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	04/30/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a comprehensive assessment within 14 calendar days after admission as required for 1 (Resident#70) of 7 resident records reviewed for assessment. The facility failed to complete Resident #70's comprehensive MDS assessment within 14 days following her admission to the facility on [DATE]. This failure could place newly admitted residents at risk of not receiving the proper care required to attain or maintain the highest practicable physical, mental, and psychosocial well-being.The findings included:Record review of Resident #70's admission Record reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her pertinent diagnoses included fracture of the superior rim of the left pubis (a break in one or more of the bones that make up the pelvis), muscle weakness (a sensation of imbalance or difficulty maintaining steady posture while standing or walking), and lack of coordination (difficulty in controlling and executing smooth, purposeful movements).Record review of Resident #70's MDS assessment dated [DATE] reflected a completion and signed date of 04/23/26. In an interview on 04/30/26 at 6:30pm, the Adm stated the MDS was supposed to be completed within 21 days from admission. She stated the facility MDS coordinator left on emergency leave on 04/06/26 and did not return so the facility terminated her for job abandonment on 04/15/26. The Adm stated that an MDS Coordinator from Corporate Office remotely worked on MDS from 04/20/26 to 04/24/26. The Adm stated the facility obtained a contract MDS coordinator on 04/24/26 and her start date was 04/27/26. In an interview on 04/30/26 at 6:24 pm, the contract MDS nurse stated she had only been working at the facility for 2-3 days and she had been advised to refer any questions back to the facility. Record review of the chart that was provided by the facility reflected in part: MDS completion date (ItemZ05008) No Later Than:14th calendar day of the resident's admission (admission +13 days).

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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(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** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident needs, that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs, for 1 of 7 residents (Resident #60) reviewed for care plans. The facility failed to ensure Resident #60's care plan reflected her ADLs with assistance needed.This failure could place the residents at risk of not receiving appropriate interventions and care to meet their needs.Findings included:Record review of Resident #60's face sheet, dated 04/28/26, reflected a [AGE] year-old female, admitted on [DATE], diagnoses included: congestive heart failure (long-term condition that affects the heart's ability to pump blood), major depressive disorder (mental health condition with persistent feelings of sadness, loss of interest, various emotional/physical problems), chronic kidney disease (condition that affects the kidneys' ability to filter waste from the blood), muscle wasting and atrophy (reduction in muscle mass and strength), and unspecified osteoarthritis (progressive, degenerative joint disease that can cause pain, stiffness, and loss of mobility). Record review of Resident #60's MDS assessment, dated 04/16/26, reflected a BIMS score of 3, indicating severe cognitive impairment. The MDS reflected Resident #60 was substantial/maximal assistance for eating and oral hygiene. Resident #60 was dependent for toileting hygiene, shower/bathe, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. Record review of Resident #60's care plan, dated 04/28/26, reflected [Resident #60] had an ADL self-care performance deficit. Date initiated: 04/01/26. Interventions included: preferred bathing on Monday, Wednesday, Friday. Date initiated: 04/01/26. Assist with turning and repositioning during routine care and as needed. Date initiated: 04/06/26. Care plan did not reflect the ADLs with assistance needed. During an attempted interview and observation, on 04/28/26 at 1:15 PM, Resident #60 was asked basic questions and she did not respond. Resident #60 was not interviewable. Resident #60 was not injured or in distress. During an interview, on 04/30/26 at 9:20 AM, the MDS Nurse stated she was not familiar with Resident #60 as she had only been contracted with the facility as of 2-3 days ago. The MDS Nurse stated ADLs and assistance needed should have been included in the care plan. During an interview, on 04/30/26 at 9:40 AM, the ADON stated Resident #60's ADLs should have been in the care plan. The ADON reviewed Resident #60's care plan and she verified the ADLs with assistance needed were not care planned appropriately. The ADON stated there was no negative outcome for Resident #60 because staff were aware of how to care for her as they were familiar with her. The ADON stated the CNAs had tasks to follow and the nurses also followed the orders for Resident #60. The ADON stated care plans were developed and updated as a team effort. The ADON stated it was important for the care plan to be developed accurately so staff knew how to care for the resident. An interview was attempted, on 04/30/26 at 10:45 AM. The DON was unavailable as she was out of the country. A call was attempted and a voicemail was left requesting a callback. Record review of the facility's Comprehensive Care Plan policy, dated November 2017, reflected - Policy: A comprehensive, person-centered care plan will be developed for each resident that includes measurable objectives and timeframes to meet the resident's medical, nursing, mental and psychosocial needs that have been identified through a comprehensive assessment 4. Each resident's comprehensive care plan will include: a. Resident goals for care and desired outcomesb. Identified resident issues, conditions, risk factors and safety issues .f. Interventions that will be implemented to enable each resident to meet her objectives.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to review and revise the comprehensive care plan by the interdisciplinary team, for 1 of 7 residents (Resident #7) reviewed for comprehensive care plan revisions. The facility failed to review and revise Resident #7's care plan to reflect she no longer used a catheter.This failure could place the residents at risk of not receiving appropriate interventions and care to meet their current needs.Findings included:Record review of Resident #7's face sheet, dated 04/29/26, reflected a [AGE] year-old female, admitted on [DATE], diagnoses included: unspecified dementia (decline in cognitive function severe enough to interfere with daily life affecting memory loss, language, problem solving, and other cognitive abilities), acute kidney failure (condition that affects the kidneys' ability to filter waste from the blood), hypertensive heart disease (condition caused by prolonged high blood pressure leading to heart damage) , anxiety disorder (uncontrollable worry about everyday issues, affecting daily functioning and quality of life), and retention of urine (inability to completely empty the bladder). Record review of Resident #7's MDS assessment, dated 01/29/26, reflected a BIMS score of 03, indicating severe cognitive impairment. The MDS reflected Resident #7 had an indwelling catheter. Record review of Resident #7's care plan, dated 04/29/26, reflected [Resident #7] had an indwelling catheter related to neurogenic bladder (nerve damage disrupts communication between the brain, spinal cord, and bladder, leading to loss of bladder control and urinary dysfunction). Date initiated: 10/13/25. Date revised: 11/08/25. During an attempted interview and observation, on 04/28/26 at 1:50 PM, Resident #7 was asked basic questions, but she did not respond coherently. Resident #7 was not interviewable. Resident #7 was not injured or in distress. Resident #7 did not have a catheter. During an interview, on 04/30/26 at 9:00 AM, LVN A stated Resident #7's catheter had been removed maybe in January or February 2026, but she was not sure on the date. LVN A stated the catheter was discontinued because Resident #7 tried to pull it out. LVN A stated Resident #7 had been doing well without the catheter and she was able to urinate in her brief without retention. During an interview, on 04/30/26 at 9:20 AM, the MDS Nurse stated she was not sure when Resident #7's catheter was discontinued but the care plan should have been updated to remove the catheter. The MDS Nurse stated she had only been contracted with the facility for 2-3 days and was not sure why Resident #7's had not been revised. The MDS Nurse stated care plans were revised upon completion of MDS assessments and as needed for any changes. During an interview, on 04/30/26 at 9:40 AM, the ADON stated she was not sure when Resident #7's catheter was discontinued but that should have been care planned. The ADON stated the care plan should have been revised to reflect that Resident #7 no longer needed or used a catheter. The ADON stated there was no negative outcome for Resident #7 because staff were aware of how to care for her. The ADON stated the CNAs had tasks to follow and the nurses followed the orders for Resident #7. The ADON stated care plans were developed and updated as a team effort. The ADON stated it was important for the care plan to be updated and revised to reflect information accurately so staff knew how to care for the resident. The ADON stated care plans could even be updated daily or as needed. An interview was attempted, on 04/30/26 at 10:45 AM. The DON was unavailable as she was out of the country. A call was attempted and a voicemail was left requesting a callback. Record review of the facility's Comprehensive Care Plan policy, dated November 2017, reflected - Policy: A comprehensive, person-centered care plan will be developed for each resident that includes measurable objectives and timeframes to meet the resident's medical, nursing, mental and psychosocial needs that have been identified through a comprehensive assessment 9. Care plans will be revised as information about the resident and the resident's' condition changes.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure a resident receives treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices, and maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or the resident preferences indicate otherwise for 1 (Resident #70) of 7 residents reviewed for nutritional status.The facility failed to ensure Resident #70 was weighed weekly for 3 weeks after admission per physician's orders. This failure could place residents at risk for nutritional deficit, weight loss, skin breakdown, and overall decline in quality of life.The findings included:Record review of Resident #70's admission Record reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her pertinent diagnoses included fracture of the superior rim of the left pubis, (a break in one or more of the bones that make up the pelvis), muscle weakness (a sensation of imbalance or difficulty maintaining steady posture while standing or walking), and lack of coordination (difficulty in controlling and executing smooth, purposeful movements). Record review of Resident #70's MDS dated [DATE] reflected a BIMS score of 4 which indicated severe cognitive impairment.Record review of Resident #70's Care Plan dated 04/02/26 reflected she had a nutritional problem or potential nutritional problem which was initiated on 04/02/26 and revised on 04/28/26. The goal was the resident would have no significant weight loss or weight gain through the review date, initiated on 04/02/26 with target date of 04/29/26. Interventions included monitor intake and record, monitor/document/report to MD for s/sx of dysphagia (difficulty swallowing) and provide and serve diet as ordered, initiated on 04/02/26. Record review of Resident #70's Order Summary Report on 04/29/26, reflected the following physician orders: Weight on admission, repeat weekly x 3 weeks ordered on 04/02/26. Regular diet. Refer to diet type for texture. Regular liquids consistency ordered on 04/02/26. Refer to Registered Dietician ordered on 04/02/26. Lasix Oral Tablet 40mg. Give 1 tablet by mouth one time a day for edema started on 04/15/26.Record review of Resident #70's progress notes reflected a physician note dated 04/14/26 that stated in part, The patient was seen sitting in her chair. She reports increased swelling to her legs causing discomfort.Record review of Resident #70's Weight Summary on 04/29/26 reflected an admission weight of 145.0 lbs. on 04/02/26, a weight of 144.2 lbs. on 04/10/26 and a weight of 133.6 lbs. on 04/18/26. The third and final weight was not obtained by facility staff. In an interview on 04/30/26 at 5:55 pm, the ADON stated all residents were weighed on admission by the admitting nurse. She stated the weight orders were entered into the TARS and indicated which residents needed to be weighed and when they needed to be weighed. She stated she and the DON provided oversight and confirmed weights were completed with a generated weight report. The ADON stated she did not know why Resident #70's final weight was not obtained and had to look at her medical record. She stated the facility monitored and kept track of nutritional and medical problems that were triggered by weight fluctuations because it could result in medical complications including death if a resident lost or gained too much weight.Record review of the facility's Weight and Height Policy dated 07/2015 and revised on 02/2018 reflected in part: Policy OverviewResidents should be weighed upon admission/re-admission, weekly for three weeks, and as needed. The resident's height should be obtained and documented upon admission/re-admission or as needed.Policy DetailA. Weight3. Residents will be weighed on admission/re-admission and then weekly for three weeks, monthly or as needed thereafter.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation and interview, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident in 2 of 2 medication rooms (4th floor and 5th floor) reviewed for pharmacy services.The facility failed the ensure expired medication was removed from the 4th floor medication storage room.The facility failed the ensure expired medication was removed from the 5th floor medication storage room.These failures could place residents at risk of not receiving the therapeutic benefit of medications and or adverse reactions to medications.The findings included:An observation of the 4th floor medication room on 04/30/26 at 11:00 am reflected 2 unopened 16 oz bottles of Geri-Tussin (an expectorant- a medication used to thin and loosen mucus) with an expiration date of 2025/07 in a cabinet where backstock OTC (over the counter) medications were stored.An observation of the 5th floor medication room on 04/30/26 at 11:30 am reflected 1 unopened 16 oz bottle of Geri-Tussin (an expectorant- a medication used to thin and loosen mucus) with an expiration date of 2025/07 in a cabinet where backstock OTC (over the counter) medications were stored.In an interview on 04/30/26 at 11:37 am, the ADON stated there should not have been any expired medications in the medication storage cabinet. She stated if expired medications were administered, they may not have the desired effect or could cause illness. The ADON stated the central supply clerk had just received the shipment of that medication from the supply company and stocked it in the medication room but did not see that the Geri-Tussin had expired. The ADON stated when she told the central supply clerk about the expired medication, the supply clerk called the supply company to let them know about the expired medication. She stated the supply company told the supply clerk they were not aware that the medication was expired, but they would send a new shipment of the medication.Record review of the facility's Storage and Expiration Dating of Medications and Biologicals dated 05/10/10 and revised 06/30/25 reflected in part: 10. Facility should ensure medications and biologicals that: (1) have an expired date on the label. are stored separate from other medications until destroyed or returned to the pharmacy or supplier.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interviews and record review, the facility failed to store food in accordance with professional standards for 1 of 1 freezer and 1 of 2 medication storage rooms (4th floor medication room) reviewed for food safety.-The facility failed to ensure food items (raw dinner rolls, breaded chicken tenders, and breaded fish) in the freezer were sealed properly.-The facility failed to ensure resident food items were disposed of according to policy. -The facility failed to ensure the resident food and drink refrigerator in a medication storage room was clean and did not have any food or drink remnants in it. These failures could place residents at risk of complications from food contamination.Findings included:Observations during the initial tour of the kitchen on 04/28/26 at 8:25 AM revealed the freezer had boxes of raw dinner rolls, breaded chicken tenders, and breaded fish that were open and exposed to the air.During an interview, on 04/30/26 at 10:55 AM, DA B stated all kitchen staff were responsible to ensure that all food was sealed and dated. DA B stated she knew that all items in the freezer should be sealed to prevent freezer burn.Observation of the resident food and drink refrigerator in the 4th floor medication storage room on 04/30/26 at 11:00 AM revealed a 16oz container labeled Butter Chicken Soup. On the top of the container there was a yellow sticky note that stated, [Resident Name] [Room number] -Please ask if she wants.? 4/19/2026. There was a sign that stated, Label all food and drink items. Food items will be discarded after 3 days (once opened) on the front of the refrigerator. This observation also revealed a pink colored sticky substance in the bottom left corner of the refrigerator and a yellow colored sticky substance in the bottom right side of the refrigerator.During an interview on 04/30/26 at 11:25 AM, the DM stated all items in the freezer should have been sealed correctly to prevent freezer burn and to prevent contamination. The DM stated it was the responsibility of all kitchen staff to ensure food was sealed correctly as it was a team effort to ensure foods were stored and dated properly. The DM stated he went through the freezer and ensured everything was fixed. The DM stated he will be retraining all staff on proper food storage.In an interview on 04/30/26 at 11:37 am, the ADON stated the soup was past 3 days of the opened date and it needed to be thrown away. She stated it was not acceptable to have spilled stuff in the bottom of the refrigerator. The ADON stated dietary was responsible for the resident food and drink refrigerator, but it was everyone's responsibility to ensure food and drinks were disposed of when they were opened. She stated expired food could cause stomach illness and spilled substances could get on other things and cause cross contamination. Record review of the facility's Food Storage policy, dated 2005 and revised June 2024, reflected in part: Policy: All foods must be stored in a manner that maximizes nutrient retention, quality, and food safety.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.The facility failed to ensure infusion therapy supplies were stored under sterile conditions in the 4th floor medication storage room.The facility failed to ensure used oxygen equipment was not stored in the 4th floor medication storage room.These failures could place residents at risk of cross contamination and infection.The findings included:An observation of the 4th floor medication room on 04/30/26 at 11:00 am reflected unused IV infusion tubing that had been removed from the packaging laying in the bottom of a drawer that contained various other properly packaged and sterile supplies. This observation also reflected a 340 ml bottle of sterile water used for oxygen humification in the back left corner of the top shelf in the bottom storage cabinet. This bottle was not full and was not in a package. The humidifier bottle had an approximately 18 inch oxygen tubing connected to it at the top that would have connected the humidifier to an oxygen concentrator machine. 1/2 was written in black marker on the end that was not attached to the humidifier. The cabinet shelf contained some oxygen supplies such as nasal cannulas and oxygen masks.In an interview on 04/30/26 at 11:37 am, the ADON stated there should not have been any opened or used supplies in the storage room and she was not sure why they were there or why they had not been discarded. She stated it was everyone's responsibility to ensure used or unsterile supplies were disposed of properly.In an interview on 04/30/26 at 5:40 pm, the IP stated IV infusion tubing was not supposed to be used if it was out of the packaging and sat in a drawer. She stated IV tubing was to be used immediately upon being removed from the packaging. The IP stated, if the IV tubing that was sitting out was used, a lot could happen; bacteria, infection, who knows what all the resident could be exposed to. She stated the humidifier was definitely not supposed to be in the cabinet and should have been disposed of immediately after resident use.Record review of the facility's Cleaning and Disinfection of Resident Care Items and Equipment Policy dated 07/2019 reflected in part: d. ii. Single-use items are disposed of after a single use.7. Disposable resident care equipment and supplies shall be immediately discarded after use.