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	03/04/2026

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 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **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 the necessary services to maintain personal hygiene for 1 of 4 residents reviewed for ADL care. (Resident #10)The facility failed to ensure Resident #10 received timely incontinent care on 03/04/2026 which caused redness to inner thighs and excoriation to buttocks.This failure could place residents at risk of embarrassment, discomfort, and skin breakdown.Findings included:Record review of an admission Record dated 3/4/2026 for Resident #10 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of type 2 diabetes, colostomy status (opening into the abdomen for the collection of stool), and hemiplegia affecting right dominant side (paralyzed on right side).Record review of a Quarterly MDS assessment dated [DATE] for Resident #10 indicated he had moderate impairment in thinking with a BIMS score of 12. He was dependent on staff for toileting hygiene. He had an indwelling catheter (for bladder contents to exit) and an ostomy (opening in the abdomen for bowel contents to exit),; urinary and bowel continence were not rated. He was at risk of developing pressure ulcers/injuries but did not have any unhealed pressure ulcers/injuries during the look back period.Record review of a care plan dated 1/27/2022 for Resident #10 indicated he had the potential for alteration in skin integrity. Interventions included to keep skin clean and dry, and provide incontinent care as quickly as possible following episodes of voiding or bowel movement.Record review of a care plan dated 8/10/2019 for Resident #10 indicated he had an ADL self-care performance deficit related to disease process. Interventions for toilet use were he required a colostomy, ensure dignity was maintained, privacy was provided and was clean, dry, and free from odor.During an observation and interview on 3/4/2026 at 9:09 am, CNA C and CNA D were in the room of Resident #10 to perform incontinent care. Both staff donned a gown prior to entering the room. Both staff washed their hands and applied gloves. Resident #10 was awake in bed, dressed in a hospital gown, and lying on an air mattress. His room had a strong smell of urine. Contractures were noted to both of Resident #10's hands, and his nails were long with a dark, brown substance underneath them. Resident #10 had a colostomy noted to his left lower abdomen, and a foley catheter that was draining clear, yellow urine into a drainage bag. CNA D placed a towel on his over the bed table as a barrier. CNA C pulled the linens back and a pillowcase was observed between his thighs that was soaked in urine that had a strong odor. CNA D removed the pillowcase and placed it into a plastic bag. Resident's #10's groin and inner thighs were wet, and redness was noted to his mid-thigh. His under pad was wet with urine and had a brown ring that extended to his upper back. Resident #10 had white, dried, flaky skin around the base of his penis. CNA D removed a wipe from a package and cleaned his penis at the base of the shaft and placed the wipe in the trash. CNA D removed more wipes and cleaned the shaft and insertion site of the foley down the tubing and placed the wipes in the trash. Resident #10 said his catheter had been leaking and started sometime during the night of 3/3/2026. CNA C rolled the resident onto his right side and CNA D removed the under pad and placed it in a bag. Resident #10's entire back was wet from urine. The skin on his back was wrinkled, and an old healed sacral wound was observed that was white with one small open area with the top layer of skin missing. CNA D placed a clean under pad under the (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 0677 Level of Harm - Actual harm Residents Affected - Few	resident's buttocks. Both staff told the resident he would get a shower and the resident said ok.During an interview on 3/4/2026 at 9:27 am, CNA C said the care provided to Resident #10 looked like he did not get changed last night 3/3/2026. She said his entire bed was wet and he had a bad urine odor. She said his nails were dirty, needed to be cleaned, and should be done on his shower days, but if he was diabetic, the nurse would trim his nails. She said they were to check the resident every 2 hours, and she would be angry if she was left in that condition. She said she cleaned Resident #10's nails Monday 3/2/2026 when she gave him a shower. She said Resident #10 did not have any redness or open areas on his buttocks when she gave him a shower on Monday 3/2/2026.During an interview on 3/4/2026 at 9:33 am, CNA D said that day was her fourth day working at the facility, and she was assigned to Hall 100 where Resident #10 resided. She said Resident #10 looked very raw like he had a bad rash down his legs and his under pad was wet with brown rings which meant he had been that way for a long time. She said they made rounds every 2 hours. She said her shift started at 6 am and that was her first time to provide incontinent care for Resident #10. She said she had been in his room earlier but only emptied his drainage bag for his catheter. She said she would be upset with the condition he was left in if it was her. She said she only checked the catheter and emptied it. She said residents could be at risk of skin breakdown if care was not provided timely.During an observation and interview on 3/4/2026 at 9:38 am, Resident #10 was in bed awake and said he had been at the facility for 4-5 years and things were good. He said his scheduled shower days were Mondays, Wednesdays, and Fridays, and they usually gave him a bed bath. He was alert to person, place, and time. He said staff came into his room last night 3/3/2026 a couple times to check on him and his catheter started leaking last night. He stated they placed something between his legs. He said that it was the first time someone came into his room that morning. He said they cleaned his nails sometimes, but they did not clean his nails on 3/2/2026. He said two people came into his room and gave him a bed bath on Monday 3/2/2026. He said he did not feel good about it when they did not provide care to him timely, and he could tell that he was wet. He stated he also did like his nails being dirty.During an interview on 3/4/2026 at 11:16 am, the DON said she was made aware of Resident #10 who was left soiled in urine. She said regardless of if a resident has a catheter and colostomy, staff should clean the anus, make sure the pad underneath them was clean and dry, and they needed to clean the penis and around the shaft. She said a minimum of every 2 hours, staff should go in and check on residents. She said the shift started at 6 am and care should have been done before 9 am. She said the staff should be doing walking rounds at the beginning of the shift with the staff that were leaving to ensure care was provided. She said nails should be cleaned at every shower, and he was diabetic and would not allow staff to cut his fingernails. She said if she was dependent, she would be enraged and dependent on staff to provide care. She said there was a risk of skin breakdown if care was not provided timely.During an interview on 3/4/2026 at 2:46 pm, the Administrator said staff should check on residents at a minimum of every 2 hours and as needed. She said the staff should conduct off going shift rounds and check them to make sure they were clean and dry. She said nails should be cleaned as needed and when visibly soiled. She said if she were not provided care timely and left wet, it would make her feel awful and it would be unacceptable. She said she expected staff to take care of the residents and make sure their needs were met. She said they started in-services with staff on rounding. She said there was a risk of skin breakdown, infections, or mental anguish if incontinent care was not provided timely.Record review of the facility's policy titled Activities of Daily Living (ADLs), Supporting revised March 2018 indicated, .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to, based on the comprehensive assessment of a resident, ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 5 residents (Resident #1) reviewed for quality of care. The facility failed to ensure Resident #1's skin was appropriately assessed and treated resulting in skin breakdown. This failure could place all residents at risk of skin breakdown, infection, and hospitalization.Findings included: 1. Review of an admission Record dated 4/7/26 for Resident #1 indicated he was an [AGE] year-old male readmitted to the facility on [DATE] with diagnoses of pneumonia (respiratory infection), type 2 diabetes, and acquired absence of right leg above the knee (amputation of right leg above the knee). Record review of an assessment MDS dated [DATE] indicated Resident #1 had intact cognition with a BIMS of 15. He required setup/clean-up assistance with eating and oral hygiene; he required partial assistance with upper body dressing and putting on/taking off footwear; he required substantial assistance with shower/bath; he required total assistance with toileting hygiene, and lower body dressing. He was always incontinent of bowel and bladder. He had no documented ulcers, wounds, or skin problems. He received skin treatments of applications of ointments/medications other than to feet. Record review of a comprehensive care plan dated 1/15/2025 indicated Resident #1 had bladder incontinence related to impaired mobility/physical limitations. Interventions were in place including providing incontinent care after each episode of incontinence. Record review of a comprehensive care plan dated 6/28/25 indicated Resident #1 had potential for alteration in skin integrity related to impaired mobility. Interventions were in place including weekly skin inspections, keeping skin clean and dry, and inform the physician, family, dietician, and DON of any new skin breakdown. During an interview on 4/7/26 at 10:50 a.m., Resident #1 said he frequently waited 30 minutes to an hour to receive incontinent care. Resident #1 said he was currently wet and had not been changed that day. Resident #1 said it made him feel bad not to receive the care he needed in the facility. Resident #1 said he had used his call light but staff would frequently answer his light and tell him they would return, but they would not come back. Resident #1 said he had pain and itching around his genitals. During an observation on 4/7/26 at 11:15 a.m., CNA A and CNA B assisted Resident #1 with incontinent care. CNAs donned appropriate PPE and utilized appropriate techniques during care provided, no deficient practice was noted. Observation of Resident #1's skin revealed his scrotum to be reddened with open wounds visualized on his right thigh/groin area. During an interview on 4/7/26 at 12:00 p.m., LVN C said Resident #1 had no active skin integrity issues. LVN C said Resident #1 had a resolved pressure ulcer on his backside. LVN C said no new skin integrity concerns had been reported to her, but staff may have reported issues to the treatment nurse. LVN C said she expected CNA staff to report any suspected skin integrity concerns to the charge nurse so it can be assessed. LVN C said the risk to residents for unreported skin integrity issues could be skin breakdown. During an interview on 4/7/26 at 1:40 p.m., CNA A said she changed Resident #1's brief around 6:15 a.m. and 11:15 a.m. that day. CNA A said she noted Resident #1 had redness to his genitals and surrounding skin, but it had been ongoing for about a week now. CNA A said she didn't report the redness to nursing staff because it comes and goes. CNA A said she just applied barrier cream to affected areas. CNA said she should report any skin issues to the nurse immediately upon noticing the changes. During an interview on 4/7/26 at 2:10 p.m., LVN D said she was the treatment nurse and Resident #1 had no open wounds to her knowledge and no active wound care orders. LVN D said no skin integrity concerns for Resident #1 had been reported to her. LVN D said she recently completed an inservice with staff about reporting skin conditions to nursing staff and the expectation was that CNAs report any skin integrity concerns to the nursing staff. LVN D said if a new skin issue was reported to her she would assess the resident, notify the provider, and obtain new orders for wound care. LVN D said (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	the risk of not reporting skin integrity issues immediately could include skin breakdown and infections. During an observation on 4/7/26 at 2:25 p.m., LVN D conducted a skin assessment on Resident #1. LVN D noted open wounds to resident's right inner thigh and redness to resident's scrotum. LVN D applied a barrier cream to reddened skin and collected wound measurements. During an interview at 4/7/26 at 3:20 p.m., the DON said CNAs were expected to monitor residents for skin integrity issues and report any findings to the charge nurse. The DON said an immense amount of education regarding reporting changes of condition had been completed already. The DON said CNAs were expected to immediately report changes in resident skin condition to the nurse who will then assess resident and notify the provider. During an interview on 4/7/26 at 4:01 p.m., the ADM said she was ultimately responsible for supervision of all staff in the building. The ADM said CNAs were expected to report any change of condition in residents, including skin integrity concerns, should be reported immediately to the nurse; the nurse was then responsible for assessing the resident and notifying providers of any change of condition. The ADM said the risk to residents for untimely change of condition notifications would be delay of treatment. Review of a facility policy titled Perineal Care dated February 2001 indicated The purposes of this procedure are to provide cleanliness and comfort to the resident, the prevent infections and skin irritation, and to observe the resident's skin condition. Review of undated in-service titled Wound care In-service: Communication & Notification Protocol indicated .Notify wound care nurse immediately for: New Wounds, Skin Tears, Rashes, Redness or suspected pressure injuries, Any skin concern or abnormal finding. The in-service was attended by CNA A and CNA B. Review of a skin assessment dated [DATE] at 2:59 p.m. by LVN A conducted on Resident #1 indicated he had new moisture associated skin damage/incontinence associated dermatitis acquired in house. The wound measurements were 10 cm x 10 cm. Review of order summary for Resident #1 dated 4/7/26 indicated new wound care orders were received on 4/7/26 including .SCROTUM AND INNER RIGHT THIGH: Cleanse site with NS or wound cleanser, pat dry and apply zinc oxide. With each dressing change observe the woundand document.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and record review, the facility failed to ensure the residents' environment remains as free of accident hazards as possible for 1 of 6 residents reviewed for quality of care. (Resident # 4)The facility failed to ensure CNA A and CNA B properly and safely transferred Resident #4 while using a mechanical lift on 3/3/2026.This failure could result in a loss of quality of life due to injuries.Findings included:Record review of an admission Record for Resident #4 dated 3/5/2026 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of Alzheimer's disease, expressive language disorder (a communication disorder that affects a person's ability to express thoughts, ideas, or emotions using language), and osteoporosis (brittle bones).Record review of a care plan for Resident #4 revised 2/13/2026 indicated she had an ADL self-care performance deficit and limitation in physical mobility. Interventions for transfers indicated she required the use of a Hoyer Lift with two staff for transfers.Record review of a Quarterly MDS Assessment for Resident #4 dated 1/1/2026 indicated she was rarely/never understood. She was dependent on staff for all ADLs including transfers.Record review of a care plan for Resident #4 revised 2/13/2026 indicated she had an ADL self-care performance deficit and limitation in physical mobility. Interventions for transfers indicated she required the use of a Hoyer Lift with two staff for transfers.During an observation on 3/3/2026 at 12:15 pm, CNA A and CNA B were in the room of Resident #4 to transfer her using a mechanical lift. Both staff applied gloves to their hands. A mechanical lift was in the room. CNA B moved the mechanical lift, widened the base, and placed the legs under the bed. Both staff applied the lift sling that was underneath the resident to the lift. CNA B did not lock the wheels and proceeded to lift the resident from the bed and CNA A assisted with guiding and holding onto the resident. CNA B closed the legs on the lift and moved it to the wheelchair. CNA B widened the base of the lift and lowered the resident into the wheelchair. As she was lowering the resident, one of the wheels lifted off the floor and CNA B stood on the lift to get the wheel to touch the floor. CNA A guided the resident in the wheelchair without any difficulty, the sling was detached from the lift, and the lift was moved out of the way.During an interview on 3/3/2026 at 12:22 pm, CNA B said she should have locked the wheels on the lift, but she could not because the lock was broken. She said that lift was usually the only one they could use because the two other lifts operated by batteries and they were never fully charged. She said she had been trained in how to use the mechanical lift in the past. She said she told the DON that the lift was broken and they could not lock the wheels. She said it had been broken since she started and had been employed at the facility for about 3 months. She said she used the lift because it was all they had to use. She said she was not sure why one of the wheels came up from the floor when she used it. She said there could be a risk for the mechanical lift to tip over, or injury could occur if the lift was broken and could not lock the wheels. She said she had refused to use that lift before, but when she did, they treated her like she was lazy and as if she did not want to use it.During an observation and interview on 3/3/2026 at 12:50 pm, the DON said she removed the mechanical lift that was used to transfer Resident #4. The lift was in her office and demonstrated the lock worked on the lift. She said the lift only had one lock and it functioned properly.During a phone interview on 3/4/2026 at 10:16 am, CNA A said she did not notice that CNA B did not lock the wheels on the lift and was not aware the wheels on the lift did not lock. She said residents could fall and get hurt if the wheels did not lock on the lifts.During an interview on 3/4/2026 at 11:16 am, the DON said two people were required for the use of a mechanical lift. She said Resident #4 would require two people for transfers with a lift. She expected that the residents were secure, everything was arranged with one to work it, and one to guide the lift to the correct location and after getting in position the wheels should be locked. She said residents could be at risk of residents falling and getting hurt if staff were not trained. She said the mechanical (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lift that was used only had one lock on one of the wheels and it worked. She said staff should not use equipment that did not work properly.During an interview on 3/4/2026 at 2:46 pm, the Administrator said staff should not use mechanical lifts if the locks did not work and should report it to the nurse, Maintenance, or the DON. She said there was a risk of an accident if staff did not lock the wheels while using the mechanical lift. She stated she expected staff to follow policy and procedure.Record review of the facility's policy titled Safe Lifting and Movement of Residents revised July 2017 indicated, .In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. 4. Staff responsible for direct resident care will be trained in the use of manual and mechanical lifting devices . 6. Staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable, physical, mental, and psychosocial well-being for 1 of 5 staff (CNA B) reviewed for nursing services.The facility failed to ensure CNA B properly and safely transferred Resident #4 while using a mechanical lift on 3/3/2026.This deficient practice could place residents at risk for injury and harm.The findings included: Record review of an admission Record for Resident #4 dated 3/5/2026 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of Alzheimer's disease, expressive language disorder (a communication disorder that affects a person's ability to express thoughts, ideas, or emotions using language), and osteoporosis (brittle bones).Record review of a care plan for Resident #4 revised 2/13/2026 indicated she had an ADL self-care performance deficit and limitation in physical mobility. Interventions for transfers indicated she required the use of a Hoyer Lift with two staff for transfers.Record review of a Quarterly MDS Assessment for Resident #4 dated 1/1/2026 indicated she was rarely/never understood. She was dependent on staff for all ADLs.Record review of a care plan for Resident #4 revised 2/13/2026 indicated she had an ADL self-care performance deficit and limitation in physical mobility. Interventions for transfers indicated she required the use of a Hoyer Lift with two staff for transfers.During an observation on 3/3/2026 at 12:15 pm, CNA A and CNA B were in the room of Resident #4 to transfer her using a mechanical lift. Both staff applied gloves to their hands. A mechanical lift was in the room. CNA B moved the mechanical lift and widened the base and placed the legs under the bed. Both staff applied the lift sling that was underneath the resident to the lift. CNA B did not lock the wheels and proceeded to lift the resident from the bed and CNA A assisted with guiding and holding onto the resident. CNA B closed the legs on the lift and moved it to the wheelchair. CNA B widened the base of the lift and lowered the resident into the wheelchair. As she was lowering the resident, one of the wheels lifted off the floor and CNA B stood on the lift to get the wheel to touch the floor. CNA A guided the resident in the wheelchair without any difficulty, and the sling was detached from the lift, and the lift was moved out of the way.During an interview on 3/3/2026 at 12:22 pm, CNA B said she should have locked the wheels on the lift, but she could not because the lock was broken. She said that lift was usually the only one they could use because the two other lifts operated by batteries and they were never fully charged. She said she had been trained in how to use the mechanical lift in the past. She said she told the DON that the lift was broken and they could not lock the wheels. She said it had been broken since she started and had been employed at the facility for about 3 months. She said she used the lift because it was all they had to use. She said she was not sure why one of the wheels came up from the floor when she used it. She said there could be a risk for the mechanical lift to tip over or injury could occur if the lift was broken and could not lock the wheels. She said she had refused to use that lift before but when she did, they treated her like she was lazy and as if she did not want to use it.During an observation and interview on 3/3/2026 at 12:50 pm, the DON said she removed the mechanical lift that was used to transfer Resident #4. The lift was in her office and demonstrated the lock worked on the lift. She said the lift only had one lock and it functioned properly.During a phone interview on 3/4/2026 at 10:16 am, CNA A said she did not notice that CNA B did not lock the wheels on the lift and was not aware the wheels on the lift did not lock. She said residents could fall and get hurt if the wheels did not lock on the lifts.During an interview on 3/4/2026 at 11:16 am, the DON said two people were required for the use of a mechanical lift. She said Resident #4 would require two people for transfers with a lift. She expected that the residents were secure, everything was arranged with one to work it and one to guide, when getting in position wheels should be locked. She said staff had competency check offs (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the lift involving the two staff on hire, as needed, and annually. She said she could not find a competency checklist for the use of a mechanical lift for CNA A. She said residents could be at risk of falling and getting hurt if staff were not properly trained. She said the mechanical lift that was used only had one lock on one of the wheels and it worked. She said staff should not use equipment that would not work properly.During an interview on 3/4/2026 at 2:46 pm, the Administrator said new hires were given skills check offs that included the use of a mechanical lift on hire, as needed, and annually thereafter. She said staff should not use the mechanical lift if the locks did not work and should report it to the nurse, Maintenance, or the DON. She said there was a risk of an accident if staff did not lock the wheels while using the mechanical lift.Record review of competency skills for CNA B revealed she did not have a skills check off on hire, and none was provided before Surveyor exit 3/4/2026.Record review of a Hoyer lift transfer check list for CNA A dated 11/5/2025 indicated she completed the Hoyer lift transfer.Record review of a facility policy titled Competency of Nursing Staff revised May 2025 indicated, .6. Facility and resident specific competency evaluations will be conducted upon hire, annually and as deemed necessary based on the facility assessment.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 5 residents (Resident #5) reviewed for infection control.The facility failed to ensure CNA A followed enhanced barrier precautions when she provided personal care that included dressing of Resident #5 on 3/3/2026.This failure could place residents at risk of exposure to infectious diseases due to improper infection control practices.Findings included:Record review of an admission Record for Resident #5 dated 3/4/2026 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of dysphagia (difficulty speaking), hypertension, and cerebral infarction (stroke).Record review of an Annual MDS Assessment for Resident #5 dated 2/9/2026 indicated she had severe impairment in thinking with a BIMS score of 3. She required substantial/maximal assistance with upper and lower body dressing.Record review of a care plan for Resident #5 revised 11/11/2025 indicated she had a stage 4 pressure ulcer to her right lateral ankle. Interventions included that she required EBP (Enhanced barrier precautions) gown and gloves were required to be worn during high contact care.Record review of active physician orders for Resident #5 dated 3/4/2026 indicated a physician order for enhanced barrier precautions during episodes of high-contact care that started on 11/4/2025.Record review of an order listing report for the facility dated 3/3/2026 indicated Resident #5 had an order for EBP with a start date of 11/4/2025.During an observation and interview on 3/3/2026 at 11:52 am, CNA A was in the room of Resident #5 dressing her. Resident #5 had a sign on her door for EBP. CNA A said she had performed incontinent care prior to Surveyor's entrance into the room. CNA did not have a gown on and was only wearing gloves. CNA A placed a shirt and a pair of pants on Resident #5 and repositioned the resident in bed. CNA A removed her gloves and placed them in the trash, exited the room, and sanitized her hands.During a phone interview on 3/4/2026 at 10:16 am, CNA A said the care she provided to Resident #5 on 3/3/2026, she was not aware Resident #5 was on EBP and did not notice the sign on the door. She said yesterday 3/3/2026 was her first day working on hall 100 where Resident #5 resided. She said usually if a resident were on EBP, there would be PPE in the hallway outside the room, and the resident did not have any in the hallway. She said if a resident was on EBP, then staff should wear a gown and gloves when care was provided that included dressing the resident. She said there was risk of spreading infections to other residents if they did not. She said she had training on EBP a long time ago.During an interview on 3/4/2026 at 11:16 am, the DON said Resident #5 was on EBP. She said if a resident was on EBP, staff should wear gowns and gloves to protect the residents and if residents had a wound like Resident #5 had a wound to her ankle. She said gowns and gloves should be worn during high contact care which included incontinent care, changing foleys, wound care, and dressing the resident. She said there was a risk for the potential of the residents to get an infection. She said she was the IP for the facility and would be responsible for ensuring that they were trained on infection control.During an interview on 3/4/2026 at 2:46 pm, the Administrator said staff had been trained on EBP with the last training being conducted December 2025. She said residents who were on EBP would have posted signs on the resident doors. Residents who required EBP included foley catheters, wounds, IVs, and ostomies. She said staff should wear gowns and gloves if the resident was on EBP while providing care that included dressing a resident. She said there was a risk of infections if they did not follow EBP.Record review of the facility policy titled Personal Protective Equipment-Enhanced Barrier Precautions revised April 2024 indicated, .To ensure personal protective equipment appropriate to specific task requirements is available at all time for staff residents when rendering high-contact direct care activities for residents with chronic wounds. 1. Enhanced barrier precautions refer to infection control interventions designed to reduce transmission of (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	03/04/2026

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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(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 - Few	multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. 5. High contact resident care activities that require Enhanced Barrier Precautions (EBP), a. Dressing.