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	01/28/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes, but is not limited to, seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Based on interviews and record review, the facility failed to ensure the resident was free from abuse for 1 (CR #1) of 11 residents reviewed.The facility failed to ensure that all staff were trained and knowledgeable in how to react and respond appropriately to resident behavior.The facility failed to protect the resident from physical abuse when staff used physical force during care that resulted in injury. This failure could place residents at risk for abuse, neglect, and exploitation and compromise their right to be free from harm.Record review of CR #1's face sheet dated 01/23/26 identified a [AGE] year-old male admitted on [DATE] (initial admission [DATE]) with diagnoses including metabolic encephalopathy, bipolar disorder with psychotic features, lack of coordination, muscle weakness, muscle wasting and atrophy, wedge compression fracture of the first lumbar vertebra, and a documented history of falls.Record review of the quarterly MDS dated [DATE] revealed a BIMS score of 6, indicating moderate cognitive impairment. The resident required supervision or touching assistance with personal hygiene and extensive assistance with transfers, bed mobility, toileting, dressing, and bathing.Record review of nursing documentation dated 09/01/25 at approximately 10:00 a.m. revealed CR #1 was yelling loudly and continuously in the hallway. The aide entered the resident's room to assess and observed the resident to be irritated and agitated. Documentation reflected the resident struck the CNA four times and attempted to strike her in the face. The CNA reported grabbing the resident's arm to prevent being struck. The resident pulled his arm away, resulting in a skin tear.Record review of nursing documentation dated 09/01/25 at 1:29 p.m. revealed the resident sustained a 5 cm x 2.5 cm skin tear to the left forearm. The wound was cleaned with normal saline, steri-strips were applied, and the Nurse Practitioner and Administrator were notified.Interview with CR #1's family member on 01/20/26 at 11:43 a.m. said the nursing facility notified her of a CNA grabbing CR #1's arm and causing a laceration during ADL care in his room. She said on video she also saw CNA A grab CR #1's arm when the CNA was assisting the resident back to bed. Family member never provided videos of these incidents. ? An interview on 01/21/26 at 12:10 p.m. with the Admin said she was on vacation when she was notified of an incident with CNA A grabbing CR 1's arm, causing a skin tear. She said the DON was the assigned abuse coordinator and the DON should have reported the incident to the state. She said the DON notified her, but she was out of the country and did not get the information to report it within the 2-hour time frame, and assumed the DON called the incident into the state. She said she personally did not report the incident, investigate the allegation, or suspend the alleged perpetrator. She said a state surveyor came into the facility and investigated the incident and everything was unsubstantiated. Admin reported an unknown surveyor told her You don't need to report it.? An (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 1/21/26 at 1:30 p.m. with CNA A said she was often assigned to the hall where CR #1 resided. She said CR #1 had severe behavioral issues; he would scream, yell, throw objects, hit staff, and attempt to break things. She said the resident needed frequent one-on-one attention to prevent him from throwing himself out of bed or against the wall. She said the resident always had bruises from his falls and behaviors. CNA A said, his whole face was one big bruise. She said as precautionary the Admin would pull a CNA to sit one-on-one with CR #1 when his behaviors were really bad to prevent falls. CNA A said there was an incident, unsure of the date, when CR #1 struck her multiple times in the chest when she was trying to assist him with ADL care. She said she reacted by grabbing his hand and blocking him from hitting her again, which caused a small skin tear on the resident's arm. She said she was unsure if an investigation had been done, and she had not been suspended after the incident. She said a state surveyor was in the building shortly after the incident and questioned her about what had happened. She said she had training on the facility's abuse and neglect policy at least every 6 weeks. She said she had not been trained on the facility policy related to residents with behaviors; however, she was a certified EMT and had been trained as part of her certification. CNA said she had worked with the Admin for several years and had followed her to this facility. ? An interview on 1/21/26 at 1:45 p.m. with LVN A said CR #1's dementia was moderate; he recognized familiar staff and could communicate needs, but exhibited increased confusion and behavioral disturbances, particularly after the installation of cameras in his room and frequent family interventions. Behavioral issues escalated with family involvement, manifesting as yelling and agitation, especially when prompted or monitored remotely. LVN A admitted she saw the resident attempt to hit CNA A, who then grabbed CR #1's hand causing a skin tear. LVN A said CNA A did this to protect herself from CR #1 from hitting at her. She said she reported the incident to the DON and Admin, who was the Abuse Coordinator for the facility. LVN A said she had not had behavioral training at the facility, but as a nurse she had behavioral training over time. She said if a resident was aggressive she would try to talk to them and ensure everyone's safety. She said sometimes the resident needs space. ? Record review of the facility's Abuse Investigation and Reporting policy (Revised July 2017) shows the facility requires all alleged violations involving abuse, neglect, or injuries of unknown source to be reported immediately, but no later than two hours if abuse or serious injury is suspected, to the facility administrator and appropriate agencies, including the State Survey Agency. The policy also requires a thorough internal investigation and timely notification of outcomes to the resident, their representative, and regulatory authorities.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interviews and record review, the facility failed to ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, to the facility administrator and to other officials, including the State Survey Agency, as required by State law and established facility procedures. Federal and state regulations require all staff to recognize, report, and document any incident or allegation of abuse, regardless of intent or injury, to ensure timely investigation and protection for one (CR #1) of eleven residents reviewed related to abuse and neglect. The facility failed to report an incident on 09/01/2025 involving CR #1, in which a Certified Nurse Aide (CNA) admitted to physically grabbing the resident's arm during care, resulting in a 5 x 2.5 cm skin tear to the left forearm. This failure placed residents at risk for allegations of abuse not being promptly reported, lack of timely investigation, continued exposure to potential harm, and psychosocial distress. Record review of CR#1's face sheet dated 1/23/26 identified a [AGE] year-old male admitted on [DATE] (initial admission 6/10/24) with diagnoses including metabolic encephalopathy, lack of coordination, bipolar disorder with psychotic features, muscle weakness, muscle wasting and atrophy, wedge compression fracture of the first lumbar vertebra, and history of falls. Record review of CR #1's quarterly MDS dated [DATE] revealed a BIMS score of 6, indicating moderate cognitive impairment, and documented a history of falls since the prior assessment. CR#1 was identified with no physical behavioral symptoms directed toward others. CR #1 required supervision or touching assistance with personal hygiene. Record review of CR#1's care plan initiated on 8/27/24 and revised on 8/27/24, revealed the resident had an ADL self-care performance deficit and limitations in physical mobility related to disease process, fatigue/ malaise/ weakness, impaired balance, limited mobility/ROM/musculoskeletal impairment. CR #1 required extensive assistance by one staff to transfer, bed mobility, toileting, dressing, and bathing. Record review of nurse's note, health status note, by unknown author dated 09/01/2025 at 10:00 a.m. revealed CR #1 was heard screaming loudly and continuously in the hallway again. The aide entered the room to assess, at which time the resident appeared irritated and agitated, continuing to scream at the aide. According to the aide, the resident struck her 4 times and then attempted to strike her in the face. The aide reported that she grabbed the resident's arm to prevent injury to herself. The resident then pulled his arm away, resulting in a skin tear. Record review of nurses note by unknown author dated 09/01/25 at 1:29 p.m. read in part .This nurse notified of CR #1's skin tear to left forearm. Upon assess he noted to have a 5 cm x 2.5 cm skin tear to left forearm. Area cleaned with normal saline, steri strips applied. NP notified at 1:12 p.m., Admin notified at 12:54 p.m. Interview with CR #1's family member on 01/20/26 at 11:43 a.m. said the nursing facility notified her of a CNA grabbing CR #1's arm and causing a laceration during ADL care in his room. She said on video she also saw CNA A grab CR #1's arm when the CNA was assisting the resident back to bed. Family member never provided videos of these incidents. An interview on 01/21/26 at 12:10 p.m. with the Admin said she was on vacation when she was notified of an incident with CNA A grabbing CR 1's arm, causing a skin tear. She said the DON was the assigned abuse coordinator and the DON should have reported the incident to the state. She said the DON notified her, but she was out of the country and did not get the information to report it within the 2-hour time frame, and assumed the DON called the incident into the state. She said she personally did not report the incident, investigate the allegation, or suspend the alleged perpetrator. She said a state surveyor came into the facility and investigated the incident and everything was unsubstantiated. An interview on 1/21/26 at 1:30 p.m. with CNA A said she was often assigned to the hall where (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CR #1 resided. She said CR #1 had severe behavioral issues; he would scream, yell, throw objects, hit staff, and attempt to break things. She said the resident needed frequent one-on-one attention to prevent him from throwing himself out of bed or against the wall. She said the resident always had bruises from his falls and behaviors. CNA A said, his whole face was one big bruise. She said as precautionary the Admin would pull a CNA to sit one-on-one with CR #1 when his behaviors were really bad to prevent falls. CNA A said there was an incident, unsure of the date, when CR #1 struck her multiple times in the chest when she was trying to assist him with ADL care. She said she reacted by grabbing his hand and blocking him from hitting her again, which caused a small skin tear on the resident's arm. CNA A said she immediately reported the incident to the DON and ADON. She said the Admin was out of the country at the time. She said LVN A was in the room at the time of the incident. CNA A identified Admin as the facility's abuse coordinator. She said since the Admin was not available, she reported it to her DON. She said she was unsure if an investigation had been done, and she had not been suspended after the incident. She said a state surveyor was in the building shortly after the incident and questioned her about what had happened. She said she had training on the facility's abuse and neglect policy at least every 6 weeks. She said she had not been trained on the facility policy related to residents with behaviors; however, she was a certified EMT and had been trained as part of her certification. CNA said she had worked with the Admin for several years and had followed her to this facility. An interview on 1/21/26 at 1:45 p.m. with LVN A said CR #1's dementia was moderate; he recognized familiar staff and could communicate needs, but exhibited increased confusion and behavioral disturbances, particularly after the installation of cameras in his room and frequent family interventions. Behavioral issues escalated with family involvement, manifesting as yelling and agitation, especially when prompted or monitored remotely. LVN A admitted she saw the resident attempt to hit CNA A, who then grabbed CR #1's hand causing a skin tear. LVN A said CNA A did this to protect herself from CR #1 from hitting at her. She said she reported the incident to the DON and Admin, who was the Abuse Coordinator for the facility. She said staff were trained on CR #1's falls. She said the family put up cameras, and it made things worse for the resident. LVN A said she had not had behavioral training at the facility, but as a nurse she had behavioral training over time. She said if a resident was aggressive she would try to talk to them and ensure everyone's safety. She said sometimes the resident needs space. Record review of the facility's Abuse Investigation and Reporting policy (Revised July 2017) shows the facility requires all alleged violations involving abuse, neglect, or injuries of unknown source to be reported immediately, but no later than two hours if abuse or serious injury is suspected, to the facility administrator and appropriate agencies, including the State Survey Agency. The policy also requires a thorough internal investigation and timely notification of outcomes to the resident, their representative, and regulatory authorities.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to revise and implement a comprehensive, person-centered care plan to address the resident's known and ongoing medical and nursing needs for 1 (CR #1) of 11 residents reviewed. The facility failed to identify and incorporate care plan interventions related to changes in condition and emergency response, including the use of Naloxone (Narcan), despite known risk factors.This failure resulted in staff responding to ongoing fall risk, behavioral escalation, and changes in condition without clear, individualized guidance.This failure could place residents at risk for unmet medical and nursing needs, delayed response to changes in condition, and inconsistent care. Record review of CR #1's face sheet dated 01/23/26 identified a [AGE] year-old male with diagnoses including metabolic encephalopathy, bipolar disorder with psychotic features, impaired mobility, muscle weakness, and a history of repeated falls.Record review of the quarterly MDS dated [DATE] revealed a BIMS score of 6, indicating moderate cognitive impairment and impaired safety awareness. The resident required extensive assistance with ADLs and transfers.Record review of facility fall tracking documentation dated 1/22/26 reflected CR #1 experienced repeated falls over multiple months, including multiple falls on the same day (09/02/25), demonstrating an ongoing pattern of unsafe transfer attempts, impulsive behavior, and poor safety awareness.Review of the CR #1's care plan (revised 8/27/25 and 9/8/25) identified the resident as high risk for falls related to confusion, impaired balance, incontinence, unaware of safety needs, use of narcotic pain meds, will attempt to transfer from bed to chair without assistance. Poor balance, psychotropic drug use, unsteady gait. The resident has had an actual fall. Interventions included encourage the resident to participate in activities, follow facility fall precautions and refer to therapy as ordered, the resident needs safe environment with even floors free from spills and/or clutter, adequate, glare free light, a working and reachable call light, the bed in lowest position at night, handrails on walls, personal items within reach, appropriate footwear when ambulating or mobilizing in w/c, and the appropriate adaptive equipment is available and in use. Attempt to anticipate the residents needs and promptly respond to all requests for assistance. Immediately after fall assess resident for injury, investigate to determine and address causative factors of the fall. Obtain statements for witnessed falls. Review the interventions from the at risk for falls care plan. Consult pharmacist for medication if necessary. Actual identified falls and interventions: 6/3/25, no injury, pharmacy review, 6/8/25, no injury, 6/10/25, skin tear and periorbital bruising, 6/13/25, no injury, 6/23/25, no injury, 6/25/25 no injury, 6/27/25 x 2 no injury, 7/1/25, abrasion to left knee, 7/5/25 no injury, 7/6/25 no injury, 7/17/25 no injury, 7/22/25 right lower extremity, sent to emergency room for evaluation, 7/23/25 no injury, 8/8/25 x2 no injury, 8/12/25 no injury, 8/17/25 no injury, 8/22/25 no injury, 8/23/25 no injury, 8/25/25 no injury, 8/25/25 no injury, 8/28/25 skin tear, 8/29/25 no injury, 8/30/25 no injury, 9/2/25 no injury, 9/2/25 no injury, 9/2/25 no injury, 9/2/25 laceration, 9/2/25 no injury, 9/4/25 no injury, 9/9/25 no injury, 9/11/25 no injury, 9/12/25 skin tear. Record review of CR #1 careplan initiated 7/10/24 identified resident has a prescription for Risperdal related to diagnoses of bipolar disorder with severe psychotic features. Intervention included a monitor/record occurrence of the target behavior symptoms (pacing, wandering, disrobing, inappropriate responses to verbal communication, violence, aggression towards staff) and document per facility protocol.Record review of the resident's care plan revealed it did not include individualized interventions addressing the resident's documented behavioral escalation, impulsivity, or aggressive behaviors during care, nor did it provide staff with guidance on de-escalation techniques or safe response strategies during (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	combative episodes.Record review of CR #1's MAR for September 2025 revealed an active physician order for Naloxone (Narcan) nasal spray to be administered as needed for suspected opioid overdose, as well as an order to monitor the resident each shift for signs and symptoms of overdose. The resident's care plan did not identify suspected overdose or changes in condition requiring emergency response as a care-planned need, nor did it include interventions to guide staff on when or how to respond to suspected overdose.Interview on 01/21/26 with CNA A revealed CR #1 frequently became agitated during care, attempted to strike staff, and threw himself during transfers. CNA A stated staff were aware the resident's behaviors escalated over time but did not identify a care-planned approach for managing these behaviors during hands-on care.Interview on 01/21/26 with LVN A confirmed the resident exhibited impulsive and combative behaviors and that staff often had to respond in the moment without structured guidance in the care plan.Interview on 01/21/26 with the DON confirmed CR #1 experienced multiple falls over time and acknowledged that no new interventions were added to the care plan despite the recurrence of falls and behavioral concerns.No careplan policy provided upon exit on 2/28/26.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews review the facility failed to ensure the resident received adequate supervision and assistive devices to prevent accidents for one (CR #1) of eleven residents reviewed for falls in that: The facility failed to provide adequate supervision and develop and implement interventions to reduce the risk of falls or injury for CR#1. This failure could affect residents who were a fall risk which could result in injury and contribute to avoidable accidents.Findings include: Record review of CR#1's face sheet dated 1/23/26 identified a [AGE] year-old male admitted on [DATE] (initial admission 6/10/24) with diagnoses including metabolic encephalopathy, lack of coordination, bipolar disorder with psychotic features, muscle weakness, muscle wasting and atrophy, wedge compression fracture of the first lumbar vertebra, and history of falls. Review of CR #1's quarterly MDS dated [DATE] revealed a BIMS score of 6, indicating moderate cognitive impairment, and documented a history of falls since the prior assessment. The resident required partial to moderate assistance with sit-to-stand and bed-to-chair transfers. Review of the CR #1's care plan (revised 8/27/25 and 9/8/25) identified the resident as high risk for falls related to confusion, impaired balance, incontinence, unaware of safety needs, use of narcotic pain meds, will attempt to transfer from bed to chair without assistance. Poor balance, psychotropic drug use, unsteady gait. The resident has had an actual fall. Interventions included encourage the resident to participate in activities, follow facility fall precautions and refer to therapy as ordered, the resident needs safe environment with even floors free from spills and/or clutter, adequate, glare free light, a working and reachable call light, the bed in lowest position at night, handrails on walls, personal items within reach, appropriate footwear when ambulating or mobilizing in w/c, and the appropriate adaptive equipment is available and in use. Attempt to anticipate the residents needs and promptly respond to all requests for assistance. Immediately after fall assess resident for injury, investigate to determine and address causative factors of the fall. Obtain statements for witnessed falls. Review the interventions from the at risk for falls care plan. Consult pharmacist for medication if necessary. Actual identified falls and interventions: 6/3/25, no injury, pharmacy review, 6/8/25, no injury, 6/10/25, skin tear and periorbital bruising, 6/13/25, no injury, 6/23/25, no injury, 6/25/25 no injury, 6/27/25 x 2 no injury, 7/1/25, abrasion to left knee, 7/5/25 no injury, 7/6/25 no injury, 7/17/25 no injury, 7/22/25 right lower extremity, sent to emergency room for evaluation, 7/23/25 no injury, 8/8/25 x2 no injury, 8/12/25 no injury, 8/17/25 no injury, 8/22/25 no injury, 8/23/25 no injury, 8/25/25 no injury, 8/25/25 no injury, 8/28/25 skin tear, 8/29/25 no injury, 8/30/25 no injury, 9/2/25 no injury, 9/2/25 no injury, 9/2/25 no injury, 9/2/25 laceration, 9/2/25 no injury, 9/4/25 no injury, 9/9/25 no injury, 9/11/25 no injury, 9/12/25 skin tear. Record review of facility documentation on Falls dated 1/22/26 reflected that CR #1 experienced repeated falls over an extended period. Facility fall tracking records and incident documentation identified falls occurring on the following dates:06/08/2025; 06/12/2025; 06/13/2025; 06/23/2025; 06/27/2025 (two separate falls); 07/05/2025; 07/06/2025; 07/07/2025; 07/16/2025; 07/21/2025; 07/23/2025; 08/08/2025; 08/09/2025; 08/12/2025; 08/17/2025; 08/22/2025; 08/23/2025; 08/25/2025; 08/29/2025; 08/30/2025; 09/02/2025 (six separate falls documented on the same date); and 09/11/2025. These incidents included both witnessed and unwitnessed falls and occurred in the resident's room and other areas of the facility. Falls documentation revealed three were 2 falls with injury, 8/29/25 and 9/7/25. Record review of the EMS report dated 09/07/2025 reflected the resident had a known history of multiple falls and presented with visible evidence of prior injuries, including an old bruise to the left cheek and a bandaged wound to the left forearm. EMS documentation (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	confirmed the resident's fall history at the time of transport to the emergency department for evaluation. Record review of the hospital records dated 09/07/2025 showed the resident was transported via EMS from the nursing facility to the local Hospital for evaluation of altered mental status. EMS documented a history of multiple falls and noted bruising in various stages of healing, including to the left cheek. The resident was documented as stable and discharged back to the facility the same day. Record review revealed this was the only fall CR #1 had an injury resulting a transfer to the hospital. Interview with CR #1's family member on 01/20/26 at 11:43 a.m. was questioned regarding CR #1's falls. Family member referred to the complaint investigation that she had submitted. An interview on 01/21/26 at 12:10 p.m. with the Admin said the facility was doing everything they could to prevent CR #1's falls. She said CR #1 was very impulsive and would not use his call light. She said CR #1 did not want to wait for staff to transfer him back to bed after he smoked. She said it was crazy, he would throw himself when he transferred. An interview on 1/21/26 at 11:30 a.m. with CNA A said she had been working at the facility for about a year. She said she was often assigned to the hall where CR #1 resided. She said CR #1 threw himself during transfers from bed to chair or chair to bed. She said the resident always had bruises from his falls and behaviors. CNA A said his whole face was one big bruise. She said as precautionary the Admin would pull a CNA to sit one-on-one with CR #1 when his behaviors were really bad to prevent falls. CNA A said they knew he would throw himself out of bed during those times. She said CR #1 had fall interventions such as lowering his bed, call light in place, and fall mat beside his bed. She said she had not been trained on the facility policy related to residents with behaviors, however, she was a certified EMT and had been trained as part of her certification. An interview on 1/21/26 at 1:45 p.m. with LVN A said when she first met CR#1 he could transfer himself to his chair, and transfer himself back to bed. She said then he got to where he needed the assistance of one person at times because he was weak in his lower extremities and his dementia was pretty bad. She said after the family installed cameras in CR#1's room his behavior worsened. He said she got along with CR #1 and he had no behavioral concerns with her. LVN A said she had not had behavioral training at the facility, but as a nurse she had behavioral training over time. She said if a resident was aggressive she would try to talk to them and ensure everyone's safety. She said sometimes the resident needs space. She explained the family member would talk to CR#1 through the camera to remind him it was smoke break time and he would try to get up and smoke. LVN A said once the cameras were installed CR #1 had a change in behaviors; he would yell all day long. She said the resident knew his legs were too weak to transfer himself but he would continue to throw himself in the wheelchair. LVN A said she tried to re-educate the resident to not transfer and use the call light, but he would do it anyway. She said often times when she found CR #1 on the floor he was in a kneeling position over his bed or a prone position on the floor. LVN A said the resident was impulsive and insistent to get up to go smoke. An interview on 1/21/26 at 1:37 p.m. with the Admin, DON, and ADON regarding CR#1, the DON said CR#1's family was not real involved with his care when he was first admitted and he did well. The DON said the family member installed cameras in the resident room and she would wake him up because it was smoke time and this would cause him to fall out of bed. The Admin explained the resident would transfer himself by throwing himself to his bed or wheelchair. The Admin said most of his falls were from the wheelchair to the bed. The Admin said the resident was impulsive and impatient and would not wait on anyone to assist him into bed. The Admin said the resident began to fall end of May or early June 2025. The Admin said the family member installed the cameras in the resident room end of June because of his falls and then the falls worsened. The Admin explained CR#1 started to yell out more and had more falls, his behaviors got really bad. (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	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Rehabilitation & Healthcare Center	314 E Caroline St Trinity, TX 75862

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The ADON said the resident refused to use the call light. The ADON said the resident had multiple bruises of different stages all over his body from his falls. DON said CR #1 had interventions for falls like bed lowered to floor, fall mats, call lights in place, rearranged his room and fridge, frequent checks, fall inservices, therapy interventions, and pharmacy reviews. Reviewed a fall timeline with DON which showed CR #1 had multiple falls and she said that there was no new interventions with each fall. In an interview on 1/22/26 at 2:48 pm with MA, described CR#1 as unpredictable and, at times, defiant. MA noted concerns about the resident's family bringing in unauthorized substances and shared that CR#1 was frequently non-compliant with prescribed medications. Additionally, MA reported CR#1 experienced frequent falls. MA stated she was trained by the facility on fall prevention and incident reporting procedures, and confirmed she knew how to appropriately report any fall incidents. In an interview on 1/22/26 at 3:18 pm with CNA B, described she had been employed for over a year and had received training on abuse and neglect. She described herself as diligent in charting and documenting any changes in residents' conditions. CNA B described CR #1 as combative, experiencing memory loss, and being wheelchair-bound. She added CR #1 was often yelling or seeking nurse attention. Review of the facility's policy titled Assessing Falls and Their Causes (MED-PASS, revised March 2018) requires assessment following each fall, identification of potential causes and patterns within 24 hours, and modification of interventions when falls recur despite existing precautions.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) were provided to meet the needs of each resident for 1 of 11 residents reviewed for pharmacy services (CR#1). The facility failed to administer Naloxone (Narcan), as ordered for suspected opioid overdose, to CR #1 on 09/09/2025. Despite staff suspicion of possible drug use and the resident presenting with unresponsiveness, facility nursing staff did not provide the emergency medication before EMS arrival. This failure could place residents at risk for delayed emergency intervention, exacerbation of life-threatening conditions, and increased potential for physical harm.Findings include: Record review of CR#1's face sheet dated 1/23/26 identified a [AGE] year-old male admitted on [DATE] (initial admission 6/10/24) with diagnoses including metabolic encephalopathy, lack of coordination, bipolar disorder with psychotic features, muscle weakness, muscle wasting and atrophy, wedge compression fracture of the first lumbar vertebra, and history of falls. Record review of CR #1's quarterly MDS dated [DATE] revealed a BIMS score of 6, indicating moderate cognitive impairment, and documented a history of falls since the prior assessment. The resident required partial to moderate assistance with sit-to-stand and bed-to-chair transfers. Record review of CR#1's care plan dated 1/23/26 revealed no use of Narcan or interventions identified for when to administer. Record review of the EMS Prehospital Care Report dated 09/09/2025 showed EMS was called by the facility at 2:48 pm. Upon EMS arrival at 3:35 pm an unknown facility staff informed Paramedic that Narcan had not been administered. EMS proceeded to give two doses of Narcan, after which the resident became alert. Documentation from EMS noted the unknown nurse stated they have not given the patient any narcotic medications and suspect that the patients family might be giving him drugs while they visits and state patient has a past history ofdrug abuse. Record review of the Prehospital Care Report dated 09/09/2025 revealed that Emergency Medical Services (EMS) were dispatched to the facility for Resident #1, who was found unresponsive but breathing. EMS documentation by the Paramedic states that upon arrival, the resident was unresponsive. EMS administered two doses of intranasal Naloxone (Narcan) at 3:46p.m. and 3:49 pm.The report notes, Patient became alert after second dose and screamed at me. Patient is now C/A/O x2. V/S stable. Record review of CR#1's MAR for September 2025 showed a standing medication for Naloxone (Narcan) nasal spray 1 spray every 2 minutes as needed for suspected opioid overdose. There was no documentation of administration by facility staff for this or any prior similar event. Record review of CR #1's September 2025 MAR revealed an order to monitor the resident for the following signs/ symptoms/ behaviors that might be indicative of abuse and/ or overdose each shift. Indicate Y for yes they are present and promptly notify the physician/ pharmacist if any occur. Indicate N if none are present. Every shift for Opioid use poor motor skills/ coordination, digestive issues, pupil constriction, slowed thinking/ impaired judgement/ problem-solving, unprovoked outbursts, requesting increased dosage, drowsiness, unresponsive/ unable to speak, slow breathing, and erratic pulse. Nursing notated a N or 0 for September 1st through September 14th 2025. An interview on 1/21/26 at 11:30 a.m. with CNA A said she had suspicions the family was bringing in street drugs. She said after the family would leave then CR #1 would have a change in condition. She said he would become unresponsive after family visits. She said one time she saw the EMS give the resident Narcan and he immediately came out of his lethargy. She stated the resident had a history of substance abuse before his admission to the facility. No timeframes were given in that interview. Family was unable to be interviewed about this statement. Interview on 01/23/2026 at 10:15 AM with LVN B, confirmed staff suspected possible drug use or opioid (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	toxicity, based on the resident's history and current symptoms such as congestive heart failure, hypertensive disorder, Bipolar disorder, chronic pain, chronic kidney disease, major depressive disorder, and acute respiratory failure. With symptoms of being unresponsive and lethargic. LVN B stated, We thought he might have taken something again, but we waited for EMS because we weren't sure if it was safe to give Narcan. Interview on 01/23/2026 at 11:30 AM with the DON confirmed Narcan was available in the facility at the time of the incident and nursing staff were trained on Narcan administration. The DON stated, Our policy says to administer Narcan if you suspect overdose. In this case, the nurse did not administer it before EMS arrival. The DON said she received the new policy via email from the corporate nurse and it was her responsibility to ensure the nurses were trained. Record review of facility policy, Prevention and Treatment of Substance Abuse Disorders (revised December 2022), states: If opioid overdose is suspected and naloxone administration is indicated, 911 should be called immediately and naloxone administered. All nurses will be provided with instructions regarding the administration of naloxone nasal spray. Two doses of naloxone nasal spray are provided in the Omnicell at all times.