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	06/04/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Record reviews and interviews, the facility failed to ensure that one resident (Resident #2) of five residents discharged did not receive the required 30-day notice of discharge. The facility failed to ensure Resident #2 was given a 30-day discharge notice. Resident #2 was discharge on [DATE]. The failure could put residents at risk for inappropriate discharge from the facility and cause psychological harm due to feelings of anger and sadness. This failure could place discharged residents at risk of being discharged from the facility causing a disruption in their care and/or services The findings included: Review of Resident #2's face sheet dated 06/04/26 revealed she was a [AGE] year-old female admitted on [DATE] with diagnosis that included chronic obstructive pulmonary disease (a progressive, incurable lung disease that restricts airflow and making breathing difficult), Acute Respiratory Failure (respiratory system suddenly fails to oxygenate the blood), Syncope (fainting or passing out). Record Review of Resident's #2 MDS Comprehensive MDS dated [DATE] revealed a BIMS Score of 12. Record Review of Resident's #2 discharged Notice dated 05/04/26 revealed a discharged date of 05/08/26. Record Review of Resident's #2 discharged Summary dated 05/04/26 revealed a discharged date of 05/08/26. Record Review of Resident's #2 Care Plan dated 03/25/26 revealed no Discharge Planning had been implemented. In an interview on 06/04/26 at 2:40 pm, Discharge Planner stated she only notified the Ombudsman of unplanned; she did not notify the Ombudsman of Resident #1 and #2 discharges. In an interview on 06/04/26 at 2:40 pm, Discharge Planner stated the facility received a discharged notice from the insurance company which gave the facility three days to discharge the resident. She stated she informed the FM of discharge the day she received notification from the insurance company. She stated she gave the FM notification via email and telephone according to the insurance time frame and not the 30-day notice as per facility policy. In an interview on 06/04/26 at 4:10pm, Assistant Director of Clinical Services stated a three-day notice of discharge was given to the FM; facility policy stated the FM or Resident must be given a 30-day discharge notice. In an interview on 06/04/26 at 4:45pm, Administrator stated the discharge was initiated the day the insurance company gave the 3-day notice of benefits ending. She stated the FM was notified of the 3-day notice of discharge and that if they chose to stay until the end of the 30 day notice it would be private pay. Review of facility policy dated August 2023 entitled Resident Transfer and Discharge reflected: F. Timing of Notice 1. Notice should be provided at least 30 days prior to the transfer or discharge. Exceptions to the 30-day requirement apply when the transfer or discharge is affected because: a) The resident's welfare is at risk, and his or her needs cannot be met in the community (i.e., emergency transfers to an acute care facility); or b) The health or safety of others in the community is endangered.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to send a copy of the discharge notice, prior to the discharge, to the representative of the Office of State Long-Term Care Ombudsman for two residents (Resident #1 and Resident #2) of five residents reviewed for discharge. The facility failed to send a copy of Resident #1 and Resident #2's discharge notice, prior to discharge, to the representative of the Office of State Long-Term Care Ombudsman. These failures could have placed the residents at risk of not knowing their rights or receiving the services of the state Long Term-Care Ombudsman. Findings Included: Review of Resident #1 face sheet dated 06/04/26 revealed she was an [AGE] year-old female admitted on [DATE] with diagnosis of dysphagia (difficulty swallowing); hypertension (a chronic condition in which the force of blood against your artery wall is consistently too high); osteoporosis (a bone disease that causes bones to become weak, brittle, and highly susceptible to fractures). In an interview on 06/04/26 at 1:30 pm, Ombudsman stated she had never received discharged notices from the facility. Record Review of Resident #1 Discharge Notice dated 05/27/6 revealed a discharge date of 05/30/26. Record Review of Resident's #1 Discharge summary dated [DATE] revealed a discharge date of 05/30/26. Record Review of Resident's #1 Orders dated 05/29/26 revealed Discharge order dated 05/29/26 from [NAME] MD. Record Review of Resident's #1 Care Plan dated 05/15/26 revealed no Discharge Planning had been implemented. Review of Resident #2's face sheet dated 06/04/26 revealed she was a [AGE] year-old female admitted on [DATE] with diagnosis that included chronic obstructive pulmonary disease (a progressive, incurable lung disease that restricts airflow and making breathing difficult), Acute Respiratory Failure (respiratory system suddenly fails to oxygenate the blood), Syncope (fainting or passing out).In an interview on 06/04/26 at 1:30 pm, Ombudsman stated she had never received discharged notices from the facility. Record Review of Resident's #2 MDS Comprehensive MDS dated [DATE] revealed a BIMS Score of 12. Record Review of Resident's #2 discharged Notice dated 05/04/26 revealed a discharged date of 05/08/26. Record Review of Resident's #2 discharged Summary dated 05/04/26 revealed a discharged date of 05/08/26. Record Review of Resident's #2 Care Plan dated 03/25/26 revealed no Discharge Planning had been implemented. In an interview on 06/04/26 at 2:40 pm, Discharge Planner stated she only notified the Ombudsman of unplanned; she did not notify the Ombudsman of Resident #1 and #2 discharges. In an interview on 06/04/26 at 4:10 pm, Assistant Director of Clinical Services stated, I already know we do not notify the Ombudsman. She stated it was because the Administrator was of the understanding the Ombudsman only needed to be notified of emergencies, unplanned or difficult cases. She stated that facility policy states, the facility is to notify the Ombudsman at the time of discharge notice is provided to the Resident or Resident Representative; or as soon as practicable on an emergency discharge. In an interview on 06/04/26 at 4:45 pm, Administrator stated, Ombudsman not being notified was due to ignorance on my part, oversight on my part. Review of facility policy dated August 2023 entitled Resident Transfer and Discharge reflected: D. Notice before Transfer 2. A copy of the notice should be sent to the representative of the Office of the State Long-Term Care Ombudsman at the time the notice is provided to the resident and the resident representative, or as soon as practicable after an emergency transfer or discharge. The discharge must include:Contact information of the managing local ombudsman and the toll-free number for the Long-Term Ombudsman Program.