STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676439	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Rehabilitation & Healthcare Center	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)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50071 Based on interview and record review, the facility failed to ensure the right to be free from misappropriation of property was provided for 1 of 3 residents reviewed for misappropriation of property. (Resident #17) The facility failed to prevent a diversion (misappropriation) of Resident #17's Hydrocodone-Acetaminophen 10-325mg tablets (a combined hydrocodone/acetaminophen narcotic pain reliever) on December 31, 2024. This failure could place residents at risk for decreased quality of life, unrelieved pain, misappropriation of property, and dignity. Findings include: Record review of an undated face sheet for Resident #17 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: Unspecified Fracture of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing, Urinary Tract Infection, Cognitive Communication Deficit, Repeated Falls. Record review of an Annual MDS dated [DATE] for Resident #17 indicated that he had a BIMS score of 09, indicating that he was moderately cognitively impaired. He was documented as receiving an opioid for the entire 7 day look back period. Record review of physician's orders for Resident #17 indicated that he had an active order for hydrocodone-acetaminophen 10-325mg, 1 tablet by mouth every 6 hours (prn) dated11/22/24. Record review of a medication administration record for Resident #17 for the month of December 2024 indicated the resident received hydrocodone routinely at 12:00 am, 6:00 am, 12:00 pm, and 6:00 pm. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/24/25 11:00am with MA L she said she's aware of the incident with Resident #17 medication(narcotic) count being off. She said the procedure for receiving medication (narcotics) from pharmacy delivery is for two nurses and the pharmacy representative to count, checks for discrepancies, and make sure all medication (narcotics) is accounted for. She said they all will sign two forms verifying the medication and count is correct. One form stays at the facility and be placed in the facility's records and one form is given to the pharmacy representative for their record. She said if there are discrepancies the nurses should have caught it and not signed for the medication. During an interview on 2/24/25 10:50am with LVN K she said she was on duty the day Resident #17's medications were reported missing. She said the medication came into the facility right at shift change. She said that she was informed of the incident by the administrator, DON and police interviewing her about the incident. She said the procedure to check in medications is to look at the name of the medication ordered, check the amount of medication delivered and log it in on medication. She said two nurses and the pharmacy delivery person are to check the medications together and all are to sign a medication log indicating the medication and count are correct. She said the facility will keep one copy for their records and the pharmacy delivery person will take a copy with him. She said medications are always to be kept locked up at all times. One blister pack is kept in a locked med cart and if there are extra blister packs, they are to be locked in the overflow box in the locked medication room. During an interview on 2/24/25 11:15am with LVN G said she's a full-time employee and is aware of the medication for resident #17 being missing. She said during report she was told that a whole card of Narco's (Hydrocodone-Acetaminophen 10-325mg tablets, a combined hydrocodone/acetaminophen narcotic pain reliever) were missing. She said she was not aware how many pills were on the card. She said two nurses and the pharmacy delivery person should have counted, and signed off on a medication log that all medications were accounted for. The medication should have then been put in a locked med cart or in their overflow lock box. She said there were a break in the process as all nurses are trained on delivery and storage of all medications including narcotics. During an interview on 2/24/25 12:56 am with RN H she said she's aware that Narco's (Hydrocodone-Acetaminophen 10-325mg tablets, a combined hydrocodone/acetaminophen narcotic pain reliever) for resident #17 went missing. She said all the nurses have been questioned about resident 17's missing medication and in-serviced on the process of medication storage, missing medications, drug administration and accepting and delivery of medications. She said two nurses are supposed to get with the person delivering the medication, count the medication and assure they are correct. Then sign an inventory form verifying the receipt of the medications and that the count and medications are correct and put a copy of the inventory form in the facility binder and give one to the person delivering the medications from the pharmacy. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/24/25 3:30 pm with the DON she said she was notified about the missing Narco's (Hydrocodone-Acetaminophen 10-325mg tablets, a combined hydrocodone/acetaminophen narcotic pain reliever) of resident #17 by the nurses on duty. Once she and the other staff realized the medication could not be found they called the police who came and searched for the missing medication by questioning the staff that was present. She said they also contacted the pharmacy who stated the medication was delivered and signed for. She said the nurses did not appropriately sign off on the medications correctly or as trained. She said two nurses along with the pharmacy representative are supposed to make sure the name of medication, dosage and amount of medication is correct, and the correct medications are present and all three are to sign a consent agreeing the medications are correct and place the medication in a locked storage cart or a locked medication room. She said the staff is to place the signed consent in the facility logbook and give the pharmacy staff a copy. During an interview on 2/24/25 3:45 pm with the ADMN, she said she's very aware of the missing medication for resident #17. She said 116 Norco's (Hydrocodone-Acetaminophen 10-325mg tablets, a combined hydrocodone/acetaminophen narcotic pain reliever) were delivered to the facility on [DATE] and only 58 Narco's were found in the medication cart. She said there were two blister packs of Narco's with 58 pills each according to the sign in sheet. She said she called the police and reported the missing Narco's. She said the police came and questioned the staff and provided her a case number did not give her a police report. She said when medications are delivered two nurses along with the pharmacy delivery person should have identified, counted, and assured the medication and were correct. Once the count and medication are deemed correct all three should sign a consent form verifying the medication and count are correct. One copy of the signed consent is to be put in the facility binder for Narcotics and a copy provided to the pharmacy delivery person. Record review of a facility policy titled Facility Abuse Prevention and Prohibition Policy dated 2001 with revision of December 2022 indicated CMS defines misappropriation of resident property as, the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Record review of a facility policy titled Accepting Delivery of Medications dated 2001 with revision date of February 2001 indicated Upon Receipt a. Two licensed nurses and the individual delivering the medication verify the name of the medication, dose and quality of each controlled substance being delivered. b. All individuals sign the controlled substance record of receipt. C. An individual resident-controlled substance record is made for each resident who is receiving a controlled substance. The record contains:1). name of resident; 20. Name and strength of the medication. Record review of a facility policy titled Abuse Prevention Program dated 2001 with revision date of June 2021 indicated .2. Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation . Record review of a facility policy titled Accepting Delivery of Medications dated 2001 with revision date of April 2019 indicated . (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy heading 1. All staff shall follow a consistent procedure in accepting medications. 2. Any errors noted in receiving medications shall be brought to the attention of the pharmacist and director of nursing services. Policy Interpretation and Implementation 1. Each medication delivery shall be personally accepted by two licensed personnel. 2. Before signing to accept the delivery, both licensed personnel must reconcile the medications in the package with the delivery ticket/order receipt. 4. Both nurses and the delivery personnel shall sign the delivery ticket, indicating review and acceptance of the delivery, and shall keep a copy of the delivery ticket. Both receiving nurses and the delivery agent must sign and make any notations about errors.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on interview and record review, the facility failed to ensure the baseline care plan that included the instructions for resident care needed to provide effective and person-centered care was completed for 3 of 6 residents reviewed for new admissions (Resident #167, #174, and #175). The facility failed to complete baseline care plans within 48 hours of admission for Residents #167, #174, and #175. This failure could place residents at risk of not receiving care and services to meet their needs. Findings included: Record review of a facility face sheet dated 2/25/25 for Resident #167 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis of cellulitis (skin infection). Review of an electronic medical record for Resident #167 indicated that no baseline care plan was completed. Review of a Nursing Home PPS MDS assessment dated [DATE] for Resident #167 indicated she had a BIMS score of 14 indicating that she was cognitively intact. She required partial/moderate assistance with toileting, showering, and dressing. She was occasionally incontinent of bowel and bladder. She had a diabetic foot ulcer, an infection of the foot, and was receiving application of dressings to feet (with or without topical medications). Record review of a facility face sheet dated 2/27/25 for Resident #174 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis of displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing (hip fracture at the top part of the thigh bone). Record review of an electronic medical record on 2/27/25 for Resident #174 indicated that no comprehensive MDS assessment had not yet been completed. Record review of a baseline care plan initiated 2/26/25 for Resident #174 indicated that it was not implemented within 48 hours of admission. Record review of a facility face sheet dated 2/24/25 for Resident #175 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including sepsis due to methicillin resistant staphylococcus aureus (Methicillin-resistant Staphylococcus aureus or MRSA is a staph infection that has become immune to many types of antibiotics; sepsis is when the body has a severe, inflammatory response to bacteria or other germs). (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a comprehensive MDS assessment dated [DATE] for Resident #175 indicated that she had a BIMS score of 15, which indicated that she was cognitively intact. She had a surgical wound and was receiving IV medications. Record review of a baseline care plan indicate that it was not initiated until 2/24/25 for Resident #175 and had the following special treatments/needs: IV Medications and Isolation. During an interview on 2/27/25 at 1:31 pm MDS nurse said DON was responsible for baseline care plans. She said the baseline care plans tell staff which necessities are needed, communicates with family and could affect discharge planning. She said going forward she would be doing admission chart checks to ensure they were completed. She said an LVN could not do them, and they must be done by an RN. During an interview on 2/27/25 at 1:38 pm DON said she was responsible for baseline care plans. She said the weekend RN was responsible for doing baseline care plans for admissions that came in on the weekend. She said if baseline care plans were not done, it could cause issues for resident care as the baseline care plan communicates residents' needs to the staff. She said she would ensure baseline care plans were done going forward. During an interview on 2/27/25 at 2:04 pm Administrator said if baseline care plans were not initiated appropriately that staff might not know how to care for the resident. She said going forward she would be implementing an audit process for new admissions. Record review of a facility policy titled Care Plans - Baseline dated 2001 and revised December 2016 read: . To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission .