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	11/26/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (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
	676439	A. Building B. Wing	11/26/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received necessary services to maintain grooming and personal hygiene for 1 of 5 residents (Resident #1) reviewed for ADLS. The facility failed to provide hair care to Resident #1 which resulted in a large hair mat at the back of her head that had to be cut out on 11/11/25. The facility failed to provide showers or baths to Resident #1 in compliance with their shower/bath schedule. This failure could place residents at risk of a decline in hygiene, at risk of skin breakdown, level of satisfaction with life, and feelings of self-worth. Findings included: Record review of Resident #1's face sheet dated 11/25/25 indicated she was an [AGE] year old female, admitted on [DATE], and her diagnoses included cognitive communication deficit (difficulties in communication that arise from underlying cognitive impairments), muscle wasting and atrophy (thinning or loss of muscle mass), Parkinson's (movement disorder), diabetes (condition that affects blood sugar levels), dementia (decline in cognitive function), major depressive disorder (mood disorder that causes a persistent feeling of sadness and a loss of interest), and need for assistance with personal care. Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated she was able to make herself understood and understood others and was cognitively intact (BIMS-13). No rejection of care was noted in the 7 day look back period. She was dependent for showers/baths. She required partial/moderate assistance with personal hygiene (combing hair). Record review of Resident #1's care plan dated 06/29/23 indicated she had an ADL self-care performance deficit and limitations in physical mobility related to fatigue/malaise/weakness, and limited mobility/ROM/musculoskeletal impairment. Interventions included extensive assistance by 2 staff with bathing/showering at least 3 times weekly and as necessary. There was no intervention specific to hair care. Record review of Resident #1's care plan dated 11/18/25 indicated she refused showers and preferred bed baths. Family Member A wanted Resident #1 to have a shower. Interventions included notify Family Member A for refusals to assist with encouraging resident to take showers. There was no focus for hair care refusals or interventions. Record review of Resident #1's ADL personal hygiene record dated 10/28/25 through 11/25/25 indicated she required 1 to 2 person physical assist for ADL-Personal Hygiene. There was no documentation for 10/31/25, 11/01/25[, 11/06/25, and 11/14/25. There were no refusals noted. There was no documentation specific to hair care. Record review of Resident #1's bath/shower record from 11/01/25 through 11/25/25 indicated:Monday 11/03/25 - no documentationWednesday 11/05/25 - no documentationFriday 11/07/25 - 2 person physical assistIndicating 1 out of 3 days bath/shower received Monday 11/10/25 refusedWednesday 11/12/25 - 2 person physical assistFriday 11/14/25 - no documentationIndicating 1 out of 3 days bath/shower received Monday 11/17/25 - no documentationTuesday 11/18/25 set up onlyWednesday 11/19/25 - no documentationThursday 11/20/25-1 person physical assistFriday 11/21/25 - no documentationIndicating 2 out of 3 days bath/shower received Monday 11/24/25 - no documentationWednesday 11/25/25 - 1 person physical assistIndicating 1 out of 2 days bath/shower received Record review of the facility's Comprehensive CNA Shower Review sheets provided by the facility on 11/25/25 indicated:11/07/25 -no documentation of Resident #1's hair wash11/10/25 - no documentation of Resident #1's hair wash11/11/25 - no documentation of Resident #1's hair wash11/12/25 - Resident #1's hair was washedThere were no additional Comprehensive CNA Shower Review sheets provided for review. Record review of nurse progress notes from 11/01/25 through 11/25/25 indicated no documentation of bath/shower refusals or hair care refusals. Record review of a grievance submitted by Family Member A dated 11/11/25 indicated Resident #1's hair was not being brushed, and she was not notified of Resident #1's refusals for showers. Resident #1 was assessed with no visible signs of neglect. The facility reported the allegation of Neglect to HHSC on 11/11/25. The facility implemented notification of Family Member A when Resident #1 refused care, medications, and showers. The grievance was noted as resolved on 11/18/25. Record review of facility investigation dated 11/18/25 indicated Family Member A came to the facility to visit Resident #1. She was upset when she saw the hair was matted on the back of Resident #1's head. She alleged the facility neglected Resident #1 and Resident #1 was not getting showers. CNA C and CNA S confirmed Resident #1 was getting bed baths. They said she did not refuse bed baths. They stated that she would not let them wash or brush her hair and she barely let them wash the important parts before saying okay okay okay, son of a bitch. Staff were educated between 11/11/25 and 11/18/25 to let Family Member A know when Resident #1

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	11/26/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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	11/26/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 5 residents (Resident #1) reviewed for accuracy of clinical records. Facility staff failed to document Resident #1's ADL for baths or showers and hair care or refusals. This failure could place residents at risk of not receiving care and services to meet their needs. Record review of Resident #1's face sheet dated 11/25/25 indicated she was an [AGE] year old female, admitted on [DATE], and her diagnoses included cognitive communication deficit (difficulties in communication that arise from underlying cognitive impairments), muscle wasting and atrophy (thinning or loss of muscle mass), Parkinson's (movement disorder), diabetes (condition that affects blood sugar levels), dementia (decline in cognitive function), major depressive disorder (mood disorder that causes a persistent feeling of sadness and a loss of interest), and need for assistance with personal care. Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated she was able to make herself understood and understood others, and was cognitively intact (BIMS-13). No rejection of care was noted in the 7 day look back period. She was dependent for showers/baths. She required partial/moderate assistance with personal hygiene (combing hair). Record review of Resident #1's care plan dated 06/29/23 indicated she had an ADL self-care performance deficit and limitations in physical mobility related to fatigue/malaise/weakness, and limited mobility/ROM/musculoskeletal impairment. Interventions included extensive assistance by 2 staff with bathing/showering at least 3 times weekly and as necessary. There was no intervention specific to hair care. Record review of Resident #1's care plan dated 11/18/25 indicated she refused showers and preferred bed baths. Family Member A wanted Resident #1 to have a shower. Interventions included notify Family Member A for refusals to assist with encouraging resident to take showers. There was no focus for hair care refusals or interventions. Record review of Resident #1's ADL personal hygiene record dated 10/28/25 through 11/25/25 indicated she required 1 to 2 person physical assist for ADL-Personal Hygiene. There was no documentation for 10/31/25, 11/01/25, 11/06/25, and 11/14/25. There were no refusals noted. There was no documentation specific to hair care. Record review of Resident #1's bath/shower record from 11/01/25 through 11/25/25 indicated:Monday 11/03/25 - no documentationWednesday 11/05/25 - no documentationFriday 11/14/25 - no documentationMonday 11/17/25 - no documentationWednesday 11/19/25 - no documentationFriday 11/21/25 - no documentationMonday 11/24/25 - no documentation Record review of the facility Comprehensive CNA Shower Review sheets provided by the facility on 11/25/25 indicated:11/07/25 -no documentation of Resident #1's hair wash11/10/25 - no documentation of Resident #1's hair wash11/11/25 - no documentation of Resident #1's hair washThere were no additional Comprehensive CNA Shower Review sheets provided for review. Record review of nurse progress notes from 11/01/25 through 11/25/25 indicated no documentation of bath/shower refusals or hair care refusals. During[KS1] an observation and interview on 11/25/25 at 12:30 p.m., Resident #1 was lying flat in bed. She appeared clean and had no odors. Her hair was combed[KS2] . She said she preferred to lay flat because if she sat up it caused her pain. She said she preferred bed baths over showers because she did not like to be taken out of bed. She said she did not have her hair washed when she was in bed or had a bed bath. She said she sometimes does not like staff to wash or comb her hair because it takes too much time[KS3] from start to finish. She said she understood that not combing her hair left her hair messy and it could develop knots that were difficult to comb out. She could not remember which days where her shower/bath days. During an interview on 11/25/25 at 2:09 p.m., MDS LVN N said staff were to document all refusals and notify the charge nurse and the charge nurse was to notify the family member. During an interview on 11/25/25 at 2:30 p.m., CNA C said Resident #1's scheduled bath/shower days were Monday, Wednesday, and Friday. She said Resident #1 refuses showers but tolerated bed baths. She said when Resident #1 received a bed bath she did not have her hair washed or combed. She said if a resident refused care, she was supposed to document the refusals and tell the charge nurse. She said it was possible she missed documenting the refusals in Resident #1's chart. During an interview on 11/25/25 at 2:40 p.m., CNA S said Resident #1's scheduled bath/shower days were Monday, Wednesday, and Friday. She said Resident #1 often refused hair care. She said she could not recall if it was documented or if she informed the nurse. She said sometimes, she did not complete the required documenting. During an interview on 11/25/25 at 3:48 p.m., RN W said