

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676319	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Corinth Rehabilitation Suites on the Parkway		STREET ADDRESS, CITY, STATE, ZIP CODE 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. (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: 676319	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Corinth Rehabilitation Suites on the Parkway		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 2 (Resident #1 and Resident #2) of 6 residents reviewed for infection control. The facility failed to ensure: LPN A and CNA C wore appropriate PPE when transferring Resident #1 on EBP isolation from bed to wheelchair on 11/04/25. CNA B wore appropriate PPE, and performed proper hand hygiene between gloves change during incontinent care for Resident #2 on 11/04/25. This failure could place residents at risk of cross contamination which could result in infections or illness. 1-Record review of Resident #1's Quarterly MDS assessment, dated 07/14/25, reflected Resident #1 was a [AGE] year-old female admitted [DATE], and readmitted [DATE]. Resident #1 had a BIMS score of 15, meaning her cognition was intact. She was completely dependent on staff for transfers. Resident #1's active diagnoses included heart failure (a condition where the heart cannot pump blood effectively enough to meet the body's needs), hypertension (elevated blood pressure), and obesity due to excess calories. Review of Resident #1's care plan, dated 09/29/25, reflected, Problem: The resident is on Enhanced Barrier Precautions related to an infectious disease process. Goal: The resident will remain on Enhanced Barrier Precautions r/t history of MDRO and will have no further complications. Approach: All PPE will be disposed of properly, including doffing gown, gloves and mask before leaving the room. All staff and visitors will wash hands before entering and before leaving the room. New PPE will be placed outside the room, including Hand Sanitizer, mask, gown and gloves. During an observation on 11/04/25 at 9:34 AM, Resident #1 had EBP signage outside her room and a PPE supplies (gloves, gowns.) stored on the door-mounted organizers and caddies. CNA C exited Resident #1's room with gloved hands looking for someone. A staff member signaled to CNA C to remove her gloves; she did and sanitized her hands. CNA C and LPN A entered Resident #1's room, both CNA C and LPN A washed hands put on clean gloves and did not put on gowns. Resident #1 was lying on her bed fully dressed and a lift sling under her. A Mechanical lift was observed next to Resident #1's bed. LPN A and CNA C attached the lift sling to the Mechanical lift and transferred Resident #1 from bed to wheelchair. Once the transfer was completed, both staff using the sling pulled Resident #1 up in her wheelchair. LPN A removed gloves, washed hands, and went and got a portable oxygen tank. LPN A washed hands, put on clean gloves, and did not put on gown and changed the portable oxygen tank attached behind Resident #1's wheelchair. LPN A removed gloves, washed hands, and exited the room. CNA C combed Resident #1's hair, made Resident #1's bed, put the trash bag, and linen bag together. CNA C removed gloves, took the Mechanical lift, the plastic bags and exited the room. CNA disposed of the plastic bags, and sanitized hands. In an interview on 11/04/25 at 09:51 AM, LPN A stated she did not put the gown on, because Resident #1 was ready for the transfer, and she was there just to help. LPN A acknowledged that residents' transfer, adjusting resident in the wheelchair, and changing the oxygen equipment was a form of high contact with the resident on EBP that required wearing a gown and gloves. She said the risk of not wearing appropriate PPE was increased risk of infection and possible cross contamination to the residents. In an interview over the phone on 11/04/25 at 11:04 AM, CNA C revealed she was a hospice Aide, that had been coming to the facility to render hospice service to Resident #1. She stated she only put on gown whenever she was giving shower to Resident #1, and today she did Resident #1 morning care and got her ready to transfer from bed to wheelchair. She stated when she stepped outside the room with gloved hands, she was looking for help with Resident #1's mechanical transfer. She said the risk of not wearing appropriate PPE was increased risk of infection and possible cross contamination to the residents. 2-Record Review of Resident # 2's Quarterly MDS assessment dated , 09/24/25, reflected Resident #2 was a [AGE] year-old female admitted [DATE], and readmitted [DATE]. Resident #2 had a BIMS score of 09, indicated she had moderately impaired cognition. She was incontinent with bowl and bladder. Resident #2's active diagnoses included hypertension (high blood pressure), Type 2 diabetes (elevated blood sugar), cerebrovascular accident (a medical emergency that occurs when blood flow to the brain is interrupted, causing brain tissue damage), and non-Alzheimer's dementia (a group of cognitive disorders that cause memory loss, confusion, and other cognitive impairments similar to Alzheimer's disease but have different underlying causes and characteristics). Review of Resident #2's care plan, dated 09/17/25, reflected, Problem: (Resident #2) is on enhanced barrier precautions related to history of ESRI in urine. Goal: Resident</p>		