

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  11/12/2025
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 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</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 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interviews, and record review, the facility failed to consult with the physician when the resident experienced a change in condition for 3 of 4 residents (Resident's #11, #12, and #13) reviewed for a change of condition.1. The facility failed to notify the wound care physician to obtain and implement wound care orders for Resident #11 until 10/20/25, 2 days after identifying unstageable pressure injury (a full-thickness tissue loss where the base of the ulcer is covered by slough or eschar, making it impossible to determine the depth of the wound) to right heel on 10/18/25.The facility failed to contact surgeon or wound care physician to obtain wound care orders for Resident #11 on 11/3/25 after debridement of pressure ulcer (the medical process of removing necrotic (dead) tissue from a wound) in surgeon's office on 11/3/25. 2. The facility failed to obtain and implement wound care orders for Resident #12 until 10/19/25 after admission on [DATE]. Resident was admitted with bilateral stage 4 pressure injuries (the most severe form of pressure ulcers. Deep, open wounds that extend through the skin and underlying tissues, potentially exposing muscle, tendons, or bone) to heels.3. The facility failed to monitor, and report wound status to wound care physician for Resident #13.An Immediate Jeopardy (IJ) was identified on 11/11/25 at 10:57 am. The IJ template was provided to the facility on [DATE] at 11:04 am. While the IJ was removed on 11/12/25 at 6:34 pm, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm due to the facility's need to monitor and evaluate the effectiveness of the plan of removal and corrective actions.These failures could place residents at risk for developing new pressure injuries, infections, decreased quality of life, and death.Findings included:1. Record review of a face sheet dated 11/10/25 for Resident #11 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: pneumonia (an infection that inflames the air sacs in one or both lungs), dementia (a disease that affects memory, thinking, and the ability to perform daily activities), and nondisplaced fracture of first metatarsal bone (fracture of the big toe), right foot. Record review of a Medicare 5-day MDS assessment dated [DATE] for Resident #11 indicated a BIMS score of 15 indicating she was cognitively intact. She required moderate to maximum assistance with most ADLs. She was not coded for pressure ulcers.Record review of a comprehensive care plan dated 9/9/25 for Resident #11 indicated she had potential for alteration in skin integrity due to impaired mobility and had an intervention to inspect skin from head to toe no less than once per week and document/measure all abnormal findings. She also had an intervention to inform physician, family, dietician, and director of nursing of any new skin breakdown.Record review of an electronic health record for Resident #11 on 11/10/25 indicated there were no skin assessments completed between the dates of 9/2/25 and 9/15/25 and no skin assessments documented between the dates of 10/18/25 to 11/10/25. There was no physician's order for skin assessments.Record review of a nursing progress note dated 10/18/25 at 8:12 pm and signed by RN K for Resident #11 indicated a new skin issue was identified; an unstageable pressure ulcer/injury to right heel. Note indicated wound measurements were 3cm X 2cm X 0.1cm and eschar was 100%. There was no documentation of physician notification.Record review of a physician's order summary report dated 11/12/25 for Resident #11 indicated the following physician orders: .consult Dr. [Wound physician name] for wound to r heel. dated 10/20/25 .wound location: right heel - skin prep daily unstageable PI to right heel. dated 10/20/25.wound location: right heel - clean wound with wound cleanser or NS, pat dry, apply medihoney and wrap with kerlix daily. dated 11/10/25. There was no order for wound care on 10/18/25 (the day wound was identified) There was no order for daily dressing changes dated 11/3/25 from surgeons' office visit.Record review of a Treatment Administration Record dated 10/1/25 to 10/31/25 for Resident #11 indicated she did not receive her wound care as ordered on 10/22/25 and 10/23/25.Record review of a Treatment Administration Record dated 11/1/25 to 11/30/25 for Resident #11 indicated she did not receive her wound care as ordered on 11/3/25, 11/7/25, and 11/8/25.Record review of a physician's office visit note dated 11/3/25 for Resident #11 indicated she had a physician visit on 11/3/25 to follow up with her foot surgeon. Note read: .Focused wound exam: Right lower extremity wound: surgical incision well healed however there is a full thickness, decubitus ulceration to the posterior heel with fluctuate eschar. Wound measurements were: 2.5cm X 1.1cm X 0.1cm. Excisional debridement was performed and post debridement measurements were 2.7cm X 1.2cm X 0.3cm. Documentation read: .Nature of tissues removed: devitalized tissue, fat necrosis, and slough.; wound care and dressing was applied and post-operative instructions read: .continue with daily dressing changes. 2 Record review of a facility face sheet dated 11/10/25 for Resident #12</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to make sure a comprehensive care plan was prepared by an interdisciplinary team, that included but not limited to the participation of the resident and the resident representative for 1 of 10 residents (Resident #2) reviewed for care plans. The facility failed to ensure Resident #2, and her representative were invited and attended the resident care plan conferences. This failure could place residents at risk of not receiving the care and services to meet their needs. Findings include: Record review of an admission Record for Resident #2 dated 11/5/2025 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of major depressive disorder (persistent sadness or loss of interest in doing things), type 2 diabetes, and hypertensive heart disease with heart failure (high blood pressure that makes it difficult for the heart to pump blood through the body). Record review of a Significant Change MDS assessment dated [DATE] for Resident #2 indicated she did not have any impairment in thinking with a BIMS score of 15. She required set-up or clean-up assistance with eating and oral hygiene but was dependent on staff for toileting. Resident #2 was active in participating in the assessment and goal setting. Record review of a Quarterly IDT care plan conference summary dated 3/12/2025 for Resident #2 indicated she was in attendance in person, and her representative was in attendance via phone. All aspects of care were discussed including medications and her care plan. The conference summary was electronically signed by the MDS Coordinator. Record review of Resident #2's care plan conference summaries indicated there were not any other conferences since 3/12/2025. Record review of the care plan meetings scheduled from June 2025 to November 2025 for the facility indicated that Resident #2 was scheduled for a care plan meeting on 6/11/2025 but she was in the hospital. The care plan meeting was not rescheduled. During a phone interview on 11/3/2025 at 11:34 AM, the RP for Resident #2 said the last care plan meeting that they were invited to was in March 2025. She said she was not sure why the facility had not contacted her for one. During an interview on 11/10/2025 at 2:40 PM, the MDS Coordinator said she was responsible for conducting the care plan meetings. She said the facility had care plan meetings weekly and each resident in the facility would have a care plan meeting quarterly and as needed. She said Resident #2's last care plan meeting was 3/12/2025. She said Resident #2 was scheduled for a care plan meeting in June 2025 but was in the hospital at that time. She said she was not sure why Resident #2 had not been scheduled for a care plan meeting. She said the care plan meetings were conducted with the residents/RP's to address any questions or concerns that they may have and also discuss their plan of care including code status and medications. She said the IDT team attended the care plan meetings which included the DOR, SW, DM, Activities and a CNA. She said if care plan meetings were not held then the facility would not know if the resident or representative had any concerns or questions. She said she did realize to put Resident #2 back on the monthly schedule for a care plan meeting after she went to the hospital in June 2025. During an interview on 11/12/2025 at 10:19 AM, the AD said she was part of the IDT team and they met once a week for care plan meetings. She said the MDS Coordinator was responsible for conducting and setting up the meetings. She said some residents attended the meetings and some families attended on the phone. She said she did not remember the last time they had a care plan meeting for Resident #2. She said during the meetings they discussed the residents medications, any changes, preferences or concerns they may have. During an interview on 11/12/2025 at 1:36 PM, the DOR said he had been employed at the facility for 1.5 years and he was a part of the IDT team. He said he attended the care plan meetings once a week and the MDS Coordinator was responsible for scheduling the meeting. He said sometimes residents attended the meeting and some family members would attend via phone conference. He said they discussed everything from their care, medications, likes and preferences and anything that came up such as complaints or concerns and they tried to correct the issues. He said it had been a while since Resident #2 had a care plan meeting and was unable to recall when her last care plan meeting was held. He said the residents had a care plan meeting about every couple of months. He said having the meetings was a benefit and the facility would not know what was going on with the entire team if they did not have the meetings. During an interview on 11/12/2025 at 3:19 PM, the DM said she had been employed at the facility since March 2025 and was part of the IDT team. She said the facility had care plan meeting every week and the residents received notification from the MDS Coordinator about the meeting once a week and sometimes the families would attend over the phone. She said that day (11/12/2025) they had a meeting with</p>		

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F 0684  Level of Harm - Actual harm  Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals.  (continued on next page)

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record reviews, the facility failed to ensure that residents received care and services in accordance with professional standards of practice for 4 of 11 residents (Resident #1, # 7, #14, and #15) reviewed for quality of care.1.The facility failed to ensure RN A assessed, provided care, conducted and documented a neuro assessment, and notify the physician and family when Resident #1 fell and hit her head on 10/30/2025. 2. The facility failed to ensure a head-to-toe skin assessment was completed by a nurse after CNA G identified possible ant bites to Resident #15 on 10/9/25, and Residents #7 and #14 on 10/10/25. These failures could place residents at risk for not receiving appropriate care and treatment and or decline in their health. The findings included: 1. Record review of an admission Record for Resident #1 dated 11/5/2025 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of dementia (loss of thinking, remembering, and reasoning skills), age related osteoporosis (brittle bones due to age), hypertension (high blood pressure), and atrial fibrillation (irregular heart rhythm). Record review of a Quarterly MDS Assessment for Resident #1 dated 10/8/2025 indicated she had severe impairment in thinking with a BIMS score of 3. She required partial/moderate assistance with sitting to standing. She required the use of a manual wheelchair for mobility. She had two falls since admission/entry without injury. Record review of a care plan for Resident #1 revised on 10/29/2025 indicated she had an actual fall. Interventions included: immediately after fall, assess resident for injury, obtain vital signs and initiate neuro checks. If unwitnessed or head involved, continue neuro checks and vital signs every 15 min x 1 hr., every 30 min x2 hr., every hr. x2 hrs. and every shift x72 hrs. Record review of a 24-hour report for Resident #1 dated 10/30/2025 indicated, knocked head on chair and has skin tear to mid forearm-small dressing in place. Record review of a 24-hour report for Resident #1 dated 10/31/2025 indicated, fall 10/30/2025 day shift, needs incident report and needs to notify family. Orders to send to ER. Record review of a progress note for Resident #1 dated 10/31/2025 at 5:37 AM by LVN N indicated, This nurse was asked by hall one aides if I was made aware of a fall resident had from morning shift. There is no incident report or note placed in chart. Record review of a progress note for Resident #1 dated 10/31/2025 at 2:04 PM by LVN L indicated, Resident had a fall on previous day shift large abrasion on forehead, increased lethargy around breakfast, with c/o of dizziness, neuro in place at this time, called [EMS] for transport to ER for a CT of the head per Physician's orders. RP notified. Record review of a facility in-service signed and dated 10/31/2025 indicated 59 staff were trained on timely response, notification, and documentation of resident events. 2. Record review of a facility face sheet dated 11/10/25 for Resident #15 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: epilepsy (seizure disorder) and dysphagia (difficulty swallowing). Record review of a Quarterly MDS assessment dated [DATE] for Resident #15 indicated he was unable to complete a BIMS assessment due to being rarely/never understood and he had moderately impaired cognition. He was dependent with most/all ADLs. Record review of a comprehensive care plan dated 2/3/25 for Resident #15 indicated he had the potential for an alteration in skin integrity and had an intervention for LVNs and RNs that read: .Inspect skin from head to toe no less than one time per week and document/measure all abnormal findings. Record review of a facility form titled Skin Monitoring: Comprehensive C.N.A. Shower Review dated 10/9/25 and signed by CNA G for Resident #15 indicated CNA G identified bites to Resident #15's abdomen around his belly button. Bottom of form read .Turn into DON after skin issues have been addressed. Shower sheet had not been signed off on by a nurse. Record review of an electronic health record for Resident #15 on 11/10/25 indicated there was no skin assessment completed by a nurse on 10/9/25 for Resident #15 and no nursing progress note dated 10/9/25 indicating Resident #15 had been assessed by a nurse for bites. There were no weekly skin assessments documented between 9/25/25 and 10/23/25.3. Record review of a facility face sheet dated 11/10/25 for Resident #7 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including acute and chronic respiratory failure with hypoxia (when the body does not get enough oxygen, leading to a condition known as hypoxia), type 2 diabetes (uncontrolled blood sugar), and dementia (a disease that affects memory, thinking, and the ability to perform daily activities). Record review of a Quarterly MDS assessment dated [DATE] for Resident #7 indicated a BIMS score of 15, indicating her cognition was intact. She required minimal assistance/was independent with most ADLs. Record review of a comprehensive care plan dated 6/15/22 for Resident #7 indicated she had the potential for alteration in skin integrity and had an</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record review, the facility failed to ensure the necessary treatment and services, in accordance with comprehensive assessment and professional standards of practice, to prevent development of pressure injuries was provided for 4 of 4 Residents (Resident's #11, #12, #13, and #16) reviewed for pressure injuries. 1. The facility failed to complete weekly skin assessments after 10/18/25 for Resident #11 who admitted on [DATE] after ORIF (Open Reduction Internal Fixation) for fracture to right foot. She was admitted with no pressure ulcers and developed an unstageable pressure injury to Right heel on 10/18/25. The facility failed to obtain and implement wound care orders for Resident #11 for 2 days after identifying unstageable pressure injury to right heel on 10/18/25. The facility failed to implement dietary recommendations from 10/28/25 from the dietician for Resident #11. The facility failed to perform wound care treatments for 5 days in October and November 2025 for Resident #11. 2. The facility failed to obtain and implement wound care orders for Resident #12 until 10/19/25 after admission on [DATE]. Resident was admitted with bilateral stage 4 pressure injuries to heels. The facility failed to complete head to toe skin assessment for Resident #12 on 10/25/25. The facility failed to perform wound care as ordered for Resident #12 for 3 days in October and November 2025. 3. The facility failed to prevent deterioration of an existing pressure wound for Resident #13 when on 10/20/25 an existing stage 3 pressure wound progressed to a stage 4 pressure injury and increased in size. The facility failed to perform wound care as ordered for Resident #13 for 10 days in October and November 2025. The facility failed to complete weekly skin assessments after 10/8/25 for Resident #13. The facility failed to implement intervention of low air loss mattress from care plan dated 10/29/25 for Resident #13. 4. The facility failed to perform wound care as ordered for Resident #16 for 10 days for October 2025. The facility failed to complete weekly skin assessments for Resident #16 after 10/5/25. An Immediate Jeopardy (IJ) was identified on 11/11/25 at 10:57 am. The IJ template was provided to the facility on [DATE] at 11:04 am. While the IJ was removed on 11/12/25 at 6:34 pm, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm due to the facility's need to monitor and evaluate the effectiveness of the plan of removal and corrective actions. These failures could place residents at risk for developing pressure injuries, decreased quality of life, infections, and death. Findings included: 1. Record review of a facility face sheet dated 11/10/25 for Resident #11 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: pneumonia (an infection that inflames the air sacs in one or both lungs), dementia (a disease that affects memory, thinking, and the ability to perform daily activities), and nondisplaced fracture of first metatarsal bone (fracture of the big toe), right foot. Record review of a Medicare 5-day MDS assessment dated [DATE] for Resident #11 indicated a BIMS score of 15 indicating she was cognitively intact. She required moderate to maximum assistance with most ADLs. She was not coded for pressure ulcers. Record review of a nursing progress note type Clinical Admission dated 9/2/25 at 1:00 pm and signed by RN A for Resident #11 indicated she had a surgical wound to right dorsal 1st metatarsal phalangeal joint (the joint where the first metatarsal bone meets the proximal phalanx of the big toe), an abrasion to left medial calf (the back of the lower leg), and bruising to right dorsum right hand (the back or posterior surface of the right hand), and there was no documentation of a pressure injury to her right heel. Record review of a comprehensive care plan dated 9/9/25 for Resident #11 indicated she had potential for alteration in skin integrity due to impaired mobility and had an intervention to inspect skin from head to toe no less than once per week and document/measure all abnormal findings. She also had an intervention to inform physician, family, dietician, and director of nursing of any new skin breakdown. Record review of an electronic health record for Resident #11 on 11/10/25 indicated there were no skin assessments completed between the dates of 9/2/25 and 9/15/25 and no skin assessments documented between the dates of 10/18/25 to 11/10/25. Record review of a nursing progress note dated 10/18/25 at 8:12 pm and signed by RN K for Resident #11 indicated a new skin issue was identified; an unstageable pressure ulcer/injury to right heel. Note indicated wound measurements were 3cm X 2cm X 0.1cm and eschar was 100%. There was no documentation of physician notification. Record review of a Nutrition/Dietary Note dated 10/28/25 for Resident #11 read . Recommendation: 1. Vitamin C 500mg po (by mouth) daily. 2. Zinc sulfate 220mg daily po x 14 days 3. mvi/min (multivitamin with minerals) po daily 4. house supplement 60ml BID. Record review of a physician's order summary report dated 11/12/25 for Resident #11 indicated the following physician orders: consult Dr</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to ensure the accurate administration of medications for 1 (Resident #2) of 16 residents reviewed for pharmacy services. The facility failed to administer ordered medications for Resident #2 on 9/3/25, 9/6/25, 9/9/25, 9/17/25, 9/30/25, 10/6/25, 10/7/25, 10/13/25, 10/14/25, 10/29/25, 10/30/25, and 11/1/25. This failure could place the residents at risk of a decline in health, and decreased quality of life. Findings included: Record review of a facility face sheet dated 11/5/25 for Resident #2 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: acute and chronic respiratory failure with hypoxia (a condition where you don't have enough oxygen or too much carbon dioxide in your body), type 2 diabetes (uncontrolled blood sugar), and hypothyroidism (Underactive thyroid - a condition where the thyroid gland does not produce enough thyroid hormones, leading to a slowdown in metabolism). Record review of a Comprehensive MDS assessment dated [DATE] for Resident #2 indicated a BIMS score of 15, indicating her cognition was intact. She required maximal assistance with most ADLs. Record review of a Comprehensive Care Plan dated 7/10/25 for Resident #2 indicated she had hypothyroidism, was on medication related to restless leg syndrome, was on routine pain medication therapy related to Chronic Pain/Fibromyalgia and neuropathy, and was on anti-anxiety medications related to anxiety disorder. An intervention was to give medications as ordered. Record review of a physician's order summary report dated 11/5/25 for Resident #2 indicated she had the following physician's orders: Ativan Oral Tablet 0.5mg (Lorazepam) Give 0.5 mg by mouth at bedtime related to anxiety disorder - dated 9/5/25. Atorvastatin Calcium Oral Tablet 80 mg (Atorvastatin Calcium) Give 1 tablet by mouth at bedtime related to hyperlipidemia - dated 6/24/25. Calcium Carbonate Tablet Chewable 500 mg Give 2 tablet by mouth four times a day related to Gastro-esophageal reflux disease - dated 6/24/25. Cyclosporine Emulsion 0.05% Instill 1 drop in both eyes four times a day for dry eyes due to inflammation related to dry eye syndrome of unspecified lacrimal gland - dated 6/24/25. Duloxetine HCL (Hydrochloride) Capsule Delayed Release Particles 60 mg Give 1 capsule by mouth two times a day for depression related to Major Depressive Disorder, recurrent, unspecified - dated 6/24/25. Levothyroxine Sodium Oral Tablet 50 mcg (Levothyroxine Sodium) Give 1 tablet by mouth one time a day related to hypothyroidism - dated 6/24/25. Lyrica Oral Capsule 100 mg (Pregabalin) Give 1 capsule by mouth three times a day related to hereditary and idiopathic neuropathy, unspecified; and other chronic pain - dated 8/24/25. Ramelteon Tablet 8 mg Give 1 tablet by mouth at bedtime for insomnia - dated 7/3/25. Ropinirole HCL Oral tablet 1 mg (Ropinirole Hydrochloride) Give 2 mg by mouth at bedtime related to restless legs syndrome - dated 6/24/25. Tizanidine HCL Oral tablet 2 mg (Tizanidine HCL) Give 1 tablet by mouth every 8 hours related to other chronic pain - dated 6/24/25. Topiramate Oral tablet 100 mg (Topiramate) Give 1 tablet by mouth two times a day related to migraine, unspecified, not intractable, without status migrainosus - dated 6/24/25. Record review of Medication Administration Record dated 9/1/25 through 9/30/25 for Resident #2 indicated the MAR had blanks on: 9/3/25 at 5:00 am for Levothyroxine, Calcium Carbonate, and Cyclosporine drops 9/3/25 at 5:00 pm for Tizanidine, Calcium Carbonate, and Cyclosporine drops 9/6/25 at 5:00 am for Levothyroxine, Calcium Carbonate, and Cyclosporine drops 9/9/25 at 5:00 pm for Tizanidine, Calcium Carbonate, and Cyclosporine drops 9/17/25 at 5:00 am for Levothyroxine 9/30/25 at 5:00 am for Levothyroxine, Calcium Carbonate, and Cyclosporine drops 9/30/25 at 4:00 pm for Lyrica 9/30/25 at 5:00 pm for Tizanidine 9/30/25 at 9:00 pm for Ativan 9/30/25 at 11:00 pm for Lyrica Record review of Medication Administration Record dated 10/1/25 through 10/31/25 for Resident #2 indicated the MAR had blanks on: 10/6/25 at 9:00 pm for Ativan, Atorvastatin, Toprol, Ramelteon, Ropinirole, Duloxetine, Entresto, and Topiramate 10/7/25 at 5:00 am for Levothyroxine, Calcium Carbonate, Cyclosporine drops 10/13/25 at 11:00 pm for Lyrica, Calcium Carbonate 10/14/25 at 1:00 am for Tizanidine 10/14/25 at 5:00 am for Levothyroxine, Calcium Carbonate, Cyclosporine drops 10/29/25 at 5:00 pm for Tizanidine, Calcium Carbonate, Cyclosporine drops 10/30/25 at 5:00 pm for Tizanidine, Calcium Carbonate, Cyclosporine drops Record review of Medication Administration Record dated 11/1/25 through 11/5/25 for Resident #2 indicated the MAR had blanks on: 11/1/25 at 5:00 pm for Tizanidine, Calcium Carbonate, and Cyclosporine drops During an interview on 11/12/25 at 10:10 am, Resident #2 said when she did not get her medications as she was supposed to, it increased her pain levels. She said she was unsure of exactly which medications she was not receiving, but she just knew she was not always getting them. She said she wanted to get better so she</p>		

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  11/12/2025
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 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>(continued on next page)</p>

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  11/12/2025
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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record reviews, the facility failed to ensure residents were free of any significant medication errors for 2 of 11 residents reviewed for medications. (Resident #4 and Resident #2)1. The facility failed to administer Metoprolol (a medication to treat high blood pressure) and Entresto (a medication to treat high blood pressure and treat heart failure) to Resident #2 on 10/6/25 at 9:00 pm as ordered.2. The facility failed to ensure Entresto 24/26 mg 1 tablet by mouth twice a day was ordered for Resident #4 when she was admitted to the facility from the hospital on 9/18/2025. 3. The facility failed to ensure Resident #4 received Eliquis (a medication used to treat and prevent blood clots) 5 mg 1 tablet by mouth twice a day as ordered by missing 8 doses in October 2025 and she was hospitalized from [DATE] to 10/28/2025 and diagnosed with atrial fibrillation with RVR (rapid ventricular response-rapid heart rate), acute on chronic systolic and diastolic heart failure along with a small pulmonary embolus in the right middle lobe of the lung (blood clot in the lung).On 11/5/2025 at 2:10 PM, an Immediate Jeopardy (IJ) was identified. While the Immediate Jeopardy was removed on 11/6/2025 at 4:15 PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm that was not Immediate Jeopardy due to the facility continuing to monitor the implementation and the effectiveness of their Plan of Removal. These deficient practices could place residents at risk of physical complications, hospitalization, and death. Findings included:1.Record review of a facility face sheet dated 11/5/25 for Resident #2 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: acute and chronic respiratory failure with hypoxia (a condition where you don't have enough oxygen or too much carbon dioxide in your body), type 2 diabetes (uncontrolled blood sugar), and hypothyroidism (Underactive thyroid - a condition where the thyroid gland does not produce enough thyroid hormones, leading to a slowdown in metabolism).Record review of a Comprehensive MDS assessment dated [DATE] for Resident #2 indicated a BIMS score of 15, indicating her cognition was intact. She required maximal assistance with most ADLs. Record review of a Comprehensive Care Plan dated 7/10/25 for Resident #2 indicated she had hypertension (high blood pressure) and cardiomyopathy (a disease of the heart muscle). She had interventions to give medications as ordered.Record review of a physician's order summary report dated 11/5/25 for Resident #2 indicated she had the following physician's orders: Metoprolol Succinate ER (Extended Release) Oral tablet extended release 24-hour 25 mg (Metoprolol Succinate) Give 1 tablet by mouth one time a day related to hypertensive heart disease with heart failure; hold for heart rate less than 60, systolic blood pressure less than 100, or diastolic blood pressure less than 60 - dated 6/24/25. Entresto (Sacubitril-Valsartan) Oral tablet 49-51 mg Give 1 tablet by mouth two times a day related to other cardiomyopathies, hold if systolic blood pressure less than 100 or pulse less than 55 - dated 9/10/25.2. Record review of an admission Record for Resident #4 dated 11/4/2025 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of acute on chronic diastolic heart failure (a sudden, life threatening condition in which your heart is unable to pump effectively), atrial flutter (a heart rhythm disorder), and hypertension (high blood pressure). She was discharged from the facility to the hospital on [DATE].Record review of an admission MDS Assessment for Resident #4 dated 9/25/2025 indicated she had moderate impairment in thinking with a BIMS score of 12. During the 7-day look back period, she took an anticoagulant. Record review of a care plan for Resident #4 dated 9/26/2025 indicated she was on anticoagulant therapy Eliquis related to atrial flutter. Interventions included to administer anticoagulant medications as ordered by the physician. Record review of hospital discharge records for Resident #4 dated 9/18/2025 indicated a medication list that included Entresto 24/26 mg 1 tablet by mouth two times a day. Eliquis 5 mg 1 tablet by mouth two times a day.Record review of a progress note by the NP for Resident #4 dated 9/30/2025 indicated her medication list consisted of Entresto 24/26 mg 1 tablet by mouth twice a day and Eliquis 5 mg 1 tablet by mouth twice a day.Record review of a progress note by the Medical Director for Resident #4 dated 10/2/2025 indicated she was on Entresto for hypertensive heart and chronic kidney disease with heart failure. Currently on Entresto 24/26 mg twice a day.Record review of a progress note by the NP for Resident #4 dated 10/7/2025 indicated the resident reported she was not always receiving her medications consistently; some days she only received one dose at night. Record review of a progress note by the NP for Resident #4 dated 10/14/2025 indicated she spoke to the cardiologist for Resident #4 to discuss Entresto and the cardiologist said there was no added benefit to taking it Record review of a progress note for Resident #4 dated 10/26/2025 at 3 pm by RN</p>		

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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 3 of 10 residents (Resident #2, Resident #17, and Resident #13) and 3 of 5 staff (CNA H, LVN F, and MDS Coordinator) reviewed for infection control. The facility failed to ensure CNA H changed her gloves and washed/sanitized her hands during incontinent care provided to Resident #2 on 11/4/2025. The facility failed to ensure LVN F changed her gloves when she changed from dirty to clean during wound care provided to Resident #17 on 11/4/2025. The facility failed to ensure the MDS Coordinator wore appropriate PPE for enhanced barrier precautions when wound care was provided to Resident #13 on 11/20/2025. These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices. Findings included: 1. Record review of an admission Record for Resident #2 dated 11/5/2025 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of major depressive disorder (persistent sadness or loss of interest in doing things), type 2 diabetes, and hypertensive heart disease with heart failure (high blood pressure that makes it more difficult for the heart to pump blood through the body). Record review of a Significant Change MDS assessment dated [DATE] for Resident #2 indicated she did not have any impairment in thinking with a BIMS score of 15. She required set-up or clean-up assistance with eating and oral hygiene but was dependent on staff for toileting. She was frequently incontinent of urine/bowel. Record review of a care plan for Resident #2 revised 12/29/2023 indicated she had occasional bladder incontinence related to an overactive bladder. Interventions included to clean peri-area with each incontinence episode. During an observation on 11/4/2025 at 11:11 AM, MA R and CNA H were in the room of Resident #2 to perform incontinent care. MA R sanitized her hands and applied gloves. CNA H did not wash or sanitize her hands and applied gloves. CNA H removed wipes from the package and Resident #2 rolled onto her left side. Resident #2 was not wearing a brief. CNA H wiped her buttocks and rectal area from front to back and rolled the linens underneath her buttocks. CNA H placed a clean fitted sheet on the bed using the same gloves and Resident #2 was rolled onto her right side and the dirty linens were removed and placed in a plastic bag. Resident #2 rolled onto her back and CNA H removed a wipe from the package to clean her abdominal skin fold. MA R removed the gown from Resident #2 and CNA H placed clean gown on the resident. CNA H removed her gloves and placed them in the trash. Resident #2 was repositioned in bed. Both MA R and CNA H removed their gloves and placed them in the trash and sanitized their hands. CNA H removed the trash and exited the room. MA R exited the room. During an interview on 11/4/2025 at 11:20 AM, CNA H said she had been employed at the facility since April 2025. She said she had a skills checkoff about 6 months ago in the facility by the previous DON. She said during the care provided to Resident #2 she did not wash her hands or sanitize before she applied gloves. She said she should have started at the front of her body instead of the back of her body but because of her tumor that was in the way of her vagina that it made it hard for the staff to clean at the front first. She said she should have changed her gloves when she touched and changed tasks from dirty to clean items and she should not have placed clean items on the bed with her dirty gloves. She said residents could be at risk for infections or cross contamination if staff did not change gloves or wash or sanitize their hands. 2. Record review of an admission Record dated 11/5/2025 for Resident #17 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of GERD (acid reflux), depression (sadness or loss of interest in doing things), type 2 diabetes and hypertension. Record review of active physician orders dated 11/5/2025 for Resident #17 indicated an order for wound care to his right heel to be performed that started on 11/2/2025. Record review of active physician orders dated 11/5/2025 for Resident #17 indicated an order for skin prep to his left heel daily that started on 11/3/2025. Record review of a Quarterly MDS assessment dated [DATE] for Resident #17 indicated he did not have any impairment in thinking with a BIMS score of 15. He had one unhealed pressure ulcers/injuries that was a stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle). Record review of a care plan revised on 10/21/2025 for Resident #17 indicated he had a stage 4 pressure ulcer/pressure injury to right heel/left heel. During an observation on 11/4/2025 at 1:41 PM, LVN F was at the door of Resident #17's room to perform wound care. LVN F washed her hands in the bathroom. There was a sign on door for EBP. She applied gloves to both hands and cleaned the over bed table of the resident with a sani-cloth bleach</p>		