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	02/20/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50039 Based on interviews, observations and record review, the facility failed to develop a comprehensive person-centered care plan based on assessed needs that included measurable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 (Resident #15 and Resident #30) of 16 residents reviewed for comprehensive person-centered care plans. The facility failed to develop and implement Resident #15's care plan to include oxygen therapy. The facility failed to develop and implement Resident #30's care plan to include oxygen therapy. This failure could affect the resident by placing them at risk for not receiving care and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The findings included: 1. Record review of Resident #15's face sheet dated 02/20/25 revealed a [AGE] year-old-male with an original admitted [DATE] and a current admitted [DATE]. Record review of Resident #15's Admission MDS assessment dated [DATE]section C, Cognitive Patterns, revealed a BIMS score of 14 (cognition intact). The MDS did not indicate anything regarding the oxygen or respiratory therapy. Record review of Resident #15's care plan dated 02/19/25 revealed no care plan for oxygen diagnosis, status or equipment. Record review of Resident #15's physician orders dated 02/14/25 revealed order of Oxygen 2 liters via nasal cannula. During an observation of Resident #15 inside his room on 02/18/25 at 8:55 AM and 5:20 PM, Resident #15 was on Oxygen 2 liters via nasal cannula. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675773	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #30's face sheet dated 02/20/25 revealed a [AGE] year-old female with an admitted [DATE]. Pertinent diagnoses included unspecified dementia and hypertensive heart disease without heart failure (prolonged high blood pressure damages the heart without causing heart failure). Record review of Resident #30's Comprehensive MDS dated [DATE] section C, cognitive patterns, stated Resident #30's BIMS score was 4 (severe impairment). Further review of Resident #30's MDS revealed section O, special treatments, stated Resident #30 received oxygen therapy while a resident in the past 14 days. Record review of Resident #30's order summary dated 02/20/25 revealed an active order initiated on 02/01/25 for O2 at 2 liters; may titrate to 4 liters. Every shift for hypoxia. Record review of Resident #30's care plan dated 02/20/25 did not list oxygen therapy as a focus and included no interventions related to oxygen therapy in any other focus. During an observation inside Resident #30's room on 02/19/25 at 9:19 AM, Resident #30 received 4 liters per minute of oxygen. An interview was attempted with Resident #30, but she was not interviewable. In an interview with LVN B on 02/19/25 at 9:33 AM, LVN B stated LVNs did not typically update the care plans. LVN B stated the care plan was typically updated by the MDS nurse, the ADON or the DON. LVN B stated the nurses did check the care plans for accuracy or to verify residents' preferences or goals. In an interview with LVN A on 02/20/25 at 11:24 AM, LVN A stated she read residents' care plans to ensure she was updated on the residents she was assigned. LVN A stated any assessments, changes in care, or changes in orders were reflected in the care plan. LVN A stated oxygen treatments should be in the care plan. LVN A stated she never edited the care plans herself. LVN A stated if she saw something wrong with the care plan, she would notify the ADON or DON. LVN A stated if the care plan was wrong then the nurse taking care of the resident may not give the resident the most up-to-date treatment. In an interview with the ADON on 02/20/25 at 11:40 AM, the ADON stated they revised care plans on new admissions, 5 days afterwards, significant changes, and quarterly. The ADON stated the floor nurses let the ADON, the DON, or the MDS nurse know if something new needed to be updated. The ADON stated Resident #15 and Resident #30 should have had their oxygen use in their care plans. The ADON stated if a resident's care plan was not updated then a nurse may not know what the most appropriate care was for a resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 02/20/25 at 11:57 AM, the DON stated anybody on the interdisciplinary team could edit care plans. The DON stated the care plan contained preferences, precautions, likes, dislikes, and activities. The DON stated that anything related to the individualized care of the resident was put on the care plan. The DON stated that regarding oxygen, the care plans should include they were on oxygen, the amount, the titration, and when and how it was ordered. The DON stated Resident #15 and Resident #30 should have had their oxygen use included in their care plans. The DON stated care plans were updated within 24-48 hours of any new change in the resident. The DON stated care plans needed to be updated so nurses on the floor had the most current information about how to care for the resident. Record review of the facility policy titled Comprehensive Care Plan - SOM dated 11/2017 stated the following: 1. The Comprehensive Care Plan will describe treatments and services to assist the resident to attain or maintain the highest level of physical, mental and psychosocial wellbeing. 2. The comprehensive care plan is based on a comprehensive assessment which includes, but is not limited to, the MDS, Care Area Assessments, clinical assessments and data collection forms, Therapy Evaluations, psychosocial and cognitive evaluations, physician assessments/consults. 3. The Interdisciplinary Team will work in coordination with the resident, the resident's family and responsible party to develop and maintain the comprehensive care plan. 50969

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748 Based on observation, interviews and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen (K2) reviewed and 2 of 2 satellite kitchens (SK4 and SK2) for storage, preparation, and sanitation. 1. Satellite Kitchen 4 (SK4) The facility failed to maintain cleanliness of the steam table holding wells and shelf, that a cleaning schedule was followed, personal items were not kept in the dry storage room, and all staff wore a hair and beard net while in SK4. 2.Satellite Kitchen 2 (SK2) The facility failed to maintain cleanliness of the steam table holding wells and shelf, that a cleaning schedule was followed, and personal items were not kept in the server room, in SK2. 3. Main Kitchen 2 (K2) The facility failed to maintain cleanliness of the steam table holding wells and shelf, the convection oven, the trash cans, a floor blower, and that a cleaning schedule was followed in K2. The facility failed to ensure spices were kept closed throughout the survey to prevent cross contamination. The facility failed to keep trash cans covered when not in use. The facility failed to keep dry storage items tightly sealed in the dry storage area and failed to keep the dry storage room door closed by using a large rat trap as a door stop throughout the survey. The facility failed to store walk-in freezer items properly. The facility failed to ensure personal items were not kept in the service area. . These failures could place residents at risk for food contamination and food borne illness. The findings included: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Observation and initial tour of SK4 (satellite kitchen 4th floor) on 02/18/25 at 10:45 am revealed 5 of 5 steam table wells had scaling, flaking, and black dots around the insides at the water line. The bottoms of the steam table wells had pale yellow scaling on them and debris floating in the water. The underside of the shelf above the steam table wells was covered in a dark brown substances, some had the appearance of drips, some were more solid. There were visible personal items in the dry storage area of SK4; a jacket, a 16 oz. partially full bottle of water, and a purse. In another part of the dry storage area, a different purse. There was no signage indicating a designated area for personal items in the dry storage area. In an interview with SERVER 1 on 02/18/25 at 11:05 am regarding SK4, she said there was no cleaning schedule the SK4 used. She said the dark brown substances on the underside of the steam table wells was directly over the food. She said the substances had probably dropped onto the food at some point and that was bad. She said they should not have sent food out because it could make residents sick because of contamination. She said she had never cleaned the underside of the steam table shelf, and she had worked at the facility for 3 years. In an interview with SERVER 2 on 02/18/25 at 11:10 am, she said kitchen staff were supposed to keep their personal items in the DM's office, which was down the hall from SK4, (approximately 20 paces). She said her purse was in the dry storage area but should have been in the DM's office. She said she did not leave her belongings in the DM's office because the lockers did not have locks on them because they were supposed to supply their own locks, and she did not have a lock for a locker. In an interview and observation of the DM's office on 02/18/25 at 11:15 am, revealed there was a tray with thawed raw meat above eggs and liquid eggs in the refrigerator. There was a large rat trap being used to prop the door open in the K2 dry storage area. He said it should not be there because of contamination and denied ever seeing rodents in the kitchen areas. The DM stated he did not know why there was a large rat trap being used to prop the door open in the K2 dry storage area. He did not indicate why the storage area was open. The DM pointed to a stack of 6 empty lockers with no locks, he said kitchen staff stored personal belongings in the lockers. He said nothing when informed the lockers were empty and there were personal items in the dry storage area in SK4. He said he conducted an in-service on personal belongings with his staff last year when the lockers were delivered and placed. He said he was not monitoring the staff. He said there was not another in-service regarding personal items and he did not provide any reminders. He said he was in charge of SK4. He said there was a cleaning schedule, but it just was not posted. He said the process for getting kitchen repairs resolved was to verbally let the MS know. He said there was no log but there was an electronic reporting system that no one used, and he did not know why. He said the MS and department managers utilized a different electronic reporting system. He said he did not know how to use the electronic reporting system. He said he had worked at this facility for 9 years, working his way up to DM. In an interview and observation with the DM on 02/19/25 at 5:55 pm revealed he entered SK4 without a hairnet or beard cover. He said he just went in for a minute. The hairnets were located inside SK4. He said he would move them back outside the door. He said the food carts would knock the container off the wall when the hairnet container was outside the door. He said there was no way to don hairnets before entering SK4 with them being stored away from the door on the opposite wall inside SK4. He said everyone was required to wear hair and beard nets (if indicated) in the kitchen areas to prevent contamination. The DM said nothing when asked why he was not wearing the required hair and beard nets. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with SERVER 1 and observation of SK4 on 02/20/25 at 9:30 am, the steam wells were not clean. She said she did not know what the yellowish and black substances were around the insides. She said it was K2 staff's job to clean them, and they took them yesterday to clean them. She said they did not look clean now. There was no cleaning schedule posted. 2. Observation and initial tour of SK2 (satellite kitchen 2nd floor) on 02/18/25 at 11:35 am revealed 5 of 5 steam table wells had scaling, flaking, and black dots around the insides at the water line. The bottoms of the steam table wells had pale yellow scaling on them and debris floating in the water. The underside of the shelf above the steam table wells was covered in dark brown spots, some had the appearance of drips, some were more solid. There was no cleaning schedule. There was a jacket on a shelf above clean plates in the server room in SK2. In an interview with the DC (dining coordinator) for SK2 on 02/18/25 at 11:40 am, she said she had worked at the facility for 1 year and 8 months. She said there was no cleaning schedule to go by for about 1 1/2 weeks. She said the substance under the shelf above the steam table looked like rust and mold. She said she had never looked there. She said it was a big health hazard because it could drop into the food and make residents sick. In an interview with SERVER 3 for SK2 on 02/18/25 at 11:42 am, he said he cleaned the steam wells weekly. He said, Last week when asked when the steam table wells were last cleaned. He said there was no cleaning schedule. He said he knew the chest type freezer needed to be defrosted and needed a new gasket. He said he did not tell the DC because she already knew. SERVER 3 did not answer but shrugged his shoulders when asked if the steam table wells and shelf looked clean. 3. Observation and initial tour of K2 (main kitchen 2nd floor) on 02/18/25 at 11:45 am revealed 5 of 5 steam table wells had scaling, flaking, and black dots around the insides at the water line. The bottoms of the steam table wells had pale yellow scaling on them and debris floating in the water. The underside of the shelf above the steam table wells was covered in dark brown spots, some had the appearance of drips, some were more solid. There was no cleaning schedule. There was a jacket on a shelf above clean plates in the K2 service area. There was a thick covering of a sticky yellowish substance on the convection oven, trash cans, and floor blower in K2. Eight of 30 16-ounce containers of spices and cornstarch were open to air. Trash cans were not covered and emitted a foul odor. A 10-pound bag of dry pasta was open to air in the dry storage room. The dry storage room door was propped open by a large rat trap as a door stop throughout the survey. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the EC (executive chef) on 02/18/25 at 11:45 am, she said she had worked at this facility for 8 1/2 years. She said personal items were not allowed in any kitchen area. She said a jacket placed above clean plates on a shelf in the service area was not supposed to be there and it was not a designated area for personal items. She said lockers were provided for staff and staff had to provide their own locks. She said they set up 2 designated drinking areas inside K2, so staff could stay hydrated. She said no one monitored staff for hand washing after touching the drinks and returning to prep areas. She said the grease on the convection oven was from the deep fryer which was right next to the convection oven. She said the grease on the convection oven looked like an accumulation of over a month, because that was how long it had been since it was cleaned. She said the floor blower had a greasy coating on it and she did not know how long it had been that way. She said there were no cleaning schedules to follow. She said it was ok for the thawed raw meat to be in the refrigerator above egg products. She said all dry storage items should be covered or sealed tightly, labeled, and dated including spices and cornstarch because cross contamination could occur and make residents sick if consumed. She said she did not know who left the pasta exposed to air in the dry storage room or how long it had been that way. She said she had no idea who or when the large rat trap was used to prop open the dry storage room door. She said the dirtiness of K2 was a health hazard because there were several opportunities for cross contamination. The EC did not answer when asked what her part was in the education of staff. The EC said the trash cans should be covered when not in use and there was an odor of vomit near one of the uncovered trash cans. She said the uncovered trash could attract gnats, flies, ants, and rodents and having bugs in the kitchen could make people sick. In an interview with the COOK and return visit to K2 on 02/20/25 at 9:30 am revealed the large rat trap was propping the dry storage door open and spices were open to air. There was ice accumulation around the fan in the walk-in freezer, boxes of food were stacked to the ceiling, several boxes of food items were open to air, and the lighting was inadequate. The COOK said boxes were supposed to be at least 6 inches from the ceiling in the walk-in freezer because they could block water hydrants and become a fire hazard. She said everyone was responsible for making sure the boxes of food were sealed tightly to prevent freezer burn and if ice accumulated on the food, it would affect the taste and possibly make the residents sick. She said the product would have to be thrown away if it had ice or freezer burn on it. She said dented pans, such as the food mill, no longer had a good seal and it could harbor bacteria in the crevices and dents and relay it to the residents and make them sick. She said the food mill was used this morning. She said the spices and cornstarch should have been closed tightly to prevent cross contamination. In an interview with the EC (executive chef) on 02/20/25 at 09:45 am, she showed this surveyor a cleaning schedule dated February 2025 with all cleaning and sanitation tasks indicating done. She said she did not monitor staff completion of the tasks. She said, According to the completed cleaning schedule, the kitchen should be spotless. She said the kitchen was far from spotless. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with DSD (dining services director) on 02/20/25 at 10:15 am, he said he started working at the facility 4 months ago and was responsible for the entirety of the satellite kitchens, the main kitchen, and the kitchen staff. He said he knew about the lack of cleaning, training, faulty equipment, old steam wells and carts, shelving, and safety issues. He said he had made lists to submit to MS so he could get it to corporate for approval. He said he first submitted the lists to the ex-administrator within 4 months ago. He said he had notified the current ADM of how bad things were in the kitchen and she was working with him to get things fixed. He said he then submitted the lists to MS on 01/15/25 and corporate denied everything on the list on 02/14/25 and told him the items were supposed to be part of the EC's monthly budget. He said the MS was working on that budget now. He said the process for reporting kitchen items that needed repair, or replacement was to report it to the EC and she would handle it. He said he learned how to use the facility electronic reporting system about a month ago. He said he entered RD (registered dietician) requests, but he could not retrieve them from the electronic reporting system and did not know how to do it. He said the facility was without a DM for about a year. He said he was responsible for monitoring the satellite kitchens and staff. He said the DM (dietary manager) was supposed to monitor healthcare staff and the EC (executive chef) was supposed to monitor main kitchen staff (K2). He said his last conducted in-service with kitchen staff was 01/21/25. He said he did daily walk-throughs in all kitchen areas and found multiple failures but would not say what they were. He said there were no records for any training that he could find. He said his plan was to continue teaching and introduce all kitchen staff to the facility's kitchen training catalog, which he said none of the kitchen staff had ever seen. He said the kitchen did not have proper cleaning solutions or cleaning equipment when he started working here. In an interview with the RD (registered dietician) on 02/20/25 at 12:25 pm, she said she had been at this building since November 2024. She said she talked with the kitchen staff last month about sanitation, tray cards, anything related to kitchen operations, prep, temps, etc. She said she would obtain the training she had conducted. She said she conducted walk-throughs in the kitchen and the satellite kitchens during her visits to the facility. She said she had been conducting process improvement plans (PIPs) on sanitation and equipment. She said the kitchen and satellite kitchens were supposed to be following cleaning schedules. She said the ADM had been helpful in advocating with corporate to get the equipment and supplies needed to improve the kitchen. In an interview with the MS (maintenance supervisor) on 02/20/25 at 2:33 pm, he said he worked at the facility for [AGE] years. He said the process of reporting kitchen repairs or replacement equipment was for them to call the receptionist at the front desk and report it to them because the receptionists had been trained to use the facility electronic reporting system. He said he made walk throughs through all the kitchen areas every Sunday. He said the staff always told him Everything was fine. He said the electronic reporting system had been in place at least 5 years. He said the list the DSD (director of dining services) created and presented to him for approval by corporate was now in the process of being refined by himself. He said he would resubmit it to corporate asset management once he was done refining the list. He said the ADM was made aware of changes before resubmitting the request. He said he had documentation of these exchanges that he would provide. He said he was not aware of the ice build-up, stacked boxes to the ceiling, and lighting in the walk-in freezer, or the rat trap utilized as a door stop for the dry storage room in K2. He said there was a red line placed around the inside of the walk-in freezer to indicate how high the boxes could be stacked. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Further review revealed an action plan for the DM initiated on 01/27/25 indicated Weekly meetings were to be conducted every Monday. Notes from the 02/10/25 meeting indicated the DM was improving. There was no meeting for 02/17/25. Record review of the facility policy revised 01/11/24, titled Equipment Maintenance revealed under policy: The maintenance department is responsible for foodservice equipment maintenance. Procedure: 1. The maintenance department is responsible for inspecting equipment annually, or more often, if needed, to ensure proper working order. 2. The food and nutrition department should notify maintenance if equipment is not working properly. Record review of the facility policy revised 06/2024, titled, Food Storage revealed under policy: All foods must be stored in a manner that maximizes nutrient retention, quality, and food safety. 2. The storerooms and walk-ins should be maintained free from dirt, dust, insects, rodents or any potential sources of contamination. 3. All foods should be stored on storeroom shelving that is no less than 6 inches from the floor and at least 18 inches from the sprinklers on the ceiling. Record review of the facility policy revised 07/11/24, titled, Food Storage revealed 4. Thawing: .Thaw meat preferably by placing in deep pans and setting on lowest shelf in refrigerator. Record review of the facility policy revised 04/06/2023, titled, Dry Storage Chart revealed Cornstarch should be kept tightly closed. Pasta dry-once opened, store in airtight container. Spices and herbs, store in airtight containers in dry places away from sunlight and heat. Record review of the facility policy revised 12/2024, titled, Hair Restraints revealed under policy overview: All associates working in food preparation must wear hair restraints. Under policy detail: 1. All hair must be kept covered. 5. Beards must be covered with a beard restraint. Record review of the facility policy revised 05/18/202, titled, Personal Hygiene/Safety/Food Handling/Infection Control revealed policy: Guidelines for personal hygiene to promote a safe and sanitary department must be followed: 3. Head covering worn: c. Beards, mustaches, or any body hair that may be exposed (i.e., arms) must be covered. 4. Conduct: c. Eating and drinking are not permitted in food preparation and service areas. 5. Designated area for employee personal belongings: a. An area in the director of food and nutrition office or dry storage area may be designated as a separate employee personal belonging area with signage. B. Personal belongings, beverages and/or food may be stored in the designated area. Record review of the facility policy revised 08/31/18 titled, Cleaning Schedules under policy: The food and nutrition services staff shall maintain the sanitation of the food and nutrition department through compliance with written, comprehensive cleaning schedules developed for the community by the director of food and nutrition services or other clinically qualified nutrition professional. Community satellite kitchens will be held to the same sanitary standards as the main kitchen, utilizing a comprehensive cleaning schedule specific to each kitchen.

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 02/20/2025
NAME OF PROVIDER OR SUPPLIER Brookdale Trinity Towers		STREET ADDRESS, CITY, STATE, ZIP CODE 317 N Carancahua Corpus Christi, TX 78401	

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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 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 50039

Based on observation, interview, and record review the facility failed to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections for 3 of 12 residents (Residents #15, #33, and #152) observed for infection control practices.

The facility failed to post Enhanced Barrier Precaution signs outside the rooms of Resident #'s 15, 33 and 152.

These failures could place residents, staff, and visitors at risk of cross contamination and/or infection.

Findings included:

1. Record review of Resident #15's face sheet dated 02/20/25 revealed a [AGE] year-old-male with an original admitted [DATE] and a current admitted [DATE]. Diagnoses included Squamous Cell Carcinoma of Skin, Scalp, and Neck (a type of skin cancer that was caused by an uncontrolled growth of abnormal squamous cells).

Record review of Resident #15's Admission MDS assessment dated [DATE], section C, Cognitive Patterns, revealed a BIMS score of 14 (cognition intact). Section M of the MDS indicated Resident #15 had one or more unhealed pressure ulcers or injuries, as well as moisture associated skin damage and application of nonsurgical dressing. Section N of the MDS revealed Resident #15 was on an antibiotic.

Record review of Resident #15's order summary dated 02/06/25 revealed Resident #15 had an antibiotic ordered for a bacterial infection, as well as wound care to an ulcerating cancer wound to the top of the head.

During an observation on 02/18/25 at 5:20 PM LVN C performed wound care on Resident #15 with only gloves and no gown.

In an interview with LVN-C on 02/18/25 and 5:30 PM she revealed that no gown was worn due to Resident #15 was not on EBP, but had he been, she would have worn a gown to prevent cross contamination.

In an interview with the ADON on 02/19/25 at 9:45 AM, the ADON stated she was not sure what Resident #15's antibiotic was for, but she had known about his open wound that he had been getting wound care for, and the antibiotic was carried over and re-ordered from his hospital stay.

2. Record review of Resident #33's face sheet dated 02/20/25 revealed a [AGE] year-old female with an admitted [DATE]. Pertinent diagnosis included a blister to the right lower leg.

Record review of Resident #33's Comprehensive MDS assessment dated [DATE] section C, Cognitive Patterns, revealed a BIMS score of 15 (cognition intact). Section M, Skin Conditions, revealed Resident #33 was at risk of developing a pressure ulcer, but did not have one at the time of asssessment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #33's care plan dated 02/20/25 listed the focus The resident has potential/actual impairment to skin integrity initiated on 01/26/25 and revised on 02/07/25. A pertinent intervention listed for the focus included: Keep skin clean and dry. Use lotion on dry skin. Do not apply to area of skin breakdown, wound or between toes initiated on 01/26/25. Record review of Resident #33's order summary dated 02/20/25 revealed an active order initiated on 02/14/25 for Cleanse blistered areas to the right anterior and inner lateral leg with normal saline and 4x4 (inch) gauze, pat dry with gauze, apply [skin protective wipe], and leave open to air. 3. Record review of Resident #152's face sheet dated 02/20/25 revealed a [AGE] year-old female with an admitted [DATE]. Pertinent diagnosis included malignant neoplasm of brain (cancerous tumor that originates in or spreads to the brain). Record review of Resident #152's PPS MDS assessment dated [DATE] section C, Cognitive Patterns, revealed a BIMS score of 14 (cognition intact). Section M, Skin Conditions, revealed Resident #152 had a surgical wound. Section N, Medications, revealed Resident #152 was taking an antibiotic. Record review of Resident #152's care plan dated 02/20/25 listed the focus The resident is on IV Medications. Infection of scalp incision initiated on 02/08/25. Record review of Resident #152's order summary dated 2/20/25 revealed an active order initiated on 02/18/25 for Vancomycin HCL (Antibiotic) Intravenous Solution Reconstituted 1 GM. Use 1 gram intravenously every 12 hours for INFECTION. During an observation on 02/19/25 at 11:00 AM of the resident halls, there were no EBP signs posted on Resident #15, #33, and #152's doors. During an observation on 02/20/25 at 10:11 AM inside Resident #152's room, LVN A hooked up the Vancomycin medication to Resident #152's PICC line with gloves only and no gown. In an interview with LVN A on 02/20/25 at 11:26 AM, LVN A stated she was unsure of what the difference between standard precautions and EBP were, but she would find out. LVN A stated she thought EBP was someone with a Foley catheter or wound care, and if a resident was on EBP she should put on both gown and gloves prior to going into the room to provide care. LVN A stated it was the manager or admitting nurse's job to put up the EBP signs and carts. In an interview with the IP on 02/20/25 at 11:17 AM, she stated she had to take a class through the CDC to become the IP and learn about the different precautions. The IP stated that with standard precautions, they were utilized on everyone, anytime you touch anyone, but with EBP, it was more detailed and more enhanced precautions for residents with things such as MDRO infections, oozing wounds, vomiting, diarrhea, Foley catheters, rectal tubes, and other similar things. The IP stated she had not reviewed the EBP policy recently, and generally only worked the weekends, so she was not sure how many residents they had or should have had on EBP. The IP stated that typically, the IP, ADON, or DON determined which residents needed EBP and let the floor nurses know where to place the signs and carts. After reviewing the facility's infection control policy, the IP stated all G-tubes, PICC lines and draining wounds required EBP. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Trinity Towers	317 N Carancahua Corpus Christi, TX 78401

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the ADON on 02/20/25 at 11:41 AM, the ADON stated standard precautions were for residents with infections like C-diff, and EBP was more for residents with Foley catheters, G-tubes, MDROs. The ADON stated the nurses and staff identified the residents on EBP by the signs on the doors, but they also identified which residents required EBP by looking at their residents and reviewing their charts and orders. The ADON stated EBP included gowns and gloves in conjunction with the signs on the doors, and if the proper precautions were not utilized, cross contamination could occur, and infections could be transmitted. In an interview with the DON on 02/20/25 at 11:50 AM, the DON stated EBP was less than contact precautions but more than standard precautions. The DON stated EBP should be utilized with close contact such bathing or doing wound care on residents with open wounds, PICC lines, other lines or tubes. The DON stated that based on their policy, any resident with an open wound, especially if they had an infection and were susceptible, should be on EBP. The DON stated if residents had a PICC line and had MRSA, they should be on EBP. The DON stated it was subjective as to who determined the precautions, but the admissions nurse typically caught it first and placed the resident on EBP. The DON stated the ADON followed up the next morning in morning rounds to make sure everyone was placed on the proper precautions, and if they had an open wound and were getting wound care, such as Resident #15 and Resident #33, they should be on EBP. Record review of the facility's Enhanced Barrier Precautions Policy, dated 09/2022 and revised 02/2025, revealed EBPs should be utilized (in conjunction to standard precautions) to reduce transmission of MDROs that employs targeted gown and glove use during high contact resident care activities. Gloves and gowns may be applied prior to performing high-contact resident care activity; Personal protective equipment was changed before caring for another resident; face protection may be used if there was also a risk of splash or spray. 50969

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748 Based on observation, interview, and record review, the facility failed to maintain all kitchen equipment in safe operating condition for 1 of 1 kitchen (K2) reviewed and 1 of 2 satellite kitchens (SK2) reviewed for safe operating equipment. The facility failed to maintain a chest type freezer with heavy ice build-up on the inside walls, bottom, and lid in SK2. The facility failed to maintain and remove a 4-foot X 3-foot char broiler that did not work, had no griddle on it, and was connected to the gas line in K2. The facility failed to maintain and remove dented holding pans and dented prep equipment (food mill) in K2. The facility failed to maintain the walk-in freezer by not allowing ice accumulation around the fan and low lighting in K2. These failures could cause food-borne illness from equipment not being maintained and/or cleaned effectively. Findings include: Observation and initial tour of SK2 (satellite kitchen 2nd floor) on 02/18/25 at 11:35 am revealed a chest type freezer had heavy ice build-up on the inside walls, bottom, and lid and a removable black substance on the gasket. The walk-in freezer in K2 had full boxes of food stacked to the ceiling and ice partially covering the fan. The walk-in freezer was dimly lit. In an interview with the DC (dining coordinator) for SK2 on 02/18/25 at 11:40 am, she said she had worked at the facility for 1 year and 8 months. She said SERVER 3 was responsible for letting her know when equipment needed repair. She said the process for getting kitchen issues resolved was she or SERVER 3 would verbally tell maintenance. She said the chest type freezer needed to be defrosted for 2-3 weeks. She said the chest type freezer lid needed a new gasket. She said the gasket had been cleaned about 2 weeks ago. She said the gasket had mold on it now. In an interview with SERVER 3 for SK2 on 02/18/25 at 11:42 am, he said he knew the chest type freezer needed to be defrosted and needed a new gasket. He said he did not tell the DC because she already knew. SERVER 3 did not answer but shrugged his shoulders when asked if the freezer looked clean. In an interview with the EC (executive chef) on 02/18/25 at 11:45 am, she said she had worked at this facility for 8 1/2 years. She said the char broiler had not worked for over 2 years and she had been trying to get maintenance to remove it. She said she had brought it up several times to the ADM and MS but had no proof because they relayed maintenance requests and repairs only verbally. She said it was not safe to have the char broiler in that condition because it was missing a griddle, the gas tubes were exposed, and it was still hooked up to the gas line. She said it was a fire hazard. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the COOK and observation in K2 on 02/20/25 at 9:30 am revealed the dented food mill was dirty with food on a prep cart, there was ice accumulation around the fan in the walk-in freezer, boxes of food were stacked to the ceiling, and the lighting was inadequate. The COOK said boxes were supposed to be at least 6 inches from the ceiling in the walk-in freezer because they could block water hydrants and become a fire hazard. She said dented pans, such as the food mill, no longer had a good seal and it could harbor bacteria in the crevices and dents and relay it to the residents and make them sick. She said the food mill was used this morning. She said the spices and cornstarch should have been closed tightly to prevent cross contamination. In an interview with DSD (dining services director) on 02/20/25 at 10:15 am, he said he started working at the facility 4 months ago and was responsible for the entirety of the satellite kitchens, the main kitchen, and the kitchen staff. He said he knew about the lack of cleaning, training, faulty equipment, old steam wells and carts, shelving, and safety issues. He said there was equipment not tagged out or inoperable such as the char broiler. He said the char broiler had been inoperable for at least 5 years. He said it was still hooked up to gas and that it was a safety issue. He said he had made lists to submit to MS so he could get it to corporate for approval. He said he first submitted the lists to the ex-administrator within 4 months ago. He said he had notified the current ADM of how bad things were in the kitchen and she was working with him to get things fixed. He said the process for reporting kitchen items that needed repair, or replacement was to report it to the EC and she would handle it. He said he learned how to use the facility electronic reporting system about a month ago. He said he did daily walk-throughs in all kitchen areas and found multiple failures but would not say what they were. He said there were no records for any training that he could find. In an interview with the MS (maintenance supervisor) on 02/20/25 at 2:33 pm, he said he worked at the facility for [AGE] years. He said the process of reporting kitchen repairs or replacement equipment was for them to call the receptionist at the front desk and report it to them because the receptionists had been trained to use the facility electronic reporting system. He said he made walk throughs through all the kitchen areas every Sunday. He said the staff always told him Everything was fine. He said the electronic reporting system had been in place at least 5 years. He said he was not aware of the ice build-up, stacked boxes to the ceiling, and lighting in the walk-in freezer, the condition of the chest freezer in SK2, or the char broiler in K2. He said there was a red line placed around the inside of the walk-in freezer to indicate how high the boxes could be stacked. He said he was informed about the chest freezer this morning. He said the facility had no roach problems. He said ants and flies were seasonal. He said there had been no rodent problems in the last few years. He said there were rodents [AGE] years ago when he first got there, but none since. In an interview with the ADM on 02/20/25 at 5:09 pm, she stated performance improvement plans via QAPI (Quality Assurance and Performance Improvement) were initiated on 09/25/24 regarding all aspects of the kitchen and satellite kitchens. She said she was working with the MS, RD, and all kitchen staff to improve the quality of food, moral, sanitation and knowledge bases. Record review of the facility policy revised 01/11/24, titled Equipment Maintenance revealed under policy: The maintenance department is responsible for foodservice equipment maintenance. Procedure: 1. The maintenance department is responsible for inspecting equipment annually, or more often, if needed, to ensure proper working order. 2. The food and nutrition department should notify maintenance if equipment is not working properly.