Environment - Must be structured in a way that PHI is not easily accessible.Example of Inappropriate Uses of PHI: unattended workstation with PHI.Protecting Patient Privacy - Electronic Devices:- Log off or lock your computer if you walk away.