

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675773	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER Brookdale Trinity Towers		STREET ADDRESS, CITY, STATE, ZIP CODE 317 N Carancahua Corpus Christi, TX 78401	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the comprehensive care plan was developed and implemented within a timely manner for each resident consistent with resident rights to include measurable objectives and timeframes to meet residents medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment for 1 (Resident #1) out of 5 residents reviewed for care plans. The facility failed to add the fall with significant injury, fall mats, and the surgical wound with wound care to Resident #1's care plan. The facility also failed to complete Resident #1's comprehensive care plan within the specified time frame. These failures could place residents at risk for receiving inadequate care and services. Findings included: Record review of Resident #1's face sheet dated 09/10/2025 revealed a [AGE] year-old female with an initial admission date of 08/18/2025 and a current admission date of 09/09/2025. Pertinent diagnoses included Displaced Oblique Fracture of Shaft of Right Femur (a traumatic injury in which the femur breaks diagonally), Orthopedic Aftercare (post-surgical care to aide in recovery), History of Falling, Muscle Weakness, and Unspecified Lack of Coordination. Record review of Resident #1's physician orders revealed an order with a start date of 08/18/2025 for wound care to surgical wound to right femur. Record review of Resident #1's admission MDS assessment dated [DATE], and signed as completed on 08/25/2025, revealed a BIMS score of 03, which revealed severely impaired cognition. The MDS assessment also revealed Resident #1 had a major orthopedic surgical procedure during the prior inpatient hospital stay which required active care during the SNF stay, and Resident #1 had a surgical wound requiring surgical wound care. The MDS assessment also revealed Resident #1 had a fracture related fall in the 6 months prior to admission/entry or reentry. Record review of Resident #1's care plan initiated 08/18/2025 and revised on 09/09/2025 revealed a care plan for risk of falls with interventions to include: keep call light within reach, prompt response to all requests for assistance, encourage appropriate footwear, medication review, OT and PT evaluation, and place bed in low position. There was not a care plan which addressed specifically the fall with major injury, or the surgical wound with wound care. There were also no interventions to address the fall mats in place. In an observation on 09/10/2025 at 9:25 AM Resident #1's bed was observed low to the floor with fall mats on both sides of the bed, and the call light within reach. In an interview on 09/10/2025 at 8:25 AM the Administrator stated Resident #1 typically resided in an ALF, but Resident #1 was admitted to the skilled unit for therapy and care after the fall which caused the fracture requiring surgical intervention. The Administrator stated the MDS nurse was the one who updated and revised the care plan, and she had 21 days from admission to complete it. In an interview on 09/10/2025 at 1:30 PM the MDS nurse stated she was not sure why the fall with major injury or the surgical wound requiring wound care was not on the care plan, but it should have been since it was the reason Resident #1 was admitted. She stated maybe it had not been added yet since the comprehensive care plan was still a work in progress as they have 21 days from admission to complete it. The MDS nurse stated there was a care plan for skin integrity, but she agreed it was for Resident #1's skin breakdown to her buttocks since one of the interventions was to apply a barrier cream. She stated there should have been one specifically for the surgical wound requiring wound care. The MDS nurse stated the care plan was a clinical tool used by staff to determine how to address the residents wants, needs, and care. The MDS nurse reiterated and clarified she had 21 days from admission or 14 days from the date of the comprehensive assessment to finish the comprehensive care plan, then after looking it up, she stated she was wrong, and it was 7 days from the date the comprehensive assessment was completed. She stated Resident #1's comprehensive assessment was completed on 08/25/2025, so her comprehensive care plan should have been completed by 09/01/2025, and Resident #1's still was not completed because she was still adding interventions, such as bed in low position (added 09/09/2025) and fall mats (added 09/10/2025). In an interview on 09/10/2025 at 3:05 PM the DON stated Resident #1 was admitted to the skilled unit for therapy and post-surgical care after a fall which caused a fracture requiring surgical intervention. She also stated she was not sure why the surgical wound requiring wound care was not on the care plan, but it should have been since it was the reason Resident #1 was admitted. The DON stated some things, such as the floor mats, had not been addressed on the care plan because she was under the impression the facility had 21 days from admission, regardless of when the comprehensive assessment had been completed. Record review of the facility's Comprehensive Care Plan Policy, dated November 2017, revealed A comprehensive, person-centered care plan will be developed for each resident</p>		