

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676439	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Trinity Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 314 E Caroline St 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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>43994</p> <p>Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety requirements and kitchen sanitation.</p> <p>The facility failed to ensure the DM and [NAME] wore a hairnet effectively to cover all of their hair on 8/27/2024.</p> <p>The failure could place residents at risk of foodborne illness and food contamination.</p> <p>Findings included:</p> <p>During an observation in the kitchen on 8/27/2024 at 9:20 AM, revealed the DM was wearing a hair net that did not completely cover her hair. The DM had a long ponytail that went down her back hair that was not covered by the hairnet.</p> <p>During an observation in the kitchen on 8/27/2024 at 9:30 AM, revealed the [NAME] was wearing a hair net that did not completely cover her hair. She had hair that was exposed on the sides of her head by her ears and at the back of her head.</p> <p>During an observation and interview on 8/27/2024 at 9:35 AM, the DM said all staff who worked in the kitchen should wear a hair net that covered all their hair. She said she did not know that she had hair out at the back of her head and needed to put it up in a bun. She said she would fix it. She informed the [NAME] that she had hair exposed and the [NAME] told her she did not know her hair was not completely covered by her hair net and would fix it. The [NAME] immediately started putting her hair in the hairnet and the DM instructed her to go to the bathroom to fix her hair and wash her hands before returning to continue the food prep. The [NAME] said hair could fall into the food if hair was not covered properly. The DM said not having hair completely covered while in the kitchen would be unsanitary and hair could fall into the food.</p> <p>During an interview on 8/28/2024 at 11:42 AM, the Administrator said he had been employed at the facility since April 2023. He said he was aware of the incident in the kitchen with staff on yesterday 8/27/2023 when staff were observed not wearing hair nets properly. He said when staff were in the kitchen they should have on a hairnet and if not worn properly hair could fall into the food. He said they conducted in-services yesterday 8/27/2024 with the kitchen staff over hair nets.</p> <p>(continued on next page)</p>

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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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Record review of a facility policy titled Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices revised October 2017 indicated, .Food and nutrition services employees will follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. 12. Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils, and linens .</p> <p>Record review of the FDA Food Code 2022 indicated, .Chapter 2. Management and Personnel; 2-402 Hair Restraints: Food employees shall wear hair restraints such as hats, hair coverings or nets that are designed and worn to effectively keep their hair from contacting exposed food .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994</p> <p>Based on observations, interviews, and record review 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 #6) and 1 of 8 staff (CNA A) reviewed for infection control.</p> <p>CNA A did not sanitize or wash her hands between glove changes when providing incontinent care to Resident #6 on 8/27/2024.</p> <p>The failure could place residents at risk of exposure to infectious diseases due to improper infection control practices.</p> <p>Findings included:</p> <p>Record review of an Admission Record dated 8/28/2024 for Resident #6 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of other psychotic disorder (lose touch with reality), abnormalities of gait and mobility (difficulty walking) and hypertension.</p> <p>Record review of a Quarterly MDS assessment dated [DATE] for Resident #6 indicated she had severe impairment in thinking with a BIMS score of 3. She was totally dependent of staff with toileting hygiene. She was always incontinent of urine and bowel.</p> <p>Record review of a care plan dated 1/17/2022 and revised on 6/21/2023 for Resident #6 indicated she had bladder incontinence related to history of UTIs with interventions to clean peri-area with each incontinent episode.</p> <p>During an observation on 8/27/2024 at 10:28 AM in the room of Resident #6, revealed CNA A was in the room to provide incontinent care. CNA A sanitized her hands before applying gloves to both hands. CNA A pulled down Resident #6's brief between her legs and removed wipes from the container. She placed the wipes on Resident #6's abdomen and took a wipe and wiped down the right inner thigh and placed the wipe in the trash. She took another wipe and wiped down the left inner thigh and placed it in the trash. She took a wipe and wiped down the middle of the vagina from front to back and placed the wipe in the trash. She rolled Resident #6 onto her right side, and removed a wipe and wiped her rectum from front to back and placed the wipe and brief in the trash. She removed her gloves and placed them in the trash, and placed clean gloves on her hands without washing or sanitizing them. She placed a clean brief underneath the resident's buttocks and secured it. Resident #6 was repositioned in her bed. CNA A gathered the trash and removed the glove from her right hand and placed it in the trash. She exited the room and walked out into the hall with a glove on her left hand to dispose of the trash. CNA A sanitized her hands after disposing of the trash.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/27/2024 at 10:37 AM, CNA A said she had been employed at the facility for 2 years. She said she had skills check off with the previous DON. She said she should have sanitized her hands between glove changes. She said should not have walked out of the room in the hallway with a glove on. She said she always used a glove to take the trash in the hallway because she did not want to touch the trash with her bare hands. She said there was a risk for infections to the residents if staff did not wash or sanitize their hands. She said she usually had sanitizer attached to her pocket or used the ones on the walls in the resident rooms.</p> <p>Record review of a skills competency check off with CNA A dated 9/1/2023 indicated she completed a perineal care/incontinent care for a female resident.</p> <p>During an interview on 8/28/2024 at 11:11 AM, the DON said she was in the process of getting her Infection Preventionist Certificate but that the Administrator had one. She said she had been employed at the facility since September 2023, but started a new role as the DON on 8/15/2024. She said she would be responsible for conducting the skills check off with staff and had planned on completing them next week. She said the skills check off should be conducted on hire and annually. She said she was not aware of the incident with Resident #6 yesterday 8/27/2024. She said staff should be washing or sanitizing their hands before entering the room, between glove changes, and anytime hands were soiled. She staff should not leave the room and enter the hallways with gloves on. She said there was a risk of cross contamination of spreading germs to other residents.</p> <p>Record review of a facility policy titled Handwashing/Hand Hygiene dated August 2019 indicated, .This facility considers hand hygiene the primary means to prevent the spread of infections. 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: a. Before and after coming on duty; m. After removing gloves .</p>		