STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675900	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Pointe of Trinity Healthcare and Rehabilitat	808 S Robb 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents who are unable to carry out activities of daily living received the necessary services to maintain good personal hygiene for 1 of 5 residents (Resident #1) reviewed for ADL care in that: The facility failed to ensure Resident #1 was provided appropriate incontinent care when CNA A and CNA B put a wet brief on her after providing incontinent care. This failure could place all residents at risk of loss of dignity, skin breakdown, infection, and hospitalization.Findings included: 1. Review of an admission record dated 4/6/26 for Resident #1 indicated she was a [AGE] year-old female readmitted to the facility on [DATE] with diagnoses of dementia (altered cognition), type 2 diabetes, and stage 4 sacral((first and second vertebrae of the lower spine toward top part of buttocks) pressure ulcer (wound that extends through the skin and underlying tissues). Record review of an assessment MDS dated [DATE] indicated Resident #1 had severely impaired cognition with a BIMS of 1. She required total assistance with toileting hygiene, shower/bathing, and lower body dressing. Review of a comprehensive care plan dated 2/4/26 indicated Resident #1 had a pressure ulcer to sacrum. Interventions were in place including bolster air mattress, nutritional supplements, monitoring sacrum dressing, notifying the nurse of any change to skin, and providing wound care as ordered. Record review of a comprehensive care plan dated 2/13/26 indicated Resident #1 had bowel and bladder incontinence related to impaired mobility. Interventions were in place including checking the resident for incontinence needs as required and assisting with incontinence episodes. During an interview on 4/1/26 at 10:55 a.m., LVN A said she worked PRN as the treatment nurse. LVN A said she had already completed wound care that day for Resident #1. LVN A said the last time she visualized the wound was approximately 2 weeks ago and she noted no significant changes. LVN A said Resident #1 was admitted with the pressure ulcer, but was unsure what stage it was on admission. LVN A said Resident #1 was incontinent of bowel and bladder and did not alert staff when she had an incontinent episode which complicated her wound healing. LVN A said staff rounded on residents every 2 hours at a minimum and as needed. During an observation on 4/1/26 at 11:10 a.m., revealed LVN A conducted a skin assessment on Resident #1. LVN A put on appropriate PPE and utilized correct technique while assessing Resident #1's skin. A bandage was observed in place on Resident #1's sacrum dated 4/1/26 at 8:50 a.m. No other skin integrity concerns were noted or observed. Resident #1 was repositioned lying on her left side. During an observation on 4/1/26 at 3:19 p.m., revealed CNA B and CNA C assisted Resident #1 with incontinent care. During the care process a clean brief was placed underneath Resident #1 and positioned underneath her buttocks. While the clean brief was in position underneath Resident #1 CNAs B and C rolled her onto her left side to reposition her, which caused Resident #1 to urinate on the clean brief that was under her. CNA C asked CNA B if Resident #1 urinated on her and CNA B said, yes, a little, as CNA B blotted the standing urine on the brief with wet wipes and CNA B and CNA C continued applying the wet brief to Resident #1. During an interview on 4/1/26 at 3:52 p.m., CNA C said she rounded on residents every 2 hours and addressed needs including skin checks to report findings to nurse, incontinent care, call light accessibility, and any other needs the resident had. CNA C said she was unsure why she and CNA B put a wet brief on (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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1. CNA B said it was not an acceptable practice and risks to the resident could include skin breakdown or an infection. During an interview on 4/1/26 at 4:00 p.m., CNA B said she rounded on residents every 2 hours. CNA B said she addressed resident needs including checking for skin issues/bruising, call light placement, water, and ask the residents for any other needs. CNA B said she did not have an answer why she placed a wet brief on Resident #1. CNA B said she should have stopped and gotten a new brief for Resident #1. During an interview on 4/1/26 at 4:15 p.m., RN D said she was responsible for supervising nursing staff including CNAs. RN D said it was her expectation that CNA staff rounded on every resident within 2 hours or as needed. RN D said staff should be addressing toileting needs, comfort needs, positioning, hydration, call light placement, remote control placement, and bed in low position. RN D said it would never be acceptable to put a wet brief on a resident due to increased risk of skin breakdown or infection. During an interview on 4/1/26 at 4:25 p.m., the ADON said she was responsible for supervising nursing staff including nurses and CNAs. The ADON said she expected CNAs to round on residents every 2 hours. The ADON said Resident #1 was care planned to be repositioned every 2 hours and incontinent care was provided every 2 hours unless needed sooner. The ADON said it was not acceptable to put a wet brief on a resident and could potentially lead to skin integrity issues or potential infection. During an interview on 4/1/26 at 4:35 p.m., the LCSW said she was the designee when the ADM was unavailable. The LCSW said she was responsible for supervision of the nursing department when the ADM was out of the building. The LCSW said it was her expectation that residents who were incontinent of bowel/bladder were rounded on as often as necessary but at a minimum of 2 hours. The LCSW said putting a resident in a wet brief could lead to skin integrity issues and infection. During multiple observations approximately every 2 hours on 4/1/26 and 4/2/26 from 10:30 a.m. to 4:45 p.m., Resident #1 was being provided regular incontinent care as well as repositioning from side-to-side in bed. The resident appeared clean and well-groomed during all observations with no noted offensive odors. There were no noted suspicious marks, bruising, or skin tears. During an interview on 4/2/26 at 10:00 a.m., the DON said Resident #1 was admitted with a Stage 4 sacral ulcer. The DON said the resident was evaluated by the physician and a Determination of Clinically Unavoidable Pressure Ulcer was prepared and signed by the physician. The DON said the facility did not have an unavoidable decline form prepared due to wanting to try everything possible to assist residents. The DON said every time Resident #1 was turned, she would dribble a small amount of urine and there was no harm posed to the resident from wearing a wet brief unless the brief indicator line showed it was time to change the brief. Review of a Determination of Clinically Unavoidable Pressure Ulcer dated 2/4/26 for Resident #1 indicated the resident was admitted with a pressure ulcer which was unable to be resolved due to medical history and diagnoses. The determination form was signed by Resident #1's physician on 2/5/26. During an interview on 4/2/26 at 10:40 a.m., the NP said he was a wound care provider and saw Resident #1 every Tuesday for wound care. The NP said he felt the facility was doing everything they could do to provide care for Resident #1 because she saturates herself all the time. The NP said he believed Resident #1 was admitted to the NF with the stage 4 ulcer present. The NP said he felt the resident's decline was in part unavoidable. The NP said the wound did not increase drastically in size; the wound consisted of nonviable tissue which had been debrided (removed) which increased the wounds measurements. During an interview on 4/2/26 at 11:45 a.m., the ADM said she was responsible for supervising all staff in the building including nursing staff. The ADM said it was not appropriate to put a wet brief on a resident but said if there was only a small amount of urine it might not pose any risk to residents. During an interview on 4/2/26 at 12:00 p.m., Resident #1's family member said she had frequently found Resident #1 wet, but she could not provide any specific dates or details. Resident #1's family member said lately the care has gotten much better and Resident #1 was receiving prompt attention for incontinent care and repositioning. Review of a facility skills checklist for Incontinent Care for CNA C indicated she completed incontinent care skills check-off on 12/3/25 with no concerns noted. Review of a facility skills checklist for Incontinent Care for CNA B indicated she (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed incontinent care skills check-off on 1/23/26 with no concerns noted. Review of a facility policy titled Section: Peri-care, Subject: Incontinence Care indicated .Assist the resident with donning a new disposable incontinent brief and/or clean clothing as preferred by the resident.