STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676319	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corinth Rehabilitation Suites on the Parkway	3511 Corinth Parkway Corinth, TX 76208

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560 Based on observation, interview and record review, the facility failed to ensure the residents' right to privacy during administering medication for 1 of 2 residents (Residents #2) reviewed for privacy in that: The facility failed to ensure LVN A provided privacy by closing the door and privacy curtain for Resident #2 on 1/1/25. This failure could place residents at risk of diminished quality of life. The findings include: Record Review of Resident #2's MDS Quarterly assessment dated [DATE] revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Resident had BIMS score of 6 which indicated Resident #2 had severe cognitive deficit. Her diagnoses included nontraumatic brain dysfunction, hypertension (high blood pressure), Diabetes Mellitus (high blood glucose), Hyperlipidemia (high blood lipids), non-Alzheimer's dementia, Blindness right eye. Record Review of Resident #2's Physician orders dated 6/26/24 reflected, Lantus Solostar U-100 Insulin pen; 100 unit/ml (3mL), amount 15 units, subcutaneous once a day at [8 PM]. In a phone interview on 2/26/25 5:20 PM with Responsible Party (RP) for Resident #1 stated that Resident #1 had electronic recording during her stay in the facility via Ring camera that captured motion and sound. She added that Resident #2 was Resident #1's roommate. RP stated that Resident #2 and her RP were aware of the electronic monitoring in the room that would capture video evidence on her side of the room, and they did not have any concerns with it. In an observation on 2/27/25 8:55 AM with DON of video footage of the Ring camera in Resident #1's Room date and time stamped 1/1/25 at 8:13:55 PM revealed LVN A walked into Resident#1 and Resident #2's room. At this time, Resident #2 was sleeping in her bed with no blanket or covers on her. She had a brief on, was not wearing any other clothes waist down , with right leg bent at the knee with foot on the bed. The video evidence revealed date and time stamped 1/1/25 at 8:14:27 PM LVN A proceeded to administer insulin injection to Resident #2. LVN A did not pull the privacy curtain while administering the medication. (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 2/27/25 8:58 AM with the DON, she stated her expectation was that privacy must be provided during nursing care or medication administration for each resident at each time. She stated that LVN A should had drawn the privacy curtain completely before administering medication to Resident #2. She stated that as a DON, staff received training on residents' rights at least once a year. She added failure to provide privacy to Resident #2 could result in failure to privacy to preserve the dignity and rights of the resident. She also stated that she was a new DON in the facility and stated that she was not aware if there was Electronic Monitoring Consent for Resident #2 and will find out about it after the interview. An attempt was made to interview RP for Resident #2 on 02/27/25 at 9:38 AM; however, call was not returned until the date and time of exit. In an interview on 2/28/25 11:57 AM with the Administrator, she stated that her expectation was residents' right to privacy should always be respected by facility staff at all times but especially during providing care. She stated that she did not see the video footage for Resident #1 fall, however her expectation was privacy curtain during care should be drawn. She stated that failure to provide privacy can lead to lack of dignity and decreased quality of life. Record review of the facility's policy titled Social Services Policies and Procedure. Subject: Patient/Resident Rights revised 6/9/2023 reflected, .The Facility employs measures to ensure patient and resident personal dignity, well-being, and self-determination are maintained and will educate patients and residents regarding their rights and responsibilities.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560 Based on interview and record review the facility failed to have evidence that all alleged violations were thoroughly investigated and measures were taken to prevent further potential abuse, neglect, exploitation or mistreatment in accordance with State law, including to the State Survey Agency, and report the results within 5 working days of the incident, and if the alleged violation is verified appropriate, corrective action must have been taken for 1 of 5 residents (Resident #1) reviewed for neglect. The facility failed to report findings to the state agency within five days for an allegation of neglect made on 1/2/25. This failure placed residents at risk of not having their allegations investigated or reviewed timely by the state survey agency. Findings included: Record Review of Resident #1's MDS Quarterly assessment dated [DATE] revealed she was a [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE]. Resident had BIMS of 9 which indicated Resident #1 had moderate cognitive impairment. Her diagnoses included nontraumatic brain dysfunction, Hypertension (high blood pressure), Diabetes Mellitus (high blood glucose), Hyperlipidemia (high lipid levels), non-Alzheimer's dementia, repeated falls, and unspecified Dementia. Record Review of the Texas form 3613- A Provider Investigation Report (PIR) completed on 2/27/25 reflected an allegation of neglect was made on 1/2/25 as a facility self-report for Resident #1. Resident #1 had staff member assigned for one-to-one observation (one to one observation us used for keeping the resident in sight at all times of day and night. LVN A came to the room to assist Resident #1 to the bathroom and to disconnect her IV medication. Resident #1 had a witnessed fall on 1/1/25 on the 2-10 PM shift. The facility concluded that investigation findings were inconclusive. Physician was immediately called, and skull series x-ray ordered. Resident #1 did not sustain any injuries post fall. Inservice given on Fall prevention and Fall Precautions. In an interview 2/26/25 2:25 PM with the DON revealed that Resident #1 had a fall in the facility on 1/1/25. She stated that incident was reported to Texas Health and Human Services (TX HHS) on 1/2/25. She also stated that Resident #1's responsible party shared the video evidence of Resident #1's fall. She reported that Resident #1 did not have any injuries related to the fall. The DON added that allegation of neglect was inconclusive. The DON stated LVN A did not handle Resident #1 falls' appropriately per facility fall policy which required post fall assessment. She stated that LVN A was placed on suspension on 1/2/25. She stated that the facility conducted an investigation of the incident, but she was not sure if the findings were reported to the state within the stipulated time frame by the previous administrator. She stated that the facility had a new administrator in the building. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/27/25 8:51 AM with the current Administrator in the facility, revealed the incident (Resident #1's witnessed fall) took place on 1/1/25. The facility Administrator and the DON were made aware of the fall on 1/1/25 and it was reported to TX HHS on the next day. She added the previous facility administrator was placed on suspension on 1/6/25 and terminated by the Corporate Management team on 1/9/25. The Administrator added after the initial report was made, the facility had five days to complete an investigation and create a report to send to the state agency. She stated that she was not sure why Form 3613 A (Provider Investigation Report) was not created and sent to the State agency, however she stated that investigation was completed. An attempt was made to interview the former Administrator on 02/27/25 at 9:25 AM; however, the former Administrator was not employed at the facility and did not return call. Record Review of the facility's policy titled Leadership Policies and Procedures. Subject: Abuse, Neglect, Exploitation or Mistreatment undated reflected, .The facility conducts an internal investigation through the Legal Department, if applicable, and reports the results to enforcement agencies within five (5) working days or as prescribed by state law .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560 Based on observation, interview, and record review, the facility failed to ensure that based on the comprehensive assessment of a resident, the residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of three residents reviewed for quality of care. LVN A failed to complete fall assessment after Resident #1 had a witnessed fall in the facility on 1/1/25. This failure could place residents at risk for injuries related to falls. The noncompliance was identified as Past Noncompliance (PNC). The noncompliance began on 01/1/25 at 8:13 PM and ended on 01/02/25. The facility had corrected the noncompliance before the Incident investigation began. Findings include: Record Review of Resident #1's MDS Quarterly assessment dated [DATE] revealed she was a [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE]. Resident had BIMS of 9 which indicated Resident #1 had moderate cognitive impairment. Her diagnoses included nontraumatic brain dysfunction, hypertension (high blood pressure), Diabetes Mellitus (high blood glucose), Hyperlipidemia (high blood lipids), Repeated falls, Unsteadiness on feet, non-Alzheimer's dementia. Resident #1 was independent and did not need assistance from a helper to walk 150 feet. Review of Resident #1's care plan, updated 12/16/2024, reflected, Problem: [Resident #1] had an actual fall. 1/5/24 Resident found on floor next to bed. No apparent injuries. 1/19/24 Resident slid out of bed due to habit of sleeping with legs dangling over the edge of bed 4/21/24 - Resident status post actual fall after losing balance and ambulating to bathroom [ROOM NUMBER]/30/2024 - Resident found on the floor in her bathroom. No apparent injury observed.8/2/24 AM patient slipped on mat 8/2/24 at 11:30AM resident found on floor mat in room, no apparent injury. 11/22/2024 - Resident found on the floor next to her bed. No apparent injuries noted. Goal: [Resident #1] have 25% decrease in fall incidents through next review. Approach: Encourage use of call light to request assistance. Demonstrate proper use of call light and resident returned demonstration. Scoop Mattress to bed, interdisciplinary team approached family regarding removing wedge heels and other sandal like shoes and provide flat shoes with skid free soles to decrease risk of future falls from footwear that increases risk of trips and falls. Fall mat to bedside when resident in bed to reduce injuries from falls from bed. Ensure resident has on skid free footwear, frequent monitoring. Record review of physician order dated 6/14/2024 reflected scoop mattress to bed. Record review of physician order dated 7/14/2022 reflected fall risk. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of LVN A Progress note in Resident #1 EHR dated 01/01/2025 23:42 reflected, While helping [Resident #1] to the bathroom resident stood up and suddenly fell could not catch her on time and she fell hitting her head on the IV pole, called [physician] and skull series ordered, family and the DON notified. Vital signs at the time 97.8 [temperature], 18 [respiratory rate], 76 [pulse rate], 138/73 [Blood pressure], 97% [oxygen saturation] at room air. All safety measure in place. Record Review of X-ray report dated 1/2/2025 reflected, Examination: Skull Clinical Indication: Fall, initial encounter Impression: No definite acute displaced or depressed calvaria fracture by plain radiography. Record Review of the Witness statement in the 3613-A form dated 1/3/25 reflected, First interview with [LVN A] [LVN A] stated she went into room to change/dc IV and told [Dietary Aide B] to take her to the bathroom and change her. She went in to discontinue [Resident #1] IV and flushed it. And told [Resident #1] to get up. She sat her on the side of the bed and stood her up. [LVN A] had to move things out of the way. [LVN A] turned around and [Resident #1] had fallen. [LVN A] tried to roll her over and asked [Dietary Aide B] to get [CNA C]. Tried to roll her over again with [CNA C]. Resisting, [CNA C] standing in front while [LVN A] was standing behind pushing and [CNA C] pulling stood her straight up and walked her to the bathroom and sat on the pot. [CNA C] held her hand while sitting and grabbed pants. [LVN A] holding back of pants walked her back to bed. Record Review of Witness Statement in the 3613-A form dated 1/3/25 reflected, Interview with [LVN A] #2 per phone call. The DON states to [LVN A] , We were able to meet with [Resident #1] family and they showed us the video of [Resident#1] 's fall. Can you walk me through that fall again. [LVN A] stated that she went to [Resident#1] room to disconnect her IV and to flush it and at the same time do the roommate, [Resident #2] last dose of Lantus. We were getting her to go back and [LVN A] told [Dietary Aide B], she would not be able to take her to the bathroom alone because she is resistant, so I told [Dietary Aide B] to go and help. The DON states, you know [Dietary Aide B] is a dietary aide she works in the kitchen she is not a CNA. [LVN A] stated I know that. That is why [LVN A] was surprised when she was here for one on one. [LVN A] only told her to give [Dietary Aide B] a brief to change into in the bathroom. [DON] stated, [Resident #1]'s family showed us the video of [Resident #1]'s fall can you walk me through that fall again. [LVN A] told [Resident #1] to get up from her laying position in the bed. [LVN A] took off her covers and [LVN a] sat [Resident #1] on the side of the bed, put on her slippers. [LVN A] said Mama we are going to banyo. She reached out her hand [LVN A] lifted her up. Stood her up. The space was small with the small tables, and I turned around to move table. [LVN D] was at the door trying to tell [LVN A] something. Then she fell . Laying face down and needed to turn her toward her back. Called to get [CNA C] to help. [CNA C] was in front and [LVN A] in back. Stood her straight up and took her to the bathroom.[LVN A] Didn't do any Range of Motion or vital signs. When asked by the DON, [LVN A] stated she did not change gloves between residents after giving insulin and changing IV. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview on 2/26/25 5:20 PM with Responsible Party [RP] of Resident #1 stated that Resident #1 had electronic recording during her stay in the facility via Ring camera that captured motion and sound. She stated that based on the video footage of the ring camera, she saw at approximately on 1/1/25 8:15 PM, a nurse removed the IV drip from resident #1's arm. She added Resident #1 was sleeping and was abruptly asked to stand and use the restroom. Resident #1 was sitting at the edge of the bed and appeared to become unconscious while collapsing and fell face-first on the floor. She added two staff members were present in Resident #1's room and neither turned her on her side to check vitals nor assessed her for injuries. Instead, LVN A continued to demand Resident #1 to stand. RP added Resident #1 remained on the floor until a third staff member arrived to help her stand. She stated that despite the fall; Resident #1 was taken to the bathroom without evaluation, increasing the risk of any further harm. In an observation on 2/27/25 8:55 AM with DON of video footage of the Ring camera in Resident #1's Room revealed the following. Date and time stamps as below: 1/1/25 8:13:56 PM LVN A walked into Resident# 1. Observed fall mat next to Resident #1 bed. 1/1/25 8:14:55 PM LVN A woke up Resident #1 by calling out her name. 1/1/25 8:15:10 PM LVN A takes out the IV tubing from the Resident#1's arm and flushes the IV Line. Resident #1 continues to be asleep with eyes closed. 1/1/25 8:15:41 PM Dietary Aide B walks into the room with her gloves on. 1/1/25 8:15:53 PM LVN A takes out the blanket from Resident #1's body and states common, get up, go pee . Get up right now Resident #1 opens her eyes. 1/1/25 8:16:10 PM LVN A bends down to get shoes for Resident #1. 1/1/25 8:16:22 PM Resident #1 gets up and wears shoes, while sitting at the edge of the bed. 1/1/25 8:16:35 PM LVN A is talking to someone at the door. 1/1/25 8:16:38 - 8:16:40 PM Resident #1 moved forward with her head slowly tilting to the ground and she fell face-first on the floor. Dietary Aide B who was standing close to Resident #1 bed, saw Resident #1 falling and rushed to help the Resident#1. However, she was not able to catch her on time. 1/1/25 8:16:45 PM LVN A still standing next to Resident #1, asked what happened. I told her to get up so she can go to the bathroom. LVN A asked Resident #1 to get up again. She sent Dietary aide out of the room to call CNA for help. 1/1/25 8:17:10 PM LVN A asked Resident #1 get up, turn around, and asked Resident #1, and stated how did you fall? 1/1/25 8:17:45 PM Resident #1 turned around with her face facing the bed , but still on the floor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/1/25 8:18:30 PM LVN A continued to ask Resident #1 to get up. CNA C walks into the room. 8:18:56 LVN A and CNA C help Resident #1 to sit up on the floor and then immediately make her stand up. 1/1/25 8:19:14 PM LVN A stated to Resident #1 let's go to the bathroom. It appeared Resident #1 was hesitant to walk to the bathroom and LVN A repeated three times, let's go to the bathroom. Dietary Aide B and LVN A assisted Resident #1 to the bathroom. 1/1/25 8:26:29 PM LVN A and Dietary Aide assist Resident #1 back to her bed from the bathroom. 1/1/25 8:27:15 PM LVN A walked out of Resident #1's room. 1/1/25 8:55:40 PM LVN A entered the room and told Resident #1 [RP] trying to talk to Resident #1, pointing to the ring camera. In an interview 2/27/25 8:58 AM with the DON, she stated LVN A reported Resident #1 fall to the DON on 1/2/25. She stated that Resident #1 had a witnessed fall in her room. LVN A and Dietary Aide B were in the Resident#1's room. She stated that Dietary Aide B was present in Resident #1's room because Resident #1 on one-to-one observation by a staff member related to previous elopement. She stated that Dietary Aide B was a non-clinical aide, and she was not expected to help with any resident care activities. She stated LVN A disconnected the IV medication and flushed the line. She then woke up Resident #1, told her to get up from her laying position in the bed. LVN A took off her covers and made her sit at the edge of the bed. LVN A then was talking to LVN C, who was at the Resident #1 door, talking to her about a phone call. Resident #1 had a fall with face down position and fell near the IV pole close to the fall mattress. She stated that once Resident #1 fell , she expected LVN A to check on her physically by bending down to assess for any injuries. She stated that LVN failed to assess vital signs, range of motion, and turn the resident on her back to check for any injuries immediately post fall. She stated that after Resident #1 was turned with the help of CNA C, she expected LVN A to make the resident sit on the bed to conduct neuro assessment before she could walk Resident #1 to the bathroom. The DON stated LVN A stood Resident #1 straight up and took her to the bathroom. She added LVN A called the physician and family and conducted skull X- ray that determined Resident #1 did not have any injuries post fall and there was no immediate or delayed harm to the resident. She stated that LVN was suspended on 1/2/25 and terminated there after the investigation was completed. She stated that LVN Progress note dated 1/1/25 and indicated that LVN A conducted post fall assessment that included vital signs, neuro checks and Range of motion, however per the electronic monitoring camera footage and LVN A witness statements, LVN A failed to conduct a thorough assessment immediately post fall. She stated that LVN A was referred to the Texas Board of Nursing for falsifying documents and customer service concern based on her prior witness statement before the DON reviewed camera footage of the fall. DON added that they conducted in services for falls after the incident for all direct care staff members. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/26/25 at 3:00 PM with Dietary Aide B stated that she was a Dietary Aide working in the kitchen, she stated that she wanted to make some extra income and took up the opportunity in the facility to provide one on one supervision to Resident #1. She stated that since she was nonclinical, her only work was one on one observation to watch Resident #1 and not perform any resident care activities. She stated that on 1/1/25 around 8:15 PM, LVN A came to the room to administer medications to Resident #1 and Resident #2. She stated that LVN A disconnected Resident #1's IV medication , took out the blanket from Resident #1's body and asked her to go to the bathroom. Resident #1 woke up, wore slippers and was sitting at the edge of the bed. In few moments, Resident #1 moved forward, while still sitting on the bed, with her head slowly tilting to the ground and she fell face-first on the floor. Dietary Aide B who was standing close to Resident #1 bed, saw Resident #1 falling, but before she could reach Resident #1, she fell and was not able to catch Resident #1 on time. She stated that LVN A was in the room at the time of the fall. LVN A then asked Resident#1 to get up and sent Dietary Aide B to find CNA for help. Dietary Aide B went out of the room to call CNA C who assisted Resident #1 to get up and then they walked Resident #1 to the bathroom. Dietary aide B stated that she had not been provided any in services on falls since she does not provide direct care to any resident. In an interview on 2/26/25 3:46 PM with CNA C, he stated that he was in the hallway rolling the dirty linen cart, when Dietary Aide B called him to Resident #1's room for assistance. When he entered the room, he saw Resident #1 lying sideways on the floormat on the floor facing the bed. LVN A and CNA C sat her on the floormat for a brief moment and got her up in the standing position. Resident#1 walked with LVN A to the bathroom and CNA C left the room. He stated he had been provided with fall in services in the past and was asked to call nurse on duty for any falls and assist as needed. He stated that Resident #1 did not need any assistance with walking, nor did she use wheelchair or walker for locomotion as far as he remembered. In an interview on 2/26/25 3:58 PM with LVN D, stated that she went to Resident #1's room to call LVN A since she had a phone call from a hospital regarding a different resident. She stated she saw Resident #1 sitting at the edge of the bed while she was talking to LVN A. She stated that she left the room soon after. She stated that fall in services was provided to her and expectation was to assess the residents for any injuries, vital signs, level of consciousness, and range of motion post fall. She also stated that Nurse will need to inform physician, DON, and family members. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview on 2/26/25 4:32 PM with LVN A stated that she went to Resident#1 room to disconnect her IV and to flush it and at the same time do the roommate Resident #2 last dose of insulin. She stated that there was Dietary Aide B who was providing one on one observation to Resident #1. She stated that Dietary Aide B did not have any patient care experience and she was aware that Dietary Aide B could not provide any patient care to Resident #1. LVN A stated that after disconnecting Resident #1's IV, she got Resident #1 up to the side of the bed. LVN A stated she made Resident #1 sit on the bed to make sure she was stable. She stated that Resident #1 was a fall risk, however Resident #1 did not need any assistance for walking. LVN A stated she turned around to make space and push the bedside table to ensure Resident #1 had adequate space to go to the bathroom. At the same time, LVN D was at Resident #1's door to tell her about a phone call for a different resident. Within few moments, she heard Dietary Aide B saying ah , ah, ah and looked back to see Resident #1 had a fall face down on the floor near the IV pole. She stated there was a fall mattress on the ground. She stated that Resident#1 was heavy, so she could not pick up Resident #1 by herself. She sent Dietary Aide B to call a CNA for help. Once CNA C arrived, they turned Resident #1 to the back and got her to sitting position and pulled her up to the standing position to take her to the bathroom immediately. LVN A added she glanced at Resident #1's face and did not observe any visible injuries. LVN A added, she failed to immediately conduct fall assessment on the resident that included checking vitals, and range of Motion before walking her to the bathroom. She stated that she could have made the Resident #1 sit on the bed or on the fall, checked her vitals, made sure there were no apparent injuries, performed range of motion before she walked Resident #1 to the bathroom. She stated that Resident #1 was able to walk to the bathroom by herself post fall. She stated she panicked and had multiple tasks to be completed. She stated she notified the MD who ordered Skull series and X rays and notified Resident #1's RP. She stated that she was aware there was electronic recording device in the room. She added she had been provided fall management in services in the facility. She stated that risk of not completing fall assessment accurately can lead to increased risk of delayed injuries, and decreased quality of care. Record review of in-services dated 10/16/24, reflected LVN A was provided fall prevention in-service. Review of the facility's titled Fall management revised May 5, 2023 , reflected, 1.The facility will identify each patient/resident who is at risk for falls and will plan care and implement interventions to manage falls. 2. Qualified staff will complete the Fall Risk Evaluation to determine if patient/resident is a fall risk. 3.The fall management program includes education for staff in creative, functional strategies while recognizing patients/resident's rights and highest practicable level of function 1.Qualified 1staff evaluates all patients/residents for fall risk at a minimum upon admission, quarterly, with a significant change, and post-fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676319	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corinth Rehabilitation Suites on the Parkway	3511 Corinth Parkway Corinth, TX 76208

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** 48560 Based on observation, interview and record review, the facility failed to 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 two (Residents #1 and Resident #2) of three residents reviewed for infection control. 1.LVN A failed to perform hand hygiene and changed gloves while administering medications to Resident #1 and Resident #2 on 1/1/2025. This failure could affect residents by placing them at risk for spread of infection through cross-contamination of pathogens and illness. Findings include: Record Review of Resident #1's MDS Quarterly assessment dated [DATE] revealed she was a [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE]. Resident had BIMS of 9 which indicated Resident #1 had moderate cognitive impairment. Her diagnoses included nontraumatic brain dysfunction, hypertension (high blood pressure), Diabetes Mellitus (high blood glucose), Hyperlipidemia (high lipid levels), non-Alzheimer's dementia, repeated falls, and unspecified Dementia. Record Review of Resident #1's Physician order dated 12/30/2024 reflected Resident #1 on Meropenem solution 1 gram intravenous three times a day 4:30, 12:30 and 20:30 with start date from 12/30/24 to 1/3/25. Record Review of Resident #1's Physician order dated 12/28/25 reflected, midline placement one time. Record review of Resident#1's Infectious disease Physician Progress note dated 1/5/25 reflected , At this point, patient is treated with Meropenem 1 gram IV q.8 [Every 8] hours daily for seven days. She is tolerating antibiotics okay. Record Review of Resident #2's MDS Quarterly assessment dated [DATE] revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Resident had BIMS score of 6 which indicated Resident #2 had severe cognitive deficit. Her diagnoses included nontraumatic brain dysfunction, hypertension (High blood pressure), Diabetes Mellitus (high blood glucose), Hyperlipidemia (high blood lipids), non-Alzheimer's dementia, Blindness right eye. Record Review of Resident #2's Physician orders dated 6/26/24 reflected , Lantus Solostar U-100 Insulin pen; 100 unit/mL(3mL), amount 15 units, subcutaneous once a day at [8 PM]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676319	A. Building B. Wing	02/28/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview on 2/26/25 5:20 PM with Responsible Party [RP] for Resident #1 she stated that Resident #1 had electronic recording during her stay in the facility via Ring camera that captured motion and sound. She stated that she reviewed video footage in Resident#1's room and noted that on 1/1/25 between 8 - 9 pm, LVN A administered medication to Resident #2, who was Resident #1's roommate. LVN A then turned around and provided care that included discontinuing Resident #1's IV therapy and flushing the IV line. She stated that she had concerns regarding infection control for Resident #1 since LVN A did not change gloves. She added that privacy curtain was not drawn for either of the resident's (Resident # 1 and Resident #2) while administering medications. She added that Resident #1 was discharged to another facility on 1/6/25. She added that she notified the facility DON and provided video footage about concerns regarding Resident #1's care. She stated unedited video footage from 1/1/25 was still available with her and she will send the video footage to the surveyor to review after the phone interview. In an observation on 2/27/25 8:55 AM with the DON of video footage of the Ring camera in Resident #1's Room date and time stamped 1/1/25 at 8:13:56 PM revealed LVN A walked into Resident#1 and Resident #2's room. She had her gloves on when LVN A entered the room. She also had insulin injection in her hand. LVN A administered insulin injection to Resident #2. The privacy curtain was not drawn hence the electronic monitoring camera captured LVN A administering medication to Resident #2. Further observation of the video footage revealed on 1/1/25 timestamped 8:14:55 PM LVN A turned around from Resident #2's bed to Resident #1's bed. She woke up Resident #1 by calling out her name. Video date and time stamped 1/1/25 at 8:15:08 PM , LVN proceeded to disconnect Resident #1's IV medication and flushed the midline. LVN A did not perform hand hygiene or changed gloves when she administered medications or disconnect IV med between the two tasks. In an interview 2/27/25 8:58 AM with the DON, she stated LVN A was in Resident #1 and Resident #2's room to administer medications. LVN A failed to follow Infection control practices. She stated that LVN A used same PPE for both the residents and did not perform hand hygiene while administering medications to both Resident #1 and Resident #2. She stated it was her expectation that LVN A should had performed hand hygiene before and after administering medication or providing care to each resident and donned new pair of gloves each time. She also added that based on the observation of the video, LVN A walked into the room with donned gloves, so it was unclear how long she had those gloves on. She added new gloves were available inside every resident room and LVN A was expected to perform hand hygiene and wear new gloves once inside the Residents room to keep them sterile. She stated risk of not performing hand hygiene or donning new PPE was increased spread of infection. In a phone interview on 2/27/25 11:44 AM with LVN A revealed she no longer works in the facility. She stated that on 1/1/25, she administered insulin injection to Resident #2 and discontinued IV medication for Resident #1 while she was in the room. She added she failed to performed hand hygiene or donned new gloves while providing medications to the residents. She stated that she was aware that hand hygiene and separate PPE should be used each time when providing care or administering medication for each resident. She stated that she was in a hurry since it was almost the end of her 2-10 shift, and she wanted to complete her remaining work. She stated that performing adequate hand hygiene and donning appropriate PPE was a part of her nurse training. She stated that failure to perform hand hygiene or donning correct PPE can lead to spread of infections. Record review of facility policy titled, Infection prevention and control policies and procedures revised May 15, 2023 , reflected, . Wearing gloves, Gowns, masks, and eye protection can significantly reduce health risks for workers exposed to blood and other potentially infectious materials .