STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676072	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corrigan Ltc Nursing & Rehabilitation	300 Hyde St Corrigan, TX 75939

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, which included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 7 residents (Resident #1) reviewed for care plans. The facility failed to develop and implement Resident #1's care plan for behavior towards other residents after he hit Resident #2 with a fly swatter on 11/18/25. This failure could place residents at risk of further incidents of aggression. Findings included: Record review of Resident #1's face sheet dated 01/07/25 indicated he was a [AGE] year old male admitted on [DATE] and his diagnoses included hemiplegia (severe paralysis) and hemiparesis (muscle weakness) following cerebral infarction (stroke) affecting left dominant side, intermittent explosive disorder (mental health condition characterized by sudden, impulsive outbursts of anger or violence that are disproportionate to the triggering situation), personality change due to known physiological condition, and anxiety disorder (persistent excessive worry). Record review of Resident #1's significant change MDS dated [DATE] indicated he was usually able to make himself understood and usually understood others. He was cognitive (BIMS-15). There was no aggressive behaviors noted. Record review of Resident #1's care plan dated 05/23/24 indicated he was aggressive and argumentative with staff. Interventions included administer medications as ordered, intervene as necessary to protect the rights and safety of others, and referred to counselling services. There was no review or update noted related to Resident #1 hitting Resident #2 with the fly swatter on 11/18/25. Record review of Resident #2's face sheet dated 01/06/25 indicated he was a [AGE] year old male, admitted on [DATE] and his diagnoses included Parkinson's (neurodegenerative disease), anxiety (persistent excessive worry), and schizoaffective disorder-bipolar type (mental health condition characterized by symptoms of both schizophrenia and mood disorders, particularly mania and depression). Record review of Resident #2's significant change MDS dated [DATE] indicated he was usually able to make self understood, was able to understand others, had moderate cognitive impairment (BIMS-9), had an acute change in mental status with fluctuating inattention and disorganized thinking. There was no aggressive behaviors noted. Record review of Resident #2's care plan dated 09/05/25 indicated he had a behavior problem related to bipolar disorder. Interventions included weekly counseling services. Record review of an incident report dated 11/18/25 at 4:28 p.m., completed by LVN C indicated Resident #1 was in the dining room and hit another resident (Resident #2) with a fly swatter. When asked what happened, Resident #1 stated He wanted to call me his kid brother and I wanted to aggravate him so I hit him with the fly swatter. Resident #1 was taken to his room to diffuse the situation and was placed on 1-1. Administrator notified of physical aggression. Physician and psychiatric services notified. Received order to send Resident #1 to behavioral hospital. Record review of the facility investigation dated 11/24/25 indicated (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 hit Resident #2 with a fly swatter on 11/18/25 at 4:30 p.m. Resident #1 and Resident #2 were separated and assessed. There were no injuries. Resident #1 was placed on 1 to 1 supervision. Resident #1 was transferred to a behavioral hospital on [DATE]. The facility confirmed resident to resident altercation. Record review of Resident #1's behavioral hospital records dated 12/03/25 indicated the reason for his admission included hitting another resident with a fly swatter and intentionally aggravating the other resident. During an interview on 01/05/26 at 1:42 p.m. Resident #2 said Resident #1 hit him to bug (bother) him with a fly swatter because he said Resident #1 could be a little brother. He said he was not hurt. He said he was not afraid and he was friends with Resident #1. During an interview on 01/05/26 at 1:50 p.m., Resident #1 said he hit Resident #2 with a fly swatter because he wanted to irritate him after Resident #2 said he (Resident #1) should be his little brother. He said he was not trying to hurt Resident #2, he was only trying to irritate him. During an interview on 01/05/26 at 3:23 p.m., the Administrator said there was no history of Resident #1 showing aggression towards other residents. She said when Resident #1 was readmitted from the behavioral hospital on [DATE]. She said the incident and care plan was reviewed on 12/04/25 and changes were supposed to be made but it was not saved in the electronic record. She said the incident that occurred on 11/18/25 was also supposed to be added to the care plan on 11/20/25 however it did not update and save in the electronic record. She said if care plans were not reviewed and updated the risks included staff not being aware of appropriate interventions for behavior management. During an interview on 01/05/26 at 3:28 p.m., the DON said Resident #1 was supposed to attend outpatient services provided by the behavior hospital however he refused to go after 1 or 2 appointments. She said the care plan was not updated as required. She said the previous DON was supposed to review and update the care plan as required. During an interview on 01/06/26 at 10:30 a.m., LVN C said she did not witness the incident between Resident #1 and Resident #2. She said Resident #1 did not have a history of aggression toward other residents. She said Resident #1 said he wanted to aggravate Resident #2 to see what he would do. She said Resident #1 was placed on 1-1 immediately after the incident until he was transferred to a behavior hospital. During an interview on 01/06/26 at 10:55 a.m. the DON said a CNA told her of the incident on 11/18/25 but she could not recall which CNA. She said she went to the dining room and Resident #1 was still holding the fly swatter. She said Resident #1 was no longer near Resident #2. She said he was still holding the fly swatter. She said Resident #1 was placed on 1-1 and remained in his room until he was transported to the behavior hospital on [DATE]. She said the fly swatter was removed from Resident #1's possession and disposed. During an interview on 01/06/26 at 11:14 a.m., Resident #3 said he witnessed Resident #1 hit Resident #2 with a fly swatter. He said Resident #1 was trying to irritate Resident #2. He said Resident #2 was upset with Resident #1 and moved to another table. He said he never saw Resident #1 hit Resident #2 or any other resident before. Record review of a text message sent to the Administrator by the previous DON on 01/06/26 indicated she did not recall anything of the incident on 11/18/25 other than she sat 1-1 with Resident #1 until he went to the behavior hospital on [DATE]. The surveyor attempted to contact CNA A regarding Resident #1 hitting Resident #2 with the fly swatter on 01/06/26 at 11:05 a.m. by phone. A voice message was sent with the surveyor's contact information. As of the investigation exit, CNA A did not respond. The surveyor attempted to contact CNA B regarding Resident #1 hitting Resident #2 with the fly swatter on 01/06/26 at 11:08 a.m. by phone. CNA B's phone was not accepting calls. A text message was sent with the surveyor's contact information. As of the investigation exit, CNA B did not respond. Record review of the facility's policy Resident-to-Resident Altercations dated 2001 (revised 09/2022) indicated .4. If two residents are involved in an altercation, staff .f. make necessary (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changed in the care plan approaches to any or all of the involved individuals; g. document in the resident's clinical record all interventions and their effectiveness; h. consult psychiatric services as needed for assistance in assessing the resident, identifying causes, and developing a care plan for intervention and management as necessary or as may be recommended by the attending physician or interdisciplinary care planning team; .