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	02/11/2026

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 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 administer medications according to physician's orders for 1 of 4 residents (Resident #1) reviewed for medications. The facility failed to follow Physician D's order by applying a second Lidocaine patch by accident to Resident #1. This failure could place residents at risk of harm by not receiving their medication as instructed by physician. Findings included: Review of the Care Plan dated 02/09/2026 for Resident #1 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included HIV (Human Immunodeficiency Virus is a virus that attacks the body's immune system which can lead to AIDS (Acquired Immunodeficiency Syndrome), Seizures, Hypokalemia (Low potassium levels), Cellulitis (Bacterial skin infection), Anxiety (Excessive worry or unease), Vitamin deficiency, Muscle Weakness, Neuralgia (Intense sudden and sever facial pain), Neuritis (Nerve or inflammation of the nervous system), Candidal balantis (Inflammation of the penis), Constipation (Difficulty passing hard stools), Neuromuscular dysfunction (impair the communication between nerves and muscles, leading to muscle weakness, atrophy, and impaired movement), Paraplegia (Paralysis that affects the lower half of the body), Depression (Persistent feelings of sadness or loss of interest), Nausea with vomiting (mild digestive issues to more serious illnesses), Insomnia (Difficulty falling asleep, staying asleep, or waking up to early), Hyperosmolality and hypernatremia (Cellular dehydration from water loss or sodium gain), Hypertension (High blood pressure), Atopic dermatitis (Dry, itchy, or inflamed skin, Scabies (Skin infestation caused by mites). Review of the BIMS (Brief Interview for Mental Status) dated 01/23/2025 for Resident #1 revealed that he received a score of 15, indicating his cognition was intact. Review of the physician's orders for Resident #1 reflected an order was written on 01/04/26 for Lidoderm (Lidocaine) adhesive patch, medicated 5%; amount to administer: 1; topical. The order was for 9:00 AM to be put on the left hip and to be removed at 9:00 PM. Review of the MAR (Medication Administration Record) dated 01/16/2026 for Resident #1 revealed that Medication Aide B administered the Lidocaine patch as scheduled at 9:00 AM. Review of the Progress Note dated 01/16/2026 entered at 2:39 PM revealed that Licensed Vocational Nurse A administered a lidocaine patch on the left lower hip area of Resident #1 and did not notice the other lidocaine patch that was located higher up on the left hip area that was being covered by Resident #1's briefs. Once the situation was discovered, Licensed Vocational Nurse A removed the additional Lidocaine patch. During an interview on 02/11/2026 at 1:25 PM, Director of Nursing C stated the Lidocaine patch incident happened, was found, and was corrected within 30 minutes. The resident told them directly that the staff applied an additional Lidocaine patch without taking the first one off. During an interview on 02/11/2026 at 1:30 PM, Administrator E stated Resident #1 was saying the staff was double dosing him with the lidocaine patch. She stated that she asked Resident #1 who gave him the additional Lidocaine patch. She stated that he said Licensed Vocational Nurse B. She stated that she personally looked. Resident #1 did have two Lidocaine patches on. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It was an over-the-counter lidocaine patch. The second Lidocaine patch was removed. The physician was notified and said there was no risk. The physician said just to monitor but that there was no adverse reaction. During an interview on 02/11/2026 at 2:04 PM, Medication Aide B stated that Resident #1 received a Lidocaine patch at 9:00 AM and had it removed at 9:00 PM. She stated that on 01/16/2026 she did give Resident #1 a Lidocaine patch at 9:00 AM. She stated that when she gave him the Lidocaine patch he did not already have one on him. She stated that Licensed Vocational Nurse A applied a second Lidocaine patch shortly after her. During an interview on 02/11/2026 at 2:34 PM, Licensed Vocational Nurse A stated that she did administer an additional Lidocaine patch to Resident #1. She stated it was by accident. She stated that she was passing medications to Resident #1. She stated Resident #1 also was scheduled to receive a Lidocaine patch at the same time. She stated that she gave him his medication and left to go get the Lidocaine patch. When she returned, she stated that she did not see the Lidocaine patch that must have been given in the time period in between from when she left to get the Lidocaine patch and when she returned with the additional Lidocaine patch. She stated that Resident #1 was verbal and could have communicated to her that he had just been given a Lidocaine patch but instead he did not tell her that Medication Aide B had just came into the room and gave him a Lidocaine patch. She stated that he was verbal and even told her where he would like to have the Lidocaine patch applied. She stated that Resident #1 had called for Director of Nursing C and told her about the additional Lidocaine patch that was put on by Licensed Vocational Nurse A. She stated that Director of Nursing C asked her about the additional Lidocaine patch and she stated that she did not see a Lidocaine patch on Resident #1 at the time that she gave him the Lidocaine patch at 9:12 AM. She stated that she went back to Resident #1's room and looked for the Lidocaine patch and discovered that it was higher up on his left hip area than where she applied hers. She stated that Resident #1 must have moved the patch on his own or it could have moved on its own from Resident #1 repositioning in the bed. She stated that normally Medication Aide B would be the one to apply the Lidocaine patch but on that day he was complaining about wanting a nurse to apply the patch so that was why she did it. During an interview on 02/18/26 at 12:20 PM, Nurse Practitioner F stated that the risk of injury from an additional Lidocaine patch for 20 minutes to Resident #1 would be very low. Review of facility policy dated 01/15/2025 and titled Medication Management Program reflected the following: The Facility implements a Medication Management program to meet the pharmaceutical needs of patients and residents, according to established standards of practice and regulatory requirements. Preparing for the Medication Pass4. Authorized staff must understand: D. The 8 Rights for administering medication: 1) The Right Patient/Resident 2) The Right Drug 3) The Right Dose 4) The Right Time 5) The Right Route 6) The Right Charting 7) The Right Results 8) The Right Reason 5. The same person authorized medical or licensed person prepares, administers,and records the medications.