

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676072	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Corrigan Ltc Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation in that: 1. Expired milk was not disposed of. 2. Hairnets were not worn properly. 3. Meat was not thawed properly in the sink. These failures could place residents who received meals from the kitchen at risk for food borne illness. During an observation on 9/15/2025 at 8:20 a.m. while in the kitchen it was observed that a tube of hamburger beef was not being thawed properly. Hamburger meat was in a kitchen sink, submerged in hot water with no water continuously agitating the surface of the water. The water was steaming and hot to the touch. It was observed that a gallon of milk was out of date, September 13th, 2025. This milk was stored in an ice chest with mostly melted ice. During an observation on 9/15/2025 at 12:12 p.m., in the dining room it was observed that [NAME] E did not have all of her hair in a hairnet. [NAME] E hair went down her back and was hanging out of her hairnet while plating food. [NAME] E brought out a bowl that contained ice, mighty shakes, and a gallon of milk that was expired on September 13th. The gallon of milk was taken away after the surveyor took a photo of it. During an interview on 9/17/2025 at 8:44 a.m. RN D said that there could be foodborne illness if food was thawed improperly, hairnets were not worn properly, or expired food was served to residents. She said it was the responsibility of all kitchen staff to ensure that these issues were not occurring. During an interview on 9/17/2025 at 9:10 a.m., the Dietary Manager said that meat should be thawed under cold water, submerged, with cold running water agitating the water. She said that her staff should also secure all of their hair in a hairnet, and it should not hang out the bottom. She said that all expired foods including milk should be disposed of and not served. She said that all these issues could cause foodborne illness. During an interview on 9/17/2025 at 9:00 a.m., the Administrator said that she expects that her kitchen staff follow facility policy. She said that facility policy dictates that kitchen staff thaw meat properly. She said that meat should have had been submerged in cold water with water continuously running. She said that she expects that kitchen staff wear their hairnets properly and throw out any expired foods. She said that residents could potentially be placed at risk of foodborne illness if these policies are not followed. A policy provided by the facility titled, Food Preparation and Service and dated November of 2022 indicated that the purpose of this policy was, Food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices. Completely submerging the item in cold running water (70 Fahrenheit or below) that is running fast enough to agitate and remove loose ice particles. Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food.		

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to treat each resident with respect and dignity in an environment that promoted maintenance or enhancement of his or her quality of life for 2 of 14 residents (Resident #3 and Resident #18) reviewed for resident rights. The facility failed to protect and value Resident #3 and Resident #18's dignity when their catheter urine collection bags either did not have a privacy bag on it or it was not properly placed on the catheter bag. This failure could place residents at risk for decreased quality of life, increased anxiety, embarrassment and increased stress. Findings included:1. Record review of Resident #3's admission Record dated 8/15/25 indicated he was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Streptococcal Sepsis (a life-threatening infection caused by bacteria known as Streptococcus), Muscle Weakness (Muscle weakness can have causes that aren't due to underlying disease. Examples include poor physical conditioning, intense exercise, recovery from strength training, or malnutrition), and Type 2 Diabetes (a chronic condition in which the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels).Record review of Resident #3's admission MDS dated [DATE] revealed that the resident had a BIMS score of 13 which indicated no cognitive impairment. The MDS also revealed, Resident #3, required maximal assistance for transfers. Record review of Resident #3's Care Plan dated 8/18/25 , revealed a problem initiated on 8/18/2025 for impaired visual function. It also indicated that Resident #3 has an ADL self-care performance deficit .During an observation and attempted interview on 9/15/2025 at 8:53 a.m. Resident #3's catheter bag was exposed to the public. There was no cover over his urine collection bag. When asked about this he did not understand the surveyor's question. During an observation on 9/16/2025 at 8:10 a.m. Resident #3 was observed lying in bed with his catheter bag viewable to the public. His door was open and there was no privacy bag over his urine collection bag. 2. Record review of Resident #18's admission Record dated 2/21/25 indicated she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Dementia (a general term describing a group of conditions that cause a progressive decline in cognitive abilities, including memory, thinking, reasoning, and judgment, which interfere with daily life), Hydronephrosis (a condition where the kidneys become enlarged due to a buildup of urine), Schizoaffective Disorder (a mental health condition that combines symptoms of schizophrenia and a mood disorder, such as depression or bipolar disorder). Record review of Resident #18's MDS dated [DATE] revealed that the resident had a BIMS score of 10 which indicated moderate impaired cognition. The MDS also revealed , Resident #18, was dependent for all her needs. Record review of Resident #18's Care Plan revealed a problem initiation on 8/18/2020 Resident #18 was dependent on staff for activities, cognitive stimulation, social interaction related to immobility. She actively participated in group activities as desired. She kept a semiactive independent activity level.During an observation on 9/15/2025 at 9:05 a.m., Resident #18 was observed with her catheter bag exposed to the public. There was a privacy bag on her urine collection bag, but it was only half on exposing the bottom half of the bag. Resident #18 was developmentally disabled and was unable to give an interview. During an observation on 9/15/2025 at 3:12 p.m., Resident #18 was observed with her catheter bag exposed to the public. There was a privacy bag on her urine collection bag, but it was only half on exposing the bottom half of the bag . During an interview on 9/17/25 at 8:44 a.m., RN D said that it was the responsibility of nurses and CNAs to ensure that privacy covers were on catheter bags to prevent them from being exposed to the public. She said that not having a privacy bag on a catheter was a resident rights and dignity issue as a resident whose catheter bag that was exposed could be embarrassed . During an interview on 9/17/2025 at 9:00 a.m., the Administrator said the CNA or whichever nurse was assigned the hall that resident resided on should ensure residents' privacy covers were on their catheter bags. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She said that it could be embarrassing to the resident if their catheter bag was exposed to the public. She said it was the facility policy to ensure that resident's dignity was maintained. Record review of a facility policy titled, Resident Rights dated February 2021 indicated that, Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to a dignified existence.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs for 1 of 5 residents (Resident #35) reviewed for unnecessary medications. The facility failed to ensure Resident #35 had an appropriate rationale for declining a gradual dose reduction for her Lexapro (antidepressant medication) and Seroquel (an antipsychotic medication) medications. This failure could put residents at risk of possible psychotropic medication side effects, adverse consequences, decreased quality of life, and dependence on unnecessary medications. Record review of Resident #35's face sheet, dated 09/16/25, indicated she was a [AGE] year-old female, originally admitted to the facility on [DATE], and most recently readmitted on [DATE]. Her diagnoses included anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities) and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). Record review of Resident #35's annual MDS assessment, dated 08/14/25, indicated she was usually able to understand others and she was usually able to make herself understood. She had a BIMS score of 15, which indicated intact cognition. She also had a diagnosis of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). She took antipsychotic medications on a routine basis only, a GDR had not been attempted, and the physician had not documented the GDR as clinically contraindicated. Record review of Resident #35's Order Summary Report, dated 09/16/25, indicated she had the following orders: *Escitalopram Oxalate (Lexapro) Tablet 10 MG Give 1 tablet by mouth one time a day related to anxiety disorder. The start date was 10/24/23. * Quetiapine Fumarate (Seroquel) Tablet 100 MG Give 1 tablet by mouth two times a day related to other schizoaffective disorders, anxiety disorder. The start date was 07/07/22. Record review of a Consultant Pharmacist / Physician Communication, dated 05/14/25, reflected: .Resident is receiving the following psychoactive medication(s) that are due for review: Lexapro 10mg [daily] Seroquel 100mg [twice daily] Per CMS regulations, please evaluate resident for a trial dose reduction or if a dose reduction is clinically contraindicated. Please document in the clinical progress note below if a dose reduction is not indicated. Physician/Prescriber Response Disagree. [continue with] same dose. During an interview on 09/16/2025 at 12:43 PM, the DON provided the most recent GDR for Resident #35. She said the provider response indicated Disagree. Continue with same dose. She said she felt like that was not a good rationale for not attempting a gradual dose reduction. During an interview on 09/17/25 at 9:38AM, the DON said she spoke with the doctor on this day and the rationale was now fixed. She said the DON at the time started in April and did not check the GDR. She said she expected the previous DON to check the GDR and ensure that it had a good rationale. She said she felt like the doctor did not give a proper rationale before she spoke with the doctor. She said the risk of not having a proper rationale was that the resident could be on unnecessary medications. During an interview on 09/17/2025 at 11:19 AM, the Administrator said she had worked as the administrator of this facility since April 7th. She said the doctor should have provided a proper rationale for continuing the dose. She said the risk was that the resident could be on an unnecessary amount of medication and/or suffer side effects. Record review of the facility's policy, Tapering Medications and Gradual Drug Dose Reduction, last revised July 2022, reflected: .2. All medications shall be considered for possible tapering. Tapering that is applicable to psychotropic medications are referred to as gradual dose reductions. 3. Residents who use psychotropic medications shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. 5. The physician will review periodically whether current medications are still necessary in their current doses; for example, whether an individual's conditions or risk factors are sufficiently prominent or (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ensuring that they require medication therapy to continue in the current dose, or whether those conditions and risks could potentially be equally well managed or controlled without certain medications, or with a lower dose.6. The physician will order appropriate tapering of medications, as indicated. 10. Residents who use psychotropic medications shall receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue the use of such drugs. Pertinent behavioral interventions will also be attempted.		

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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 resident environment remained free of accident hazards for 2 of 14 residents (Resident #3 and Resident #31) reviewed for accidents and hazards.1. The facility failed to keep prohibited items, Povidone-Iodine 10% solution, out of Resident #3's room.2. The facility failed to keep prohibited items, chemical cleaning solution, out of Resident #31's room.This failure could place residents at risk for injury, harm, and impairment or death.This failure could place residents at risk for injury, harm, and impairment or death.Findings included:1. Record review of Resident #3's admission Record dated 8/15/25 indicated he was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Streptococcal Sepsis (a life-threatening infection caused by bacteria known as Streptococcus), Muscle Weakness (Muscle weakness can have causes that aren't due to underlying disease. Examples include poor physical conditioning, intense exercise, recovery from strength training, or malnutrition), and Type 2 Diabetes (a chronic condition in which the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels).Record review of Resident #3's admission MDS dated [DATE] revealed that the resident had a BIMS score of 13 which indicates no cognitive impairment. The MDS also revealed, Resident #3, required maximal assistance for transfers. Record review of Resident #3's Care Plan dated 8/18/25, revealed a problem initiation on 8/18/2025 for impaired visual function. It also indicated that Resident #3 has an ADL self-care performance deficit.During an observation and interview on 9/15/25 at 8:53 a.m. it was observed that Resident #3 had a bottle of Povidone-Iodine 10% solution in his room on a dresser next to his refrigerator. Resident #3 did not know what the solution was for. There was no staff in the room performing any type of care . 2. Record review of Resident #31's admission Record dated 6/9/2022 indicated she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), General Anxiety Disorder (Severe, ongoing anxiety that interferes with daily activities), Adult failure to thrive (a condition in older adults where there is a significant decline in physical, mental, and social well-being)Record review of Resident #31's MDS dated [DATE] revealed that the resident had a BIMS score of 06 which indicated severe cognitive impairment. The MDS also revealed, Resident #31 was dependent or required moderate assistance with most ADLs. Record review of Resident #31's Care Plan revealed a problem initiation on 5/11/2021 that Resident #31 had impaired cognitive function/dementia or impaired thought processes.During an observation on 9/15/2025 at 8:42 a.m. Resident #31 was observed to have a bottle of all-purpose chemical cleaning solution in her room. There was no staff in the room actively cleaning . During an interview on 9/17/2025 at 8:44 a.m., RN D said that it was not allowed for residents to have Iodine or chemical cleaning solutions in their room. She said that these items should be stored in separate places. She said that Iodine should be stored on the nurse's treatment cart. She said that chemical cleaning solutions should be kept by housekeeping. She said that residents could harm themselves if they improperly misuse a chemical product. She said that residents could get sick and need medical attention. She said it was the responsibility of all staff to ensure that residents do not have chemicals in their rooms. During an interview on 9/17/2025 at 9:00 a.m., the Administrator said that Iodine and brand-named chemical cleaning solutions should not be left in residents' rooms. She said that they contract out their cleaning supplies and a brand name cleaning supply should not have even been in the building. She said that housekeeping should keep and maintain all cleaning products. She said that Iodine solution should not be left in residents' rooms it should be kept on the nurses' medication cart. She said it was likely used for wound care and left by a nurse. She said Iodine should not have been left in a resident's room. She said that residents could potentially be harmed if they misused a chemical that was left in their room especially if that (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had a cognitive decline. Record review of a facility policy titled, Storage Areas, Maintenance dated December 2009 indicated that, Maintenance storage areas shall be maintained in a clean and safe manner. Cleaning supplies, etc., must be stored in areas separate from food storage rooms and must be stored as instructed on the labels of such products. Record review of a facility policy titled, Accidents/Incidents dated April 2013 indicated that, Our facility shall provide a safe and secure environment for staff and residents. Therefore, all accidents or incidents occurring on facility premises or to facility employees while performing their jobs shall be reported and investigated.		

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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 interview and record review, the facility failed to ensure that drug records were in order and that an account of all controlled drugs were maintained and periodically reconciled for 1 of 13 residents (Resident #28) reviewed for pharmacy services. The facility failed to ensure that 8 tablets of Resident #28's prescribed morphine (opiate pain medication) were properly accounted for and not missing on 09/15/25. This failure could place residents at risk for decreased quality life and unrelieved pain. Findings included: Record review of Resident #28's face sheet, dated 09/16/25, indicated she was an [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions.), peripheral vascular disease (a slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel) and poly-osteoarthritis (characterized by the degeneration of cartilage and the underlying bone within a joint, leading to pain, stiffness, and impaired movement). Record review of Resident #28's annual MDS assessment, dated 07/24/25, indicated a BIMS score of 99 which indicated the resident was unable to complete the BIMS interview. She was sometimes able to make herself understood and she was sometimes able to understand others. She was taking an opioid medication. Record review of Resident #28's Order Summary Report, dated 09/16/25, reflected this order: *Morphine Sulfate Oral Tablet 15 mg Give 1 tablet by mouth every 12 hours as needed for pain/dyspnea. The start date was 08/07/25. Record review of Resident #28's MAR for the month of August 2025, printed on 09/16/25, indicated the morphine sulfate medication was not administered during the month of August to Resident #28. Record review of Resident #28's MAR for the month of September 2025, printed on 09/16/25, indicated one dose of the morphine sulfate medication was administered to Resident #28 on 09/12/25 and 09/13/25. Record review of an undated investigative report completed by the Administrator and provided to the survey team on 09/16/25 reflected: .Around 5PM on 09/15/2025 [RN F] from [hospice company] was routinely reviewing medications for refills on [Resident #28] when it was discovered that the remaining Morphine Sulfate tablets were missing, not only was the card missing but the narcotic count sheet was gone as well. A search for the medication, card, and narcotic sheet was initiated on all carts, med room, drug destruction areas, medication storage, and shredder box. When the medication was not found we looked at the EMR to see when it was last given, per administration record it was given the evening of 09/13/2025 [at] 1945 (7:45 pm) by [LVN G]. [LVN G] was phoned by the facility and was interviewed by [the DON], [LVN G] stated that she gave the last pill in the card, took the empty blister pack and the narcotic count sheet and put them in the Business Office's box before end of shift. Day shift nurse [LVN H] was also contacted and stated that there were more pills on the card when she used it prior to [LVN G] on 09/12/2025. [The hospice company] was contacted via phone for order information on the Morphine Sulfate oral tablets, that were ordered from [Resident #28's Pharmacy] on 08/05/2025 in the amount of 10 tablets and was delivered to the facility by hospice on 08/07/2025 when the order was initiated. Medication administration record shows 2 tabs were given to the resident between 08/07/2025 and 09/13/2025. We presume 8 tablets are missing but we have no count sheet to verify this information. At approximately 6pm this administrator met with [an officer of the police department]. Information regarding missing count sheet and controlled drug by name of Morphine 15mg tablets- 8 tabs missing- was reviewed. [an officer of the police department] contacted [LVN G] via phone and interviewed her. [Police Officer and Police Sergeant] concluded that it would be a he said she said situation and no evidence was available to pinpoint to one person. [Police Sergeant] requested list of nurses with access and phone numbers from night shift 09/13/2025 to day shift 09/15/2025, the last time the medication was seen up to the time when it was discovered missing. This administrator sent an email to the [police (continued on next page)]		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	department] with names and numbers as requested.[Facility's Legal Department] was contacted regarding follow-up on drug testing for nurses that may have been involved, and facility was advised to not drug test at this time due to the police report stating that too much time had passed between the drug being on hand and discovery of the missing drug. During an interview on 09/17/25 at 7:56AM, LVN H said she administered morphine to Resident #28 on 09/12/25. She said there were 8 or 9 pills left in the card after her administration of the medication. She said when her and the other nurse reconciled the medications at the end of her shift the count was correct. A phone call was attempted to LVN G on 09/17/25 at 8:29AM. LVN G did not answer, and the voicemail box was full. The call was not returned prior to exit. During an interview on 09/17/25 at 9:03AM, RN F said she visited the facility on 09/15/25 to check on Resident #28. She said she was a hospice nurse for Resident #28. She said during her visit she checks the resident's medication supply against her list to ensure there is enough supply on hand. She said during her check she was unable to locate the morphine medication. She said the other controlled medication the resident was taking was in the cart, but the morphine was not there. She said the last time she visited the facility there were 10 pills in the morphine card. She said she immediately notified the nurses and the facility's administration. She said the records showed that the morphine was administered 2 times in September and there should have been 8 pills left. She said she ordered more and was going to bring it on 09/17/25. During an interview on 09/17/25 at 8:54AM, the DON said she was alerted by the hospice nurse on 09/15/25 that Resident #28's morphine medication was missing. She said she reviewed the MAR and it had been administered twice by two different nurses over the past weekend. She said she spoke with LVN G and she had given the last dose on 09/13/25. She said the nurse was part time at the facility and was not sure where to put the sheet and card after administering the last dose. She said the nurse gave the last dose and put the card in the Business Office Manager's box. She said they searched the facility and were unable to locate the morphine medication or the count sheet. She said she in-serviced LVN G on the proper procedure for disposal of controlled medications. She said LVN G also told her she had also put a timesheet in the Business Office Manager's box before that had gone missing. She said the policy was that the nurse should have given the count sheet to the DON, or slid under the door of the DON's office, or placed in the DON's box. She said the empty medication card should have been torn and shredded. She said the resident was monitored for pain and did not have pain while they did not have the morphine medication. She said she notified hospice and other pain medications were already ordered. She said she spoke with LVN H and she was unsure how many pills were left after she administered a dose of the medication. She said they were unable to identify an alleged perpetrator and it was ultimately a he said/she said situation. During an interview on 09/17/2025 at 11:19 AM, the Administrator said she had been the administrator in this facility since April 7th, 2025. She said she has no new information to add to the statement provided to the surveyor. She said the nurse should have followed the policy and ensured that an empty medication card and narcotic sheet was properly disposed of. She said the risk was a medication could go missing and since they do not have the count sheet they are unable to reconcile the drug. Record review of the Facility's policy, Controlled Substances, last revised November 2022, reflected: .Dispensing and Reconciling Controlled Substances1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up.2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following:a. Records of personnel access and usage;b. Medication administration records;c. Declining inventory records; andd. Destruction, waste and return to pharmacy records.3. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count.4. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services.7. Waste and/or disposal of controlled medication are done in the presence of the nurse and a witness who also signs the disposition sheet.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676072	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Corrigan Ltc Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 15 residents reviewed for infection control practices (Resident #38). The facility failed to ensure CNA A changed her gloves and performed hand hygiene appropriately while providing incontinent care to Resident #38. These failures could place residents at risk of exposure to communicable diseases, cross-contamination, and infections. Findings included: Record review of Resident #38's undated face sheet indicated she was a [AGE] year-old-female that admitted [DATE], with a readmit date of 7/9/23. Record review of the physician's orders dated 9/16/25 indicated Resident #38 had diagnoses that included: hypertension (the force of blood against the arterial walls is too high), diabetes (the body cannot properly regulate blood sugar), dementia (characterized by loss of at least 2 brain functions, such as memory loss and judgment), and Alzheimer's Disease (a progressive brain disorder-most common cause of dementia, characterized by memory loss, difficulty with thinking and problem solving that gets worse over time). Record review of the annual MDS dated [DATE] indicated Resident #38 had clear speech, was sometimes understood by others and sometimes understood others. The MDS revealed she had a BIMS score of 3 indicating severe cognitive impairment. Resident #38 was always incontinent of bowel and bladder. Record review of the care plan dated 6/13/25 indicated Resident #38 had impaired cognitive function/dementia and bowel and bladder incontinence. During an observation and interview on 9/16/2025 at 1:19 PM, CNA A performed incontinence care for Resident #38 with CNA B assisting. CNA A did not change her gloves or sanitize her hands until she had finished and had repositioned Resident #38. CNA A touched Resident #38's clean brief, gown, sheet, blanket, her legs, and the remote control for the bed with her dirty gloves. CNA A said We failed. I forgot to change my gloves. During an interview on 9/16/25 at 1:29 PM, CNA A said she got confused and touched Resident #38's clean brief, legs, gown, sheet, blanket, and the bed remote control with dirty gloves and that was a risk of contamination to residents and staff. She said it was an infection control issue. She said she had been trained to change her gloves and sanitize her hands when going from dirty to clean and should have changed her gloves after cleaning Resident #38 front peri area and before going to her backside, then again after cleaning her backside and before touching anything considered clean. During an interview on 9/16/25 at 1:31 PM, CNA B said CNA A should have changed her gloves after she cleaned Resident #38's front peri area because her gloves were dirty and she could have been contaminating everything she touched which was an infection control problem for staff and residents. She said staff had to change gloves anytime they were considered to be dirty. During an interview on 9/17/2025 at 7:54 AM, LVN C said during incontinent care staff would need to change their gloves after cleaning a resident's front peri area and before going to the back area. She said not changing dirty gloves and touching clean items or the resident would spread infection. She said all CNA's know they have to change their gloves before going from dirty to clean, otherwise it could spread serious infection to residents and staff. During an interview on 9/17/2025 at 8:01 AM, RN[VT1] D said during incontinent care staff should change their gloves anytime when going from dirty to clean to prevent infection and contamination. She said staff should never use the same gloves without changing them during an entire incontinent care. She said dirty gloves touching a resident or clean items could contaminate and cause illness to staff and or residents. She said all staff have been trained and educated to change their gloves and sanitize their hands when going from dirty to clean. During an interview on 9/17/2025 at 9:00 AM, the Regional RN said during incontinent care staff should change their gloves and sanitize their hands after cleaning the front peri area and before going to the back, and again after cleaning the back area, and anytime gloves would be considered dirty. She said there was a risk of spreading infection and contamination to staff and (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Corrigan Ltc Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Hyde St Corrigan, TX 75939	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents when staff touched clean items with dirty gloves. During an interview on 9/17/2025 at 9:11 AM, the ADM said when performing incontinent care staff should change their gloves and sanitize their hands after cleaning the front peri area and before going to the back. She said they should change their gloves again and sanitize their hands after cleaning the back area. She said not changing their gloves and touching clean items with dirty gloves could cause a transfer of bacteria and cause infection to staff and residents. Record review of a Nurse Aide Proficiency dated 4/15/25 indicated CNA A was proficient in handwashing and perineal care. Record review of Policies and Practices - Infection Control with a revised date of October 2018 indicated: Policy StatementThis facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. Record review of Perineal Care with a revised date of October 2018 indicated: After performing incontinent care .9.Discard disposable items into designated containers.10.Remove gloves and discard into designated container.11.Wash and dry your hands thoroughly.12.Reposition the bed covers. Make the resident comfortable. Record review of Handwashing/Hand Hygiene with a revised date of October 2023 indicated: Policy StatementThis facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections.Policy Interpretation and ImplementationAdministrative Practices to Promote hand Hygiene1.All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.2.All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors[VT2] . [VT2]Good job!		