| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675900 | A. Building<br>B. Wing | 07/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| River Pointe of Trinity Healthcare and Rehabilitat | 808 S Robb<br>Trinity, TX 75862 |

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 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(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: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675900 | A. Building<br>B. Wing | 07/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| River Pointe of Trinity Healthcare and Rehabilitat | 808 S Robb<br>Trinity, TX 75862 |

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 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents' environment remained free from accident hazards and the residents received adequate supervision and assistance to prevent accidents for 1 of 11 residents (Resident #2) reviewed for accidents. The facility failed to ensure a safe transfer of Resident #2 using a mechanical lift with two staff. On 6/21/2025 Resident #2 was being transferred from her bed to a wheelchair and CNA A failed to ensure all 4 straps were secured and Resident #2 flipped out of the mechanical lift to the floor and hit her head that resulted in a golf ball sized bump to the back of her head. Hospitality aide B sat in a recliner in the room and talked on a phone during the transfer. On 6/29/2025 x-ray conducted in the facility revealed a displaced right proximal femur fracture (hip fracture). The noncompliance was identified as PNC. The Immediate Jeopardy (IJ) began on 6/21/2025 and ended on 6/30/2025. The facility had corrected the noncompliance before the investigation began.This failure could place residents at risk for falls resulting in injury, pain, and hospitalization. Findings include:Record review of an admission Record for Resident #2, dated 7/28/2025, indicated a [AGE] year-old female who was admitted to the facility on [DATE].Record review of active physician orders for Resident #2, dated 7/28/2025, indicated she had diagnoses which included hypertension, dementia (memory loss that affects daily life), contractures of right and left knee (bent and unable to straighten out causing restricted mobility), and cerebral infarction (stroke). An order documented to include the facility may use a Hoyer lift to transfer, started on 10/1/2021. Record review of a Significant Change MDS Assessment for Resident #2, dated 7/2/2025, indicated she was rarely/never understood. She was dependent on staff with all ADL's.Record review of a care plan for Resident #2, revised on 12/21/2023, indicated she had an ADL self-care performance deficit related to CVA (stroke). Interventions for transfers indicated she was dependent on transferring via Hoyer lift, using mechanical swing and staff x2.Record review of a progress note for Resident #2, dated 6/21/2025, by LVN O at 12:15 PM, indicated .notified by staff that resident had fallen in room during assisted transfer with Hoyer lift. On assessment resident observed lying on back at foot of bed, legs facing towards hallway. Resident alert to verbal and tactile stimuli, no s/s of pain. Golf ball sized bump noted to back right side of head, small amount of blood noted at site. Mechanical lift noted in raised position towards middle of bed. Hoyer sling attached to lift at 3 of 4 hooks. Head to toe assessment, neuros initiated, in-service staff that was in room during transfer. Tylenol administered to resident. Medical director/NP/RP, hospice notified. Vitals WNL. Record review of a progress note for Resident #2, dated 6/21/2025, by LVN O at 12:50 PM, indicated, .RP arrived at facility, declines ER eval, educated on possible risks associated with fall and head trauma, states understanding.Record review of a progress note for Resident #2, dated 6/21/2025, by LVN O at 2:15 PM indicated, .RN with hospice arrived at facility for assessment, education provided on risks associated with fall and head trauma by RN with hospice, RP still declines ER eval.Record review of a signed witness statement, dated 6/21/2025, by CNA A, indicated, it was time to get [Resident #2] up and we went to her room, and I checked her and placed the Hoyer pad underneath her. I then brought the Hoyer over her and hooked her onto it and then lifted her up. Once I was done lifting her up, I moved the Hoyer and Resident #2 fell. We checked on her.Record review of a signed witness statement, dated 6/21/2025, by Hospitality aide B, indicated, we went to get Resident #2 up when she got her up, I got up and went to help move her and she fell out the pad.Record review of a counseling/disciplinary notice for CNA A, dated 6/21/2025, indicated her date of hire was 11/25/2024 and the notice was a suspension for incorrect use of Hoyer lift causing injury and did not use spotter during transfer. Corrective action was suspension pending investigation. Sent home by LVN O. Signed by CNA A and the DON.Record review of a counseling/disciplinary notice for CNA A, dated 6/25/2025, indicated a discharge with last day worked 6/21/2025. Corrective action was termination. Signed by CNA A and the DON.Record review of a counseling/disciplinary notice for Hospitality aide B, dated 6/21/2025, indicated her date of hire was 2/6/2025 and the notice was a suspension for improper use of Hoyer lift, on the phone at time of incident. Corrective action was in-service and suspension. Signed by Hospitality aide B and the DON.Record review of a counseling/disciplinary notice for Hospitality aide B, dated 6/25/2025, indicated a discharge with last day worked 6/21/2025. Corrective action was termination. Signed by the DON. Hospitality aide B was contacted by phone because she did not have a babysitter.Record review of an x-ray report for Resident #2, dated 6/29/2025, indicated an x-ray of her right hip reflected: bones were osteoporotic with an acute femoral neck fracture During an observation of video evidence in the room |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675900 | A. Building<br>B. Wing | 07/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| River Pointe of Trinity Healthcare and Rehabilitat | 808 S Robb<br>Trinity, TX 75862 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675900 | A. Building<br>B. Wing | 07/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| River Pointe of Trinity Healthcare and Rehabilitat | 808 S Robb<br>Trinity, TX 75862 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews 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 for 1 of 6 residents (Resident #4) and 2 of 4 staff (CNA C and CNA D) reviewed for infection control. 1.The facility failed to ensure CNA C and CNA D followed EBP (enhanced barrier precautions) for Resident #4 when providing care on 7/28/2025. 2. The facility failed to ensure CNA D changed gloves and washed or sanitized her hands when providing care to Resident #4 on 7/28/2025.These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices.Findings include: Record review of an admission Record for Resident #4, dated 7/28/2025, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Record review of active physician orders for Resident #4, dated 7/28/2025, indicated he had diagnoses which included pneumonia (lung infection), emphysema (chronic lung disease that leads to shortness of breath and difficulty breathing) and Huntington's Disease (an inherited condition that causes the nerve cells in the brain to die). He had an order for enhanced barrier precautions and PPE was required for high resident contact care activities, wounds every shift that started on 5/29/2025.Record review of a Quarterly MDS Assessment for Resident #4, dated 6/4/2025, indicated he was rarely/never understood and had a BIMS score was not calculated. He was dependent on staff for all ADL's. He was always incontinent of bowel and bladder. He had one or more unhealed pressure ulcers.Record review of a care plan for Resident #4, dated 5/22/2025, indicated he had a pressure ulcer related to adult failure to thrive (weight loss from poor nutrition) and impaired mobility. Interventions included to use enhanced barrier precautions.During an observation on 7/28/2025 at 11:22 AM, revealed Resident #4's door had PPE hanging on the door which consisted of gowns and gloves on the wall in the room. Resident #4 was sitting in a wheelchair and CNA C and CNA D were in the room to transfer him using a mechanical lift. Both staff sanitized their hands and donned (put on) gloves. Resident #4 was transferred from his wheelchair to his bed by CNA C and CNA D using a mechanical lift. CNA C removed her gloves, placed them in the trash, washed her hands in the bathroom and exited the room. CNA D remained in the room and performed incontinent care and did not perform hand hygiene or change her gloves. CNA D opened Resident #4's brief and used wipes to clean his penis and placed the wipes in the trash. CNA D rolled Resident #4 onto his right side, removed the brief, placed it in the trash and she cleaned Resident #4's rectal area with wipes and placed them in the trash. CNA D placed a clean brief underneath Resident #4's buttocks and rolled him onto his back and secured it. CNA D removed her gloves and placed them in the trash and washed her hands in the bathroom. During an interview on 7/28/2205 at 1:51 PM, CNA D said she had been at the facility since around the middle of June 2025 and worked 12-hour shifts from 6 am to 6 pm. She said she rotated halls when she worked and did not have an assigned hall. She said the PPE on the door for Resident #4 was to be worn when wound care was provided only. She said she was not assigned to the hall with Resident #4 all the time. She said she did not change her gloves when she changed him and was not sure why she did not and should have changed her gloves after the transfer and when she changed from removing dirty items to clean items. She said she sanitized her hands before care was started but she did not touch anything else. She said she would normally have extra gloves with her because the door was locked to get gloves from the supply closet. She said residents could be at risk for infections and bacteria from not changing gloves. She said she received training on infection control and enhanced barrier precautions. During an interview on 7/29/2025 at 10:57 AM, CNA C said on 7/28/2025, when she assisted with putting Resident #4 in bed, she should have put on a gown. She said the resident had a wound and was on EBP. She said she forgot and was not thinking she needed to put on a gown. She said the resident's door had PPE present for the staff which included gowns and gloves. She said she had training on EBP a while ago. She said residents could be at risk for infections if they did not follow proper procedures when residents were on EBP.During an interview on 7/29/2025 at 11:31 AM, the Staffing Coordinator said she was responsible for skills check offs with nurse aides and did a round with them during orientation and checked them annually and as needed. She said all staff were trained on EBP a while ago by the previous ADON, but new hires and all staff were trained on EBP. She said Resident #4 was on EBP and if direct patient care was provided to him then the staff needed to wear a gown and gloves while care was performed. She said he had a wound and was on EBP. She said hand hygiene |