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 04/15/2026

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 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on interview and record review, the facility failed to provide effective communications mandatory training for 6 of 17 direct care staff (CNA K, CNA F, LVN A, LVN L, LVN M and the ADON) reviewed for training requirements. The facility failed to ensure effective communication training was provided to CNA K, CNA F, LVN A, LVN L, LVN M and ADON.This failure could affect residents and place them at risk of miscommunication and social isolation due to lack of staff training. Findings included: Record review of the personnel file for CNA K revealed a hire date of 05/19/2025 and no evidence of initial hire training on effective communication. Record review of the personnel file for CNA F revealed a hire date of 05/22/2025 and no evidence of initial hire training on effective communication. Record review of the personnel file for LVN A revealed a hire date of 12/10/2025 and no evidence of initial hire training on effective communication. Record review of the personnel file for LVN L revealed a hire date of 01/06/2026 and no evidence of initial hire training on effective communication. Record review of the personnel file for LVN M revealed a hire date of 10/06/2025 and no evidence of initial hire training on effective communication. Record review of the personnel file for ADON revealed a hire date of 12/05/2025 and no evidence of initial hire training on effective communication. During an interview on 4/15/2026 at 10:00 AM, The ADON said he said was not aware that the training on effective communication had not been completed on his hire date before he started resident care. He said initial training with assigned in a computer program, and the staff completed the topics that were assigned by HR or corporate. He said he assisted with getting nursing staff trained during orientation, prior to employment and annually. She said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care. During an interview on 04/15/2026 at 10:30 AM, HR said she was new to her position at the facility and was responsible for completing the orientation and other paperwork. She said she was not aware that effective communication training had not been completed as required for all employees. She said going forward she would complete a checklist for the required training and ensure completion. She said staff could be at risk of lack of information and residents could be at risk of harm for a multitude of things if staff did not receive the training they needed. HR said going forward she will make sure all training is completed before resident care is started and annually as required by regulations.During an interview on 4/15/2026 at 11:38 AM, The Administrator said the staff were initially trained by logging into a website and have continued to watch the training videos that included abuse/neglect, blood borne pathogens, misuse of resident property, resident rights, effective communication, dementia, and fall prevention. She said she was ultimately responsible for ensuring the staff received the required training during orientation prior to employment and annually. She said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care. She said she would ensure there was a system in place and a check list for the training. During an interview on 4/15/2026 at 12:05 PM, The DON said She said responsible for ensuring the nursing received the required training on effective communication during orientation prior to employment and annually. She said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care. Record (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: 676439	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2026

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of a facility policy revised 02/2026 indicated, .Staff Development Program.Policy StatementAll personnel must participate in initial orientation and regularly scheduled in-service training classes.Policy Interpretation and Implementation1. Staff development is defined as initial orientation, followed by regularly scheduled in-service training programs.2.The primary objective of our facility's Staff Development Program is to ensure that staff have the knowledge, skills and critical thinking necessary to provide excellent resident care.5.Required training topics include: a. Effective communication with residents and family (direct care staff).

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on interviews and record review, the facility failed to provide the mandatory training on standards, policies, and procedures for an infection prevention and control program for 9 of 17 direct care staff (CNA K, CNA F, CNA E, LVN A, LVN L, LVN M, the Dietary Manager, the Activity Director and the ADON) reviewed for training requirements.The facility failed to ensure mandatory training on standards, policies, and procedures for an infection prevention and control program effectively was provided to CNA K, CNA F, CNA E, LVN A, LVN L, LVN M, Dietary Manager, Activity Director and the ADONThis failure could place residents at risk of illness or spread of infections due to lack of staff training.Findings included:Record review of the personnel file for CNA K revealed a hire date of 05/19/2025 and no evidence of initial hire training on infection prevention and control.Record review of the personnel file for CNA F revealed a hire date of 05/22/2025 and no evidence of initial hire training on infection prevention and control.Record review of the personnel file for CNA E revealed a hire date of 06/29/2024 and no evidence of annual training on effective infection prevention and control.Record review of the personnel file for LVN A revealed a hire date of 12/10/2025 and no evidence of initial hire training on infection prevention and control.Record review of the personnel file for LVN L revealed a hire date of 01/06/2026 and no evidence of initial hire training on infection prevention and control.Record review of the personnel file for LVN M revealed a hire date of 10/06/2025 and no evidence of initial hire training on infection prevention and control.Record review of the personnel file for the Dietary Manager revealed a hire date of 03/06/2026 and no evidence of initial hire training on infection prevention and control.Record review of the personnel file for Activity Director revealed a hire date of 04/01/2026 and no evidence of initial hire training on infection prevention and control.Record review of the personnel file for ADON revealed a hire date of 12/05/2025 and no evidence of initial hire training on infection prevention and control.During an interview on 4/15/2026 at 10:00 AM, The ADON said he said was not aware that the training on infection control and prevention had not been completed on his hire date before he started resident care. He said initial training with assigned in a computer program and the staff completed the topics that were assigned by HR or corporate. He said he assisted with getting nursing staff trained during orientation prior to employment and annually. He said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care and spread infections.During an interview on 04/15/2026 at 10:30 AM, HR said she was new to her position at the facility and was responsible for completing the orientation and other paperwork. She said she was not aware that infection control training had not been completed as required for all employees. She said going forward she would complete a checklist for the required training and ensure completion. She said staff could be at risk of lack of information and residents could be at risk of harm for a multitude of things if staff did not receive the training they needed. HR said going forward she will make sure all training is completed before resident care is started and annually as required by regulations.During an interview on 4/15/2026 at 11:38 AM, The Administrator said the staff were initially trained by logging into a website and have continued to watch the training videos that included abuse/neglect, blood borne pathogens, infection control, misuse of resident property, resident rights, behavioral health, effective communication, dementia, and fall prevention. She said she was ultimately responsible for ensuring the staff received the required training during orientation prior to employment and annually. She said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care. She said she would ensure there was a system in place and a check list for the training.During an interview on 4/15/2026 at 12:05 PM, The DON said She said responsible for ensuring the nursing received the required training on infection control during orientation prior to employment and annually. She said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care by (continued on next page)

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	676439	A. Building B. Wing	04/15/2026

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	spreading infections.Record review of a facility policy revised 02/2026 indicated, .Staff Development Program.Policy StatementAll personnel must participate in initial orientation and regularly scheduled in-service training classes.Policy Interpretation and Implementation1. Staff development is defined as initial orientation, followed by regularly scheduled in-service training programs.2.The primary objective of our facility's Staff Development Program is to ensure that staff have the knowledge, skills and critical thinking necessary to provide excellent resident care.5.Required training topics include: e. The infection prevention and control program standards, policies and procedures.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on interviews and record review, the facility failed to provide mandatory behavioral health training for 9 of 17 direct care staff (CNA K, CNA F, CNA E, LVN A, LVN L, LVN M, the Dietary Manager, the Activity Director and the ADON) reviewed for training requirements.The facility failed to ensure effective communication training was provided to CNA K, CNA F, CNA E, LVN A, LVN L, LVN M, the Dietary Manager, the Activity Director and the ADONThis failure could place residents with behaviors at risk of not receiving care to attain or maintain their highest practicable physical, mental, and psychosocial well-being due to lack of staff training. Findings included:Record review of the personnel file for CNA K revealed a hire date of 05/19/2025 and no evidence of initial hire training on behavioral health.Record review of the personnel file for CNA F revealed a hire date of 05/22/2025 and no evidence of initial hire training on behavioral health.Record review of the personnel file for CNA E revealed a hire date of 06/29/2024 and no evidence of annual training on behavioral health.Record review of the personnel file for LVN A revealed a hire date of 12/10/2025 and no evidence of initial hire training on behavioral health.Record review of the personnel file for LVN L revealed a hire date of 01/06/2026 and no evidence of initial hire training on behavioral health.Record review of the personnel file for LVN M revealed a hire date of 10/06/2025 and no evidence of initial hire training on behavioral health.Record review of the personnel file for the Dietary Manager revealed a hire date of 03/06/2026 and no evidence of initial hire training on behavioral health.Record review of the personnel file for Activity Director revealed a hire date of 04/01/2026 and no evidence of initial hire training on behavioral health.Record review of the personnel file for ADON revealed a hire date of 12/05/2025 and no evidence of initial hire training on behavioral health.During an interview on 4/15/2026 at 10:00 AM, The ADON said he said was not aware that the training on behavioral health had not been completed on his hire date before he started resident care. He said initial training with assigned in a computer program and the staff completed the topics that were assigned by HR or corporate. He said he assisted with getting nursing staff trained during orientation prior to employment and annually. He said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care.During an interview on 04/15/2026 at 10:30 AM, HR said she was new to her position at the facility and was responsible for completing the orientation and other paperwork. She said she was not aware that behavioral health training had not been completed as required for all employees. She said going forward she would complete a checklist for the required training and ensure completion. She said staff could be at risk of lack of information and residents could be at risk of harm for a multitude of things if staff did not receive the training they needed. HR said going forward she will make sure all training is completed before resident care is started and annually as required by regulations.During an interview on 4/15/2026 at 11:38 AM, The Administrator said the staff were initially trained by logging into a website and have continued to watch the training videos that included abuse/neglect, blood borne pathogens, misuse of resident property, resident rights, behavioral health, effective communication, dementia, and fall prevention. She said she was ultimately responsible for ensuring the staff received the required training during orientation prior to employment and annually. She said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care. She said she would ensure there was a system in place and a check list for the training.During an interview on 4/15/2026 at 12:05 PM, The DON said She said responsible for ensuring the nursing received the required training on behavioral health during orientation prior to employment and annually. She said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care.Record review of a facility policy revised 02/2026 indicated, .Staff Development Program.Policy StatementAll personnel must participate in initial orientation and regularly scheduled in-service training classes.Policy Interpretation and (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implementation1. Staff development is defined as initial orientation, followed by regularly scheduled in-service training programs.2.The primary objective of our facility's Staff Development Program is to ensure that staff have the knowledge, skills and critical thinking necessary to provide excellent resident care.5.Required training topics include: j. Behavioral Health Fundamentals, Person-Centered Behavior Management and Dementia Care.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents have the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the option he or she prefers for 1 of 4 residents (Resident #1) reviewed for resident rights.The facility failed to ensure Resident #1 had a signed medication consent form for Olanzapine (an antipsychotic medication) when ordered on 10/15/25.This failure could place residents at risk for treatment or services provided without their informed consent.Findings included:Record review of a facility face sheet dated 4/14/26 for Resident #1 indicated she was a [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnosis of pneumonia (infection in the lungs).Record review of a quarterly MDS assessment dated [DATE] for Resident #1 indicated a BIMS score of 13, which indicated she had intact cognition. She received antipsychotic medication.Record review of a comprehensive care plan dated 9/9/25 for Resident #1 indicated she used antipsychotic medication Olanzapine with an intervention that read: .Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of psychotropic medication drugs being given.Record review of a physician's order summary report dated 4/14/26 for Resident #1 indicated a physician's order dated 3/10/26 which read: .Olanzapine oral tablet 5mg . give one tablet by mouth one time a day related to major depressive disorder, recurrent, severe with psychotic symptoms.Record review of Resident #1's medication administration records for October 2025 through April 2026 indicated Resident #1 had been receiving Olanzapine daily as ordered.Record review of Resident #1's consents for medications revealed an HHSC form 3713 dated 10/15/25 had been uploaded into Resident #1's electronic medical record indicating she was to begin Olanzapine 5 mg every night for Major Depressive Disorder, severe, with psychotic symptoms on 10/15/25. The form had not been signed by Resident #1 or responsible party.During an interview on 04/15/2026 at 1:00 pm, the consultant pharmacist said she came to the facility every month and had been coming for about a year. She said she would keep track of GDRs, recommend GDRs, make care plan recommendations, and observe risks with medications. She said she did look for medication consents if they were due. She said she would not necessarily look for consents unless there was a new order. She said she would expect any resident that was on Olanzapine to have a signed consent in place. She said by not obtaining informed consent, residents could be at risk of side effects and that was why they should be monitored carefully.During an interview on 4/15/26 at 1:10 pm, the DON said she was unsure how the consent was scanned into the resident's chart without a signature. She said the ADON was responsible for ensuring consents were signed and in place. She said residents could be at risk for adverse side effects and families may not be made aware of the residents' condition if they were not informed and given the opportunity to consent to treatment.During an interview on 4/15/26 at 1:15 pm, the Administrator said nursing staff were responsible for ensuring medication consents were signed and in place for psychotropic medications. She said she would not want her mother in a facility to be given any psychotropic medications without giving consent. She said not getting consents obtained and signed prior to administering psychoactive medications could take away the residents right to being informed regarding their medications and could possibly take away their right to refuse treatment.During an interview on 04/15/2026 at 1:52 pm, the ADON said he was responsible for ensuring psychoactive consents were signed and in place. He said, going forward, he would have to hold the nursing staff accountable for ensuring informed consent was obtained prior to starting treatment. He said he tried to them often to ensure they were being done, but he had to work the floor often and sometimes things would be missed. He said he was not aware Resident #1 did not have a signed consent in place, or he would have had it signed before now. He said all psychotropic drugs needed to have consents completed before beginning treatment.Record review of a facility policy (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled Psychotropic Medication Use dated January 2025 read: .Residents will only receive psychotropic medications when necessary to treat specific conditions for which they are indicated/effective and after informed consent is obtained.Antipsychotic/Neuroleptic medications will have consent obtained via the Texas Health and Human Services form 3713 .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the facility coordinated with the appropriate, State-designated authority, to ensure that individuals with a mental disorder, intellectual disability or a related condition for 1 of 3 residents (Residents #45) reviewed for resident assessments.The facility did not refer Resident #45 to the appropriate state-designated mental health authority for review when she received a new diagnosis of bipolar disorder.This failure could affect residents with psychiatric diagnoses at risk of not receiving beneficial and needed services and care.Findings included:Record review of an admission Record for Resident #45 dated 4/14/2026 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnosis of dementia, bipolar disorder (alternating mood swings with extreme highs and lows), depression (loss of interest in doing things that affect daily life) and anxiety disorder (fear, dread, or worry that interferes with daily life).Record review of a Quarterly MDS Assessment for Resident #45 dated 2/20/2026 indicated she had severe impairment in thinking with a BIMS score of 3. She had psychiatric/mood disorders of anxiety disorder, depression, and bipolar during the 7 day look back period.Record review of a care plan for Resident #45 dated 3/22/2024 indicated she used a mood stabilizing medication related to bipolar disorder. Review of active physician orders dated 4/14/2026 for Resident #45 indicated she had a diagnosis of bipolar disorder with a start date of 3/6/2024.Record review of a psychiatric progress note for Resident #45 dated 3/20/2024 indicated her primary treating diagnosis was bipolar disorder.Record review of a PASRR Level 1 (PL1) for Resident #45 dated 2/26/2024 indicated she was negative for mental illness, intellectual disability, and developmental disability. Attempted a phone interview with the previous MDS Coordinator on 4/15/2026 at 8:48 am. There was no answer and a voicemail message was left for a return phone call.During an interview on 4/15/2026 at 10:23 am, the Regional MDS Coordinator said the previous MDS Coordinator was responsible for PASRR, but no longer worked at the facility and she was now completing the MDS assessments for the facility. She said they conducted an audit in December 2025 and January 2026, and they checked all residents in the facility that had a new psychiatric diagnosis and had form 1012 (a form used to evaluate if a resident with a negative PL1 screening needed a new positive screening due to the potential for mental illness or dementia) completed for them. She said if a resident received a new mental illness diagnosis, they were to complete a 1012 form and have the physician sign it along with submitting a new PL1 and PE if necessary. She said Resident #45 did not have a new PL1 after receiving the new diagnosis from the psychiatric physician and should have. She said residents could be a risk of not receiving benefits from PASRR if new mental illness diagnosis were given. During an interview on 4/15/2026 at 2:31 pm, the Administrator she said currently the Regional MDS was responsible for entering the PASRR information and form 1012's with new diagnosis of mental illness. She said the previous MDS Coordinator was responsible for Resident #45 and should have completed the form 1012 as soon as the new diagnosis was given. She said, going forward, they would review the diagnosis changes daily as they received them in the morning meetings, and if a new psychiatric diagnosis was received then a form 1012 would be completed. She said residents could be at risk of delays in services through PASRR, if they qualified for it, and new diagnosis were missed.Record review of a facility policy titled Preadmission Screening and Resident Review revised December 2024 indicated, .Our facility ensures compliance with all federal and state requirements regarding Preadmission Screening and Resident Review (PASRR) for individuals with serious mental illness, intellectual disability, or released conditions. 5. Resident Review (Significant Change) 1. A PASRR resident review will be requested when a resident experiences a significant change in condition suggesting the presence of mental illness that was not previously identified. 2. Social Services Director or designee is responsible for initiating referrals for Resident Review when indicated .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the resident and or the resident representative with a summary of the baseline care plan for 1 of 4 residents (Resident #58) reviewed for the base line care plans.The facility did not provide a summary of the Baseline Care Plan to Resident #58 or their Responsible Party (RP).This failure could place newly admitted residents at risk of not receiving continuity of care and communication among nursing home staff.Findings included:Record review of an admission Record for Resident #58 dated 4/14/2026 reflected she admitted to the facility on [DATE] and was [AGE] years old with a diagnosis of displaced intertrochanteric fracture of right femur (hip fracture), age related osteoporosis (brittle bones), and COPD (a group of lung disorders that affect breathing).Record review of an admission MDS assessment dated [DATE] indicated she had moderate impairment in thinking with a BIMS score of 12. She was dependent on staff for personal hygiene. Active participants in the assessment process were the Resident and family.Record review of a care plan for Resident #58 dated 2/26/2026 indicated to provide the Resident and their representative with a summary of the baseline care within 48 hours of admission. Interventions included the Resident will have all needs anticipated and met to ensure the highest practicable level of well-being and dignity preservation.Record review of the schedule for care plan meetings for the past 4 months (January 2026-April 2026) revealed Resident #58 was not scheduled for a care plan meeting. During an observation and interview on 4/13/2026 at 3:23 PM, Resident #58 was in her room sitting in a wheelchair, and said she had not had a care plan meeting since she was admitted to the facility.During an interview on 4/15/2026 at 8:52 am, the SW said she started at the facility in December 2025 and at that point the previous MDS Coordinator was responsible for the coordinating the care plan meetings. She said she worked part time in the facility and meetings were held every Wednesday. She said Resident #58 did not have any initial care plan meeting within 48 hours, and she did not know why. She said a new admission should have an initial meeting within 48-72 hours after admission and the resident and RP would be provided with a copy of the summary. During an interview on 4/15/2026 at 10:23 am, the Regional MDS said the previous MDS Coordinator was responsible for the care plan meetings, but it had been reassigned to the SW. She said if a resident was a new admission, then they should have a care plan meeting within 48 hours after admission, and the resident/family should be given a copy of the care plan. She said after the initial meeting, the meeting would be held every 90 days and PRN after. She said if care plan meetings were not held, the IDT team and staff would not know what care the resident needed or if they had the same goals initially.Attempted a phone interview with the previous MDS Coordinator on 4/15/2026 at 8:48 am, there was no answer and a voicemail message was left for a return phone call.During an interview on 4/15/2026 at 2:31 pm, the Administrator said the Regional MDS was responsible for the care plans, including the baselines, and should be done within 72 hours of admission and quarterly meeting thereafter. She said the purpose of the meeting was for the residents/RP to be aware of what was going on and any risks along with ADL function. She said going forward, the plan would be to have the SW manage the care plan meetings. She said residents/families could be at risk of not being informed of what was going on with them if the meetings were not conducted.Record review of a facility policy titled Care Plans-Baseline revised December 2016 reflected, .A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. 4. The resident and their representative will be provided a summary of the baseline care plan .

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 4 residents (Resident #16) reviewed for care plans.The facility failed to ensure Resident #16 has care plan conferences at least every 3 months, and her representative, were invited to the resident care plan conferences.This failure could place residents at risk of not being able to provide input on their care, and receiving the care and services to meet their needs.Findings include:Record review of an admission Record for Resident #16 dated 4/14/2026 reflected she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of atrial fibrillation (irregular heart rhythm), major depressive disorder (persistent sadness or loss of interest in doing things), and GERD (acid reflux disease).Record review of a Quarterly MDS Assessment for Resident #16 dated 2/27/2026 indicated she did not have any impairment in thinking with a BIMS score of 15. She required substantial/maximal assistance with personal hygiene. She had an indwelling catheter and an ostomy. Urinary and bowel continence was not rated because she had a catheter or ostomy during the entire 7-day look back period.Record review of a care plan for Resident #16 dated 9/9/2025 indicated she had an indwelling catheter with interventions to provide catheter care at least one time per shift and after each bowel movement. Record review of a quarterly care plan conference summary for Resident #16 indicated her last care plan meeting was held on 12/10/2025 and the resident was not in attendance. She was invited and opted not to attend. The resident representative/family was not in attendance.During an observation and interview on 4/13/2026 at 2:59 PM, Resident #16 was in bed and said she was not sure about any care plan meetings and had not been asked to attend one since she has been at the facility.Attempted a phone interview with the previous MDS Coordinator on 4/15/2026 at 8:48 am, there was no answer and a voicemail message was left for a return phone call.During an interview on 4/15/2026 at 8:52 am, the SW said she started in December 2025, and at that point, the previous MDS Coordinator was responsible for the care plan meetings. She said she worked part time in the facility, and meetings were held every Wednesday. She said Resident #16 was scheduled for a meeting that day at 3 pm. She said she was not aware Resident #16 did not have her last meeting which should have been in March 2026.During an interview on 4/15/2026 at 10:23 am, the Regional MDS said the previous MDS Coordinator was responsible for the care plan meetings, but they had been recently reassigned to the SW. She said after the initial meeting, a resident would have a meeting every 90 days and prn after. She said if care plan meetings were not held, then the IDT team and staff would not know what care was needed or if they had the same goals initally. She said she was not aware Resident #16 did not have her scheduled meeting last month. She said residents and their RP's were invited to attend the care plan meetings.During an interview on 4/15/2026 at 2:31 pm, the Administrator said the Regional MDS was responsible for the care plans meetings. She said the facility did not have an MDS Coordinator in the facility at that time. She said the purpose of the meetings was for residents and RPs to be aware of what was going on and of any risks, along with ADL function. She said she planned to have the SW manage the care plan meetings going forward. She said she was not aware Resident #16 did not have her scheduled meeting last month. She said there was a risk of not being informed of what was going on with the residents if they did not have care plan meetings. She said residents and their RP's were invited to attend the care plan meetings.Record review of a facility policy titled Care Plans, Comprehensive Person-Centered revised December 2016 indicated, .A comprehensive, person-centered care plan that includes measurable objective and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 7. The care planning process will: a. facilitate resident and/or representative involvement .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assures accurate acquiring, receiving, dispensing, and administering of medications for 1 of 6 residents (Resident #16) reviewed for pharmacy services.The facility did not ensure LVN A watched Resident #16 take administered medications, and they were not left in her room on 4/14/2026.This failure could place residents at risk for the unsafe administration of medications. Findings included:Record review of an admission Record for Resident #16 dated 4/14/2026 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of atrial fibrillation (irregular heart rhythm), major depressive disorder (persistent sadness or loss of interest), and GERD (acid reflux disease).Record review of a Quarterly MDS Assessment for Resident #16 dated 2/27/2026 indicated she did not have any impairment in thinking with a BIMS score of 15. She required substantial/maximal assistance with personal hygiene.Record review of a care plan for Resident #16 did not indicate she was able to self-administer medications to herself.Record review of a MAR for Resident #16 for 4/14/2026 revealed: LVN A had her initials present for medication administration at 9:00 am for the following medications: ascorbic acid 500 mg tablet (1), loratadine 10 mg tablet (1), magnesium oxide 400 mg (1), multivitamin (1), saccharomyces 250 mg (1), and peppermint oil 180 mg (1).During an observation and interview on 4/14/2026 at 9:51 am, Resident #16 was in her room in bed awake. There was a cup of pills in a small plastic cup on her over bed table. She said the nurse gave them to her earlier, and she had not taken them yet. During an interview on 4/14/2026 at 9:58 am, LVN A said she worked as the medication nurse on the hall where Resident #16 resided. She said she gave Resident #16's morning medications to her but the roommate in the room started grimacing and she was distracted and did not make sure Resident #16 took her medication. She said they were trained to stay with the residents to ensure they took all their medications and never leave medications at the bedside for the residents to take. She said the resident was given her OTC medications that included: vitamin c 500 mg, loratadine 10 mg, magnesium 400 mg, multivitamin, peppermint oil, and saccharomyces bouvardia. She said she still needed to give the resident her routine prescription medications. She said if staff did not stay with the residents to ensure they took them, the residents could choke or not take them.During an interview on 4/15/2026 at 1:56 pm, the ADON said he was responsible for conducting skills check offs with the staff annually and on hire. He said he conducted skills check offs with the nurses and medication aides annually and on hire. He said the staff should stay in the room with the residents while they took the medications, and should never leave the room without ensuring they had taken them. He said there could be a lot of bad things that could happen and LVN A had a 1:1 in-service with the DON on yesterday 4/14/2026.During an interview with the DON on 4/15/2026 at 2:15 pm, she said she and the ADON were responsible for training the nursing staff and medication aides on medication administration. She said they did it frequently with random audits monthly. She said she did not have any residents in the facility that were able to self-administer medications. She said staff should make sure they were getting the medications, and watched the resident take and swallow them before they walked out of the room. She said she had a 1 on 1 verbal in-service with LVN A on yesterday 4/14/2026. She said if medications were left in the rooms for residents to take, there could be a risk of other residents entering the rooms and taking them or a risk of being overmedicated. She said they planned to continue monitoring going forward with random audits.During an interview on 4/15/2026 at 2:31 pm, the Administrator said the nurse managers were responsible for training staff on medication administration. She said they did not have any residents in the facility that were able to self-administer. She said staff should ensure and watch residents take their medications. She said residents could be at risk of not taking them, or other residents taking them if they were left in the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rooms.Record review of a facility policy titled Medication Administration revised April 2019 indicated, .27. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely and after the completion of a Medication Self-Administration Evaluation .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews, and record reviews, the facility failed to serve food that was palatable for 1 of 1 meal reviewed for food palatability. (noon meal 4/14/26).The facility did not provide palatable and appetizing food for the residents receiving pureed food for the 10/28/2025 noon meal.This failure could place residents who received food from the kitchen at risk for diminished meal satisfaction and potential weight loss due to poor meal intake.Findings included:During interview during the initial tour on 4/13/26 at 10:58 am, Resident #49 said she ate meals in her room and complained of cold food.During an observation on 4/14/26 at 1:05 pm, the test trays left the kitchen after the dining room had been served. The test trays were observed by the surveyor after leaving the dining room and at 1:18 pm, the test trays were delivered to the conference room. The test trays consisted of 1 regular tray which included chopped chicken, rice, peas/carrots, and a roll, and 1 puree tray which included chicken, carrots, green beans, and roll. The covers were removed from the plates of food, and the puree food was felt to be cold. Temperature with surveyor's temperature gun showed 88 degrees . The regular food was warm, and the taste was ok. The puree food was cold to taste, and the green beans were bland.During an observation and interview on 4/14/26 at 1:25 pm, the DM checked temperature of pureed food with her thermometer as well, which was 88 degrees. The Dietary Manager tasted the green beans, made a face and said, those are awful, and she said the food was cold. She said if residents were served cold food, they might not eat it, which might make them lose weight.During an interview on 04/14/2026 at 2:28 pm, the Administrator said she would not want to be served cold food. She said if residents were served cold food, they might not eat, they might lose weight, and their health could decline. She said she would have the dietician do some extra training with the kitchen staff going forward to ensure meals were served hot.During an interview on 4/15/26 at 1:10 pm, the DON said if residents were being served cold food, they may not eat it and may be at risk for weight loss. She said, going forward, they would educate kitchen staff and may be getting an enclosed cart for taking trays down the hall.Record review of a facility policy titled Food Preparation and Service dated April 2019 indicated it did not address serving temperature of food on trays when served to residents in their rooms. It read: .Proper hot and cold temperatures are maintained during food service.

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure professional licensed, certified, or registered in accordance with applicable State laws standards of quality for 1 of 6 licensed staff (LVN B) reviewed for administration.The facility failed to ensure LVN B's nurse license did not expire as of [DATE].This failure could place residents at risk for not receiving nursing services from a licensed nurseThe findings include:Record review of a personnel file for LVN B indicated she was hired at the facility on [DATE].Record review of the Texas Board of Nursing verification for LVN B checked on [DATE] indicated her license expired [DATE].Record review of a daily staffing assignment/sign in log dated [DATE] revealed LVN B worked on this day as indicated by her initials.During an interview on [DATE] at 9:30 am, the DON said she was not aware LVN B had an expired nurse license.During an interview on [DATE] at 9:32 am, the Administrator said she was unaware LVN B had an expired nurse license until yesterday, [DATE]. She said she was conducting an audit of licensed nurses for the facility and discovered her license was expired. She said they immediately removed LVN B from the schedule.During an interview on [DATE] at 11:30 am, HR said she was responsible for conducting background checks and license verifications. She said they checked their license on hire and annually. She said she started in the position of HR back in [DATE]. She said the Administrator trained her and there was a corporate person she could reach out to. She said the last check for all licensed staff was checked in [DATE]. She said LVN B's expiration was missed, and she checked it [DATE]. She said the report she ran with the board of nursing was not thorough and did not reveal her expiration date, and she did not realize there was an additional step that was needed to see the expiration date. She said if licenses were not checked, residents could be at risk of having an unlicensed person working in the building. During a phone interview on [DATE] at 11:44 am, LVN B said the last day she worked was Sunday [DATE] and was currently off. She said she did not know her license had expired. She said her last renewal was in [DATE]. She said she was made aware that her license expired yesterday, [DATE], by the Administrator who texted her and said they had expired. She said she was told she would not be able to return to work until her license was active. She said she did not receive any email correspondence by the board of nursing, and thought it may have gone to a family member's email address, and they did not notify her.During a follow up interview on [DATE] at 2:31 pm, the Administrator said she discovered the expired license of LVN B yesterday, [DATE], and informed her she could not return to work until it was back active. She said it expired [DATE]. She said HR checked all the licensed employees in [DATE] and did not click to view the report to see the expiration dates. She said there was a risk for a lot to go wrong if they had unlicensed nurses working in the facility along with staff practicing out of scope. She said they would be reporting LVN B to the board of nursing.Record review of a facility policy titled Credentialing of Nursing Service Personnel revised [DATE] indicated, .Nursing service personnel who require a license or certification to provide resident care or treatment without direction or supervision within the scope of the individual's license or certification must present verification of such license .

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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 observation, interview, 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 6 residents (Resident #16) reviewed for infection control. The facility failed to ensure CNA C and CNA D washed or sanitized their hands during incontinent care provided to Resident #16 on 4/14/2026.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 #16 dated 4/14/2026 reflected she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of atrial fibrillation (irregular heart rhythm), major depressive disorder (persistent sadness or loss of interest in doing things), and GERD (acid reflux disease).Record review of a Quarterly MDS Assessment for Resident #16 dated 2/27/2026 indicated she did not have any impairment in thinking with a BIMS score of 15. She required substantial/maximal assistance with personal hygiene. She had an indwelling catheter and an ostomy. Urinary and bowel continence was not rated because she had a catheter or ostomy during the entire 7 day look back period.Record review of a care plan for Resident #16 indicated she had an indwelling catheter with interventions to provide catheter care at least one time per shift and after each bowel movement. During an observation on 4/14/2026 at 2:47 pm, in the room of Resident #16, CNA C and CNA D were in the room to provide incontinent and foley care. Staff entered the room with supplies in a plastic bag, and sanitized their hands and applied gloves and a gown. CNA C and CNA D pulled the linens down to the foot of the bed. Resident #16 was not wearing a brief and had a ileostomy (a surgical opening that brings the end of the small intestine through the opening to allow waste to leave the body in an external pouch) to her right upper abdomen and a urinary catheter (a tube placed in the bladder to drain urine) with a drainage bag attached that was attached to the bed frame on the side of the bed. CNA C removed wipes from the package and cleaned the resident's inner thighs and placed the wipes in the trash. CNA C removed a wipe and cleaned down the middle of the vagina from front to back and placed the wipe in the trash. CNA C removed a wipe and cleaned the foley tubing from near the insertion site down the tubing and placed the wipe in the trash. CNA D went to the other side of the bed and emptied the urine drainage bag and emptied the urine in the toilet. While in the bathroom CNA D removed her gloves and placed them in the trash and washed her hands. CNA D donned (put on) clean gloves. CNA C touched a clean brief that was on the nightstand and placed it on the bed near the resident with her dirty gloves. CNA C then removed her gloves and placed them in the trash and donned clean gloves without washing or sanitizing her hands. CNA D assisted with rolling the resident onto her right side, removed wipes from the package, wiped the resident's buttocks and perineal area from front to back, and placed the wipes in the trash. CNA D applied barrier cream using her left hand to the resident's buttocks and perineal area and removed the glove from her left hand only and placed it in the trash. CNA D used the hand sanitizer that was mounted on the wall and attempted to sanitize her left hand and placed a glove on her left hand only. CNA C applied the brief and secured it. Both staff repositioned Resident #16 in bed and doffed (took off) their gown and gloves in the room and placed them in the trash, and exited the room with the trash. CNA D washed her hands.During an interview on 4/14/2026 at 3:10 pm, CNA D said she was taught that one hand would be for dirty things, and the other hand for clean things. She said she removed the glove from her left hand because that was the hand she used to apply the barrier cream and was told she could just change the one glove. She said she sanitized that hand before she applied a clean glove.Record review of the CNA Skills Checklist for CNA D dated 3/24/2026 indicated the ADON was the examiner and CNA D was successful with hand washing and perineal/incontinent care with a female with or without a catheter.During an interview on 4/14/2026 at 3:13 pm, CNA C said, during the care provided to Resident #16, she should have changed her gloves (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when she moved from cleaning the front of her body to the back of her body. She said she touched the clean brief with her dirty gloves and did not sanitize between gloves changes. She said she did not know why she did not follow proper procedure and there was a risk for residents to get infections if they did not. Record review of a CNA Skills Checklist for CNA C dated 3/31/2026 indicated the ADON was the examiner and CNA C was successful with hand washing and perineal/incontinent care with a female with or without a catheter.During an interview on 4/15/2026 at 1:56 pm, the ADON said he was responsible for conducting skills check offs with the staff annually and upon hire. He said staff could not have one clean hand and one dirty. He said staff should remove both gloves and wash or sanitize between glove changes. He said hand hygiene should be done before care was started, when changing tasks from dirty to clean, between glove changes, and when care was complete. He said staff should never touch clean items with dirty gloves. She said residents could be at risk of infection control issues and planned to have more training with the staff. During an interview on 4/15/2026 at 2:15 pm, the DON said she was the IP for the facility, and she along with the ADON, were responsible for training staff on infection control, and sometimes it was done once a week. She said staff should not change one glove during care and should remove both gloves as they would both be contaminated. She said she would reeducate the staff and conduct random audits for proper hand hygiene. She said hand hygiene that included washing or sanitizing should be done before care was started and between glove changes. She said staff should never touch clean items with dirty gloves. She said if staff did not follow proper procedures, residents could be at risk of infections and UTI's.During an interview on 4/15/2026 at 2:31 pm, the Administrator said the IP had been training staff on infection control all the time and were required to do it annually and as needed. She said staff should not remove one glove during care and was not sure where CNA D received that information. She said staff should remove both gloves, perform hand hygiene, and never touch clean items with dirty gloves. She said hand hygiene should be performed between glove changes, and they should wash their hands. She said there was a risk of infections if staff did not follow the facility's policy. Record review of a facility policy titled Handwashing/Hand Hygiene revised August 2015 indicated, .This facility considers hand hygiene the primary means to prevent the spread of infections. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: e. before and after handling an invasive device (e.g., urinary catheters; m. after removing gloves .

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on interviews and record review, the facility failed to develop, implement, and maintain an effective training program for 2 of 17 employees (Dietary Manager and the Activity Director) new and existing staff reviewed for training requirements. The facility failed to ensure the Activity Director was trained in effective communication, HIV, dementia, infection control and restraint reduction on hire.The facility failed to ensure the Dietary Manager was trained in falls, dementia, infection control and behavioral health on hire This failure could place residents at risk of not receiving care to attain or maintain their highest practicable physical, mental, and psychosocial well-being due to lack of staff training. Findings included:Record review of the personnel file for the Activity Director indicated she was hired at the facility on 04/01/2026 and did not have evidence of on hire training in effective communication, HIV, dementia, infection control and restraint reduction on hire. Record review of the personnel file for the Dietary Manager indicated she was hired at the facility on 03/10/2026 and did not have evidence that the Dietary Manager received annual training on ineffective communication, HIV, dementia, infection control and restraint reduction on hire.During an interview on 04/15/2026 at 10:30 AM, HR said she was new to her position at the facility and was responsible for completing the orientation and other paperwork. She said she was not aware that new hire training had not been completed as required for all employees. She said, going forward, she would complete a checklist for the required training and ensure completion. She said staff could be at risk of lack of information and residents could be at risk of harm for a multitude of things if staff did not receive the training they needed. HR said going forward, she would make sure all training was completed before resident care was started and annually as required by regulations.During an interview on 4/15/2026 at 11:38 AM, the Administrator said the staff were initially trained by logging into a website and have continued to watch the training videos that included abuse/neglect, blood borne pathogens, HIV, misuse of resident property, resident rights, behavioral health, effective communication, dementia, and fall prevention. She said she was ultimately responsible for ensuring the staff received the required training during orientation, prior to employment and annually. She said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care. She said she would ensure there was a system in place and a check list for the training. During an interview on 4/15/2026 at 12:05 PM, the DON said she was responsible for ensuring the nursing staff received the required training during orientation, prior to employment and annually. She said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care. Record review of a facility policy revised February 2026 indicated, .Staff Development Program.Policy StatementAll personnel must participate in initial orientation and regularly scheduled in-service training classes.Policy Interpretation and Implementation1. Staff development is defined as initial orientation, followed by regularly scheduled in-service training programs.2.The primary objective of our facility's Staff Development Program is to ensure that staff have the knowledge, skills and critical thinking necessary to provide excellent resident care.5.Required training topics include:. (3) Dementia management and resident abuse prevention.e. The infection prevention and control program standards, policies and procedures; and.g. Restraint Reduction and Fall Prevention.j. Behavioral Health Fundamentals, Person-Centered Behavior Management and Dementia Care.l. Blood borne pathogens and HIV Training

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	04/15/2026

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 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on interview and record review, the facility failed to provide the required education on the rights of the residents and the responsibilities of a facility to properly care for its residents for 1 of 17 employees (CNA E) reviewed for training requirements, in that:The facility failed to ensure that annually required education was provided on the rights of the residents and responsibilities of a facility to properly care for its residents were conducted with CNA E.This failure could affect residents and place them at risk of being uninformed due to lack of staff training. The findings were: Record review of the personnel file for CNA E revealed a hire date of 06/29/2024. There was no evidence of annual training since hire date on resident rights and the responsibilities of a facility to properly care for its residents. Record review of electronic records of training for CNA E indicated she initiated training on 04/15/2026, after surveyor entrance on 04/13/2026, but training was not completed.During an interview on 04/15/26 at 9:22 AM, the Human Resource Coordinator said she was responsible for ensuring the employees resident Rights training was completed annually and upon hire. The HR Coordinator said effective mandatory training should be completed on hire and annually to ensure that all employees are knowledgeable. The HR coordinator said CNA E's training was not completed annually as required by policy. During an interview on 04/15/26 at 11:38 AM, the Administrator said all mandatory training was required at the time of hire before any staff started employment. The Administrator said they were assigned annually. The Administrator said the risk for not completing resident rights training could cause the employee to not know what the rights were and could lead to violations. The Administrator said the HR Coordinator was responsible for ensuring all required training was completed upon hire and annually. During an interview on 04/15/26 at 12:05 PM, the DON stated she was responsible for monitoring for incomplete training modules of the nursing staff. The DON stated one reason for staff failing to complete training was a breakdown in communication. She stated the consequences to residents was they may not receive the care expected.Record review of a facility policy revised 02/2026 indicated, .Staff Development Program.Policy StatementAll personnel must participate in initial orientation and regularly scheduled in-service training classes.Policy Interpretation and Implementation1. Staff development is defined as initial orientation, followed by regularly scheduled in-service training programs.2.The primary objective of our facility's Staff Development Program is to ensure that staff have the knowledge, skills and critical thinking necessary to provide excellent resident care.5.Required training topics include :.b. Resident rights and responsibilities;

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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	

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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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on interviews and record review, the facility failed to ensure employees received the required training on Abuse, Neglect, and Exploitation and dementia management training for 1 of 17 (CNA E) reviewed for required training.The facility did not ensure Abuse, Neglect, and Exploitation and dementia management training was completed by the CNA E during annual training for 2025. This failure could place residents with dementia at risk of abuse, neglect, and exploitation and poor quality of care by staff with inadequate training when caring for dementia residents. Findings included:Record review of the personnel files for CNA E indicated a hire date 06/29/2024. There was no evidence that CNA E had not completed the required annual training for Abuse, Neglect, and Exploitation and dementia management. Annual training was not completed by CNA E since her hire date 06/29/2024.Record review of electronic training for CNA indicated it was initiated by CNA E on 4/15/2026 but not fully completed, after entrance of the survey team on 04/13/2026.During an interview on 04/15/2026 at 10:30 AM, HR said she was new to her position at the facility and was responsible for completing the orientation and other paperwork. She said she was not aware that CNA E had not completed her assigned training on Abuse, Neglect, and Exploitation and dementia management training during annual training for year 2025. She said going forward she would complete a checklist for the required training and ensure completion. She said staff could be at risk of lack of information and residents could be at risk of harm for a multitude of things if staff did not receive the training they needed. HR said going forward she will make sure all training is completed before resident care is started and annually as required by regulations.During an observation and interview on 4/15/2026 at 11:38 AM, the Administrator looked in the training files for CNA E and found no evidence in required annual training for Abuse, Neglect, and Exploitation and dementia management. The Administrator said the staff were initially trained by logging into a website and have continued to watch them that included abuse/neglect, blood borne pathogens, misuse of resident property, resident rights, dementia, and fall prevention. She said she was ultimately responsible for ensuring the staff received the required training during orientation prior to employment and annually. She said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care. She said there was a system in place and a check list for the training.Record review of a facility policy revised 02/2026 indicated, .Staff Development Program.Policy StatementAll personnel must participate in initial orientation and regularly scheduled in-service training classes.Policy Interpretation and Implementation1. Staff development is defined as initial orientation, followed by regularly scheduled in-service training programs.2.The primary objective of our facility's Staff Development Program is to ensure that staff have the knowledge, skills and critical thinking necessary to provide excellent resident care.5.Required training topics include: c. Preventing abuse, neglect, exploitation, and misappropriation of resident property including: (1) Activities that constitute abuse, neglect, exploitation or misappropriation of resident property; (2) Procedures for reporting incidences of abuse, neglect, exploitation or misappropriation of resident property; and (3) Dementia management and resident abuse prevention.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interviews and record review, the facility failed to ensure the required minimum 12 hours annual in-service education was provided for 1 of 5 CNAs (CNA E) reviewed for training requirements.The facility did not provide the required 12 hours of annual in-service education to CNA F. This failure could place residents with dementia at risk of abuse, neglect, exploitation and poor quality of care by staff with inadequate training when caring for residents. The findings included:Record Review of a personnel file for CNA E indicated a hire date of 06/29/2024 and did not include the required 12 hours of annual in-service. The personnel file revealed no training for the year 2025 for Resident Rights, Abuse, Dementia, Infection Control, Effective communication, Falls, Restraints and Behavioral Health.Record review of electronic training for CNA E indicated she initiated training on 04/15/2026 after surveyor entrance on 04/1/2026 but training was not completed.During an interview on 4/15/2026 at 10:00 AM, The ADON said annual CNA training with assigned in a computer program and the staff completed the topics that were assigned by HR or the corporation. He said he assisted with getting nursing staff trained during orientation prior to employment and annually. He said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care.During an interview on 04/15/2026 at 10:30 AM, HR said she was new to her position at the facility and was responsible for completing the orientation and other paperwork. She was responsible for ensuring annual requirements were met. She said going forward she would complete a checklist for the required training and ensure completion. She said staff could be at risk of lack of information and residents could be at risk of harm for a multitude of things if staff did not receive the training they needed. HR said going forward she will make sure all training is completed before resident care is started and annually as required by regulations.During an interview on 4/15/2026 at 11:38 AM, The Administrator said the staff were initially trained by logging into a website and have continued to watch the training videos that included abuse/neglect, blood borne pathogens, misuse of resident property, resident rights, effective communication, dementia, and fall prevention. She said she was ultimately responsible for ensuring the staff received the required training during orientation prior to employment and annually. She said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care. She said she would ensure there was a system in place and a check list for the training.During an interview on 4/15/2026 at 12:05 PM, The DON said She said responsible for ensuring the CNA's received the required training prior to employment and annually. The DON said that the CNA Staff are to complete an additional 12 hours of training annually in addition to the required training assigned in the computer system. She said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care.Record review of a facility policy revised 02/2026 indicated, .Staff Development Program.Policy StatementAll personnel must participate in initial orientation and regularly scheduled in-service training classes.Policy Interpretation and Implementation1. Staff development is defined as initial orientation, followed by regularly scheduled in-service training programs.2.The primary objective of our facility's Staff Development Program is to ensure that staff have the knowledge, skills and critical thinking necessary to provide excellent resident care.7.In addition to the in-service training requirements outlined above, nurse aides (CNAs) are required to complete no less than 12 hours annually of in-service training that is sufficient to ensure the continuing competency of nurse aides and address any specific areas of weakness identified in performance evaluations and through the facility assessment. This requirement can be met through the TX HHS Modules for CNAs and the Infection Control Module through TX HHS.12.Records are filed in the employee's personnel file or maintained by the Department Director.