Florida State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130471040	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY REGIONAL REHAB CENTER	2144 WELBILT BLVD , TRINITY, Florida, 34655

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0000	INITIAL COMMENTS An unannounced complaint survey for complaint numbers 2025007123 and 2025008689 were conducted in conjunction with a revisit survey (Event ID: 4EQI12) at Trinity Regional Rehab Center on . Deficiencies were identified related to complaint number 2025007123.	N0000		
N0040 SS = D	Facility Policies Required CFR(s): 59A-4.106( ) FAC (2) Each nursing home licensee must adopt, implement, and maintain written policies and procedures governing all services provided in the facility. (3) All policies and procedures must be reviewed at least annually and revised as needed with input from the facility Administrator, Medical Director, and Director of Nursing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews and interviews, the facility failed to follow resident care policies that are consistent with current professional standards of practice for three residents (#8, #9 and #7) of four sampled residents. Findings included: Review of a facility policy titled care, Version 1.2, showed the following: The purpose of this procedure is to provide guidelines for the care of to promote healing... Steps in the Procedure-13) ...Mark tape with initials, time, and date and apply to 1. On at 9:15 AM during an interview and observation, while lying in bed, Resident #8 said he was admitted to the facility for care. An occlusive was observed on his left and was not dated.	N0040		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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N0040 SS = D	Continued from page 1 Review of Resident #8's admission record showed he was admitted on with diagnoses to include of the left lower and left and . Review of Resident #8's "Order Summary Report" showed an order to "cleanse to left with cleanser, , dry. Apply , , then cover with dry every day (QD) and as needed (PRN), night shift." 2. On at 12:20 PM Resident #9 was observed in the second-floor hallway with three undated on the right lower extremity. Review of Resident #9's admission record showed he was admitted on with diagnoses to include , and , , . Review of Resident #9's Treatment Administration Record (TAR) dated showed an order for Xeroform Petrolatum ...apply to lower extremities at bedtime for , cover with (ABD) pads and wrap with [gauze] , start date at 8:00 P.M. 3. Review of the "Admission Record" for Resident #7 showed she was admitted to the facility on with diagnoses including but not limited to , , , , , and type 2 with , , . On at 9:45 AM Resident #7 was observed participating in restorative , , located in the media lounge. Resident #7 had a on his lower left lateral with no date, time, or initials. During an interview on at 11:42 AM Staff K, Licensed Practical Nurse (LPN), said after are changed "label with date and initials." During an interview on at 2:30 PM, Staff O, LPN, Unit Manager (UM) said staff are expected to follow a resident's care orders and the facility	N0040		

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N0040 SS = D	Continued from page 2 policies. During an interview on at 6:10 PM during an in-person interview with the Director of Nursing (DON) and a phone interview with the Nursing Home Administrator (NHA). The DON said staff are expected to date and initial the bandage when care is completed. Class III	N0040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106079	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY REGIONAL REHAB CENTER	**2144 WELBILT BLVD , TRINITY, Florida, 34655**

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F0000	INITIAL COMMENTS An unannounced complaint survey for complaint numbers 2025007123 and 2025008689 were conducted in conjunction with a revisit survey (Event ID: 4EQI12) at Trinity Regional Rehab Center on . The facility was in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities.	F0000		

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 reverse for further 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