STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675773	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Trinity Towers	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 1 of 6 residents (Resident #1) reviewed for medical records.The facility failed to document the amount of food Resident #1 ate during her 3 meals per day for 10 times from March 1st through March 15th, 2026. This failure could place residents at risk of not receiving proper care or having needs met due to inappropriate documentation.The findings included:Record review of Resident #1's face sheet, dated 05/19/26, revealed a [AGE] year-old female, admitted [DATE] and discharged [DATE]. The pertinent diagnosis included Type 1 Diabetes (chronic autoimmune disease where the body's immune system attacks insulin-producing cells in the pancreas). Record review of Resident #1's admission MDS Assessment, dated 05/06/26, revealed a BIMS score of 13 indicating her cognition was intact. Record review of Resident #1's comprehensive care plan, dated 05/16/26, revealed the focus The resident has Diabetes Mellitus initiated on 04/15/26. An intervention listed for the focus included Dietary consult for nutritional regimen and ongoing monitoring initiated on 04/15/26. Record review of Resident #1's EHR on 05/19/26 revealed several meals had not been documented by staff during March 2026. Resident #1 had only 1 meal documented on 05/02/26, 05/04/26, 05/06/26, 05/07/26, 05/08/26, 05/10/26, 05/11/26, and 05/13/26. Resident #1 had only 2 meals documented on 05/03/26 and 05/09/26. During an interview with CNA A at 9:38 A.M. on 05/21/26, CNA A stated the CNAs recorded the amount of food eaten by residents during their meals in the residents' EHR. CNA A stated if the amount was less than 50% then she reported it to the nurse. CNA A stated it was important to document the amount of food eaten by the residents to help manage their weight gain or weight loss. During an interview with CNA B at 10:14 A.M. on 05/21/26, CNA B stated the CNAs charted the percentage of food eaten during meals in the residents' EHR. CNA B stated if the amount was less than 50% she reported it to the nurse. CNA B stated it was important to document the amount of food eaten by the residents to help manage their weight gain or weight loss. During an interview with the DON at 4:40 P.M. on 05/21/26, the DON stated staff recorded the amount of food eaten by residents for breakfast, lunch, and dinner every day. The DON stated it was typically the CNAs that input the information into the EHR. The DON stated she reviewed Resident #1's food consumption record and found several entries were missing. The DON stated it was important to document how much food was being eaten by the residents to prevent weight loss or weight gain, ensure they received adequate macronutrients, and help manage glucose in residents with diabetes. Record review of the facility policy titled Routine Clinical Documentation, revised 03/26, revealed the following policy: After admission, all services routinely provided to the resident will be documented in the resident's medical record, regardless of payor source.Policy DetailCertified Nursing Assistant (CNA):Daily:Activities of daily livingAmount eaten.Measured intake and output, as indicated

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