

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>676319 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>09/11/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Corinth Rehabilitation Suites on the Parkway |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3511 Corinth Parkway<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                           |
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>(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:<br><br>676319   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>09/11/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Corinth Rehabilitation Suites on the Parkway   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3511 Corinth Parkway<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure in response to allegations of abuse, neglect, exploitation, or mistreatment, all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. for 1 of 5 residents (Resident #1) reviewed for abuse/neglect. The facility failed to ensure they self-reported neglect for Resident #1. Resident #1 fell and had to call EMS to help him get off the floor on 08/10/25. This failure could place residents at risk for not having their allegations for neglect reported which could lead to additional neglect. The findings included: Record review of Resident #1's admission MDS assessment, dated 08/07/25, revealed the resident was a [AGE] year-old male admitted on [DATE]. His BIMS score was 15 indicating his cognitive ability was intact. His diagnoses included non-Alzheimer's disease and unsteadiness on feet. The resident required maximum assistance to transfer between surfaces. Record review of Resident #1's Care Plan, dated 08/26/25, reflected: Resident is at risk for falling related immobility, muscle weakness, diabetes, and chronic pain. Facility interventions included: Keep call light in reach at all times. Record review of Resident #1's Incident Report, dated 08/10/25 at 3:00 AM, and signed by the DON reflected: Resident #1 was found on the bathroom floor with no injuries. The resident was alert and oriented and said he did not hit his head. Resident started on neurological checks. Findings included: Resident did not call for assist with transferring and resident was possibly drowsy due to pain management and narcotics. Resident required supervision. Follow-up steps taken: educate resident on calling for help especially when taking narcotics. Review of Resident #1's Falls Investigation Worksheet, dated 08/10/25, not signed, reflected: Resident was using his electric wheelchair, his call light was within reach, and he did not call for assistance to transfer. Resident #1 needed to be toileted. Review of Resident #1's Nurse Notes, dated 08/10/25, reflected: 08/10/25 at 2:55 AM Patient had fall in bathroom while attempting to transfer from chair to toilet independently. Patient then called 911 for assistance instead of pulling the call light for assistance. Patient is alert and oriented x4 and able to make needs known. EMT s/Fire Department was able to transfer patient back to electrical wheelchair. Patient education on call light system and to use call light before attempting to transfer. Patient refused to go to emergency room for further evaluation. Neurological checks initiated. Vital signs assessed and stable at this time. No new acute complaints of pain voiced. - RN B An observation and interview on 09/11/25 at 10:45 am with Resident #1 revealed he was awake, alert, and oriented. He was seated in his electric wheelchair. The resident said on 08/10/25 on the 10:00 PM - 6:00 AM shift he pressed his call light to go to the bathroom. The resident said he waited as long as he could and got up to go to the bathroom because staff did not come help him. He said he fell trying to get back in his wheelchair. Resident #1 said he yelled for help, and no one came to help him. He said he reached his phone and call 911. The resident said the fire department came to his room and helped him to get off the floor. The resident said he did not have any injuries. The resident said he was told that both the CNA (unknown) and nurse (unknown) for the hall were on break. An interview on 09/11/25 at 11:50 AM with the DON revealed she investigated the fall for Resident #1 on 08/10/25 but had not interviewed the resident. The DON said she did not always interview residents after falls but would speak to the staff and ADON. The DON said she did not need to speak to the resident because the incident did not need to be investigated further. The DON said she did not know the resident said he called for help, but no help came when he fell. The DON said failing to interview the resident could lead to missed information or a different perspective. An interview on an undisclosed date at an undisclosed time with an Anonymous Person revealed they arrived at the facility on 08/10/25 at 2:30 AM to help Resident #1 off the floor. The Anonymous Person said when they arrived the resident was alone in his room on the floor, and they assisted him off the floor. The Anonymous Person said they saw two staff members seated at the nurse's desk and was told the other staff were at lunch break. An interview was attempted with RN B on 09/11/25 at 2:50 PM. RN B did not return the call of the Surveyor. An interview on 09/11/25 at 3:20 PM with CNA C revealed she was working on the 10:00 PM - 6:00 AM shift on 08/10/25. She said she was not assigned to Resident #1</p> |  |  |

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>676319 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>09/11/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Corinth Rehabilitation Suites on the Parkway |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3511 Corinth Parkway<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|--|---|
| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>                                   |

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>676319  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>09/11/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Corinth Rehabilitation Suites on the Parkway   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3511 Corinth Parkway<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure that in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility had evidence that all alleged violations were thoroughly investigated for 1 of 5 residents (Resident #1) reviewed for abuse/neglect. The facility failed to ensure they investigated an allegation of neglect for Resident #1. Resident #1 fell and had to call EMS to help him get off the floor on 08/10/25. This failure could place residents at risk for not having their allegations for neglect investigated which could lead to additional neglect. The findings included:Record review of Resident #1's admission MDS assessment, dated 08/07/25, revealed the resident was a [AGE] year-old male admitted on [DATE]. His BIMS score was 15 indicating his cognitive ability was intact. His diagnoses included non-Alzheimer's disease and unsteadiness on feet. The resident required maximum assistance to transfer between surfaces.Record review of Resident #1's Care Plan, dated 08/26/25, reflected:Resident was at risk for falling related immobility, muscle weakness, diabetes, and chronic pain.Facility interventions included:Keep call light in reach at all times.Record review of Resident #1's Incident Report, dated 08/10/25 at 3:00 AM, and signed by the DON reflected:Resident #1 was found on the bathroom floor with no injuries. The resident was alert and oriented and said he did not hit his head. Resident started on neurological checks. Findings included: Resident did not call for assist with transferring and resident was possibly drowsy due to pain management and narcotics. Resident required supervision.Follow-up steps taken: educate resident on calling for help especially when taking narcotics. Review of Resident #1's Falls Investigation Worksheet, dated 08/10/25, not signed, reflected:Resident was using his electric wheelchair, his call light was within reach, and he did not call for assistance to transfer. Resident #1 needed to be toileted.Review of Resident #1's Nurse Notes, dated 08/10/25, reflected:08/10/25 at 2:55 AMPatient had fall in bathroom while attempting to transfer from chair to toilet independently. Patient then called 911 for assistance instead of pulling the call light for assistance. Patient is alert and oriented x4 and able to make needs known. EMT s/Fire Department was able to transfer patient back to electrical wheelchair. Patient education on call light system and to use call light before attempting to transfer. Patient refused to go to emergency room for further evaluation. Neurological checks initiated. Vital signs assessed and stable at this time. No new acute complaints of pain voiced. - RN BAn observation and interview on 09/11/25 at 10:45 am with Resident #1 revealed he was awake, alert, and oriented. He was seated in his electric wheelchair. The resident said on 08/10/25 on the 10:00 PM - 6:00 AM shift he pressed his call light to go to the bathroom. The resident said he waited as long as he could and got up to go to the bathroom because staff did not come help him. He said he fell trying to get back in his wheelchair. Resident #1 said he yelled for help, and no one came to help him. He said he reached his phone and call 911. The resident said the fire department came to his room and helped him to get off the floor. The resident said he did not have any injuries. The resident said he was told that both the CNA (unknown) and nurse (unknown) for the hall were on break. An interview on 09/11/25 at 11:50 AM with the DON revealed she investigated the fall for Resident #1 on 08/10/25 but had not interviewed the resident. The DON said she did not always interview residents after falls but would speak to the staff and ADON. The DON said she did not need to speak to the resident because the incident did not need to be investigated further. The DON said she did not know the resident said he called for help, but no help came when he fell. The DON said failing to interview the resident could lead to missed information or a different perspective.An interview on an undisclosed date at an undisclosed time with an Anonymous Person revealed they arrived at the facility on 08/10/25 at 2:30 AM to help Resident #1 off the floor. The Anonymous Person said when they arrived the resident was alone in his room on the floor, and they assisted him off the floor. The Anonymous Person said they saw two staff members seated at the nurse's desk and was told the other staff were at lunch break.An interview was attempted with RN B on 09/11/25 at 2:50 PM. RN B did not return the call of the Surveyor. An interview on 09/11/25 at 3:20 PM with CNA C revealed she was working on the 10:00 PM - 6:00 AM shift on 08/10/25. She said she was not assigned to Resident #1. CNA C said she was on a different hall, and she saw LVN D pacing in the Hall looking for CNA A and RN B. CNA C said CNA A and RN B were on break outside in their cars. CNA C said she saw the paramedics were in the facility and she did not know why. CNA C said CNA A told her that Resident #1 had fallen and called 911 for help. An interview on 09/11/25 at 3:45 PM with CNA A revealed she worked the 10:00 PM - 6:00 AM shift on 08/10/25. CNA A said she was assigned to Resident #1. CNA A said she went to Resident #1's room</p> |  |  |

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>676319 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>09/11/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Corinth Rehabilitation Suites on the Parkway |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3511 Corinth Parkway<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                             |
|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>676319  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>09/11/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Corinth Rehabilitation Suites on the Parkway   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3511 Corinth Parkway<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents (Resident #1) reviewed for accident hazards. The facility failed to provide adequate supervision for Resident #1. Resident #1 fell and had to call EMS to help him get off the floor on 08/10/25. This failure could place residents at risk for injury for not having adequate supervision. The findings included: Record review of Resident #1's admission MDS assessment, dated 08/07/25, revealed the resident was a [AGE] year-old male admitted on [DATE]. His BIMS score was 15 indicating his cognitive ability was intact. His diagnoses included non-Alzheimer's disease and unsteadiness on feet. The resident required maximum assistance to transfer between surfaces. Record review of Resident #1's Care Plan, dated 08/26/25, reflected: Resident is at risk for falling related immobility, muscle weakness, diabetes, and chronic pain. Facility interventions included: Keep call light in reach at all times. Record review of Resident #1's Incident Report, dated 08/10/25 at 3:00 AM, and signed by the DON reflected: Resident #1 was found on the bathroom floor with no injuries. The resident was alert and oriented and said he did not hit his head. Resident started on neurological checks. Findings included: Resident did not call for assist with transferring and the resident was possibly drowsy due to pain management and narcotics. Resident required supervision. Follow-up steps taken: Educate resident on calling for help especially when taking narcotics. Review of Resident #1's Falls Investigation Worksheet, dated 08/10/25, not signed, reflected: Resident was using his electric wheelchair, his call light was within reach, and he did not call for assistance to transfer. Resident #1 needed to be toileted. Review of Resident #1's Nurse Notes, dated 08/10/25, reflected: 08/10/25 and 2:55 AM Patient had fall in bathroom while attempting to transfer from chair to toilet independently. Patient then called 911 for assistance instead of pulling the call light for assistance. Patient is alert and oriented and able to make needs known. EMTs/Fire Department was able to transfer patient back to electrical wheelchair. Patient education on call light system and to use call light before attempting to transfer. Patient refused to go to emergency room for further evaluation. Neurological checks initiated. Vital signs assessed and stable at this time. No new acute complaints of pain voiced. - RN B An observation and interview on 09/11/25 at 10:45 am with Resident #1 revealed he was awake, alert, and oriented. He was seated in his electric wheelchair. The resident said on 08/10/25 on the 10:00 PM - 6:00 AM shift he pressed his call light to go to the bathroom. The resident said he waited as long as he could and got up to go to the bathroom because staff did not come help him. He said he fell trying to get back in his wheelchair. Resident #1 said he yelled for help, and no one came to help him. He said he reached his phone and call 911. The resident said the fire department came to his room and helped him to get off the floor. The resident said he did not have any injuries. The resident said he was told that both the CNA (unknown) and nurse (unknown) for the hall were on break. An interview on 09/11/25 at 11:50 AM with the DON revealed she investigated the fall for Resident #1 on 08/10/25 but had not interviewed the resident. The DON said she did not always interview residents after falls but would speak to the staff and ADON. The DON said she did not need to speak to the resident because the incident did not need to be investigated further. The DON said she did not know the resident said he called for help, but no help came when he fell. The DON said failing to interview the resident could lead to missed information or a different perspective. An interview on an undisclosed date at an undisclosed time with an Anonymous Person revealed they arrived at the facility on 08/10/25 at 2:30 AM to help Resident #1 off the floor. The Anonymous Person said when they arrived the resident was alone in his room on the floor, and they assisted him off the floor. The Anonymous Person said they saw two staff members seated at the nurse's desk and was told the other staff were at lunch break. An interview was attempted with RN B on 09/11/25 at 2:50 PM. RN B did not return the call of the Surveyor. An interview on 09/11/25 at 3:20 PM with CNA C revealed she was working on the 10:00 PM - 6:00 AM shift on 08/10/25. She said she was not assigned to Resident #1. CNA C said she was on a different hall, and she saw LVN D pacing in the Hall looking for CNA A and RN B. CNA C said CNA A and RN B were on break outside in their cars. CNA C said she saw the paramedics were in the facility and she did not know why. CNA C said CNA A told her that Resident #1 had fallen and called 911 for help. An interview on 09/11/25 at 3:45 PM with CNA A revealed she worked the 10:00 PM - 6:00 AM shift on 08/10/25. CNA A said she was assigned to Resident #1. CNA A said she went to Resident #1's room (unknown time) and asked if he needed anything and he said no. CNA A said she told RN B she was going</p> |  |  |