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	04/30/2026

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 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 that the resident environment remained free of accident hazards and each resident received adequate supervision for 1 of 3 residents (Resident #1) reviewed for accidents and hazards. The facility did not implement interventions per the Speech Therapist and the Nurse Practitioner when they did not provide recommendations of occasional supervision, upright posture during meals and upright posture for greater than 30 minutes after meals for Resident #1 on 3/7/26 after a choking incident. The facility failed to implement the interventions of occasional supervision, upright posture during meals and upright posture for greater than 30 minutes after meals recommended by the speech therapy to help prevent choking episodes for Resident #1 after she was discharged from speech therapy. These failures could put residents at risk of frequent accidents and decline in health.Record review of Resident #1's face sheet date 4/28/26 reflected an admission date of 4/6/25. Resident #1 was a [AGE] year-old female with the following pertinent diagnoses: Chronic obstructive pulmonary disease (a disease causing restricted airflow and breathing problems), mild protein-calorie malnutrition, Pneumonitis (inflammation of lung tissue) due to inhalation of food and vomit, dysphagia (a condition that makes it difficult to communicate), food in larynx causing asphyxiation (a deficient supply of oxygen to the brain caused by an inability to breath), gastro-esophageal reflux disease (when stomach acid frequently comes up into the esophagus), cognitive communication deficit and Type 2 Diabetes (a disease that causes the body to not use insulin correctly and sugar builds up in the blood). Record review of Resident #1's MDS assessment, dated 4/9/26, reflected her cognition was intact with a BIMS of 15. Resident #1's diet was mechanically altered and therapeutic. Resident #1 needed setup or clean up assistance for eating. Record review of Resident #1's Care Plan revised on 3/16/26 reflected .Problem Start Date: 03/13/2026 Resident #1 with documented episode of choking while eating. Edited: 03/16/2026 Long Term Goal Target Date: 06/27/2026Resident #1 will safely consume meals without choking through next review. Created: 03/16/2026 Approach Start Date: 03/13/2026 Chest Xray as ordered Created: 03/16/2026 Approach Start Date: 03/13/2026 Down grade diet to mechanical soft Created: 03/16/2026 Approach Start Date: 03/13/2026 Ensure resident is in proper positioning prior to meals. Created: 03/16/2026 Approach Start Date: 03/13/2026 Speech Therapy to assess and treat as indicated Created: 03/16/2026. Further review revealed the care plan did not address the choking incident on 3/7/26 and was not revised to include discharge recommendations of occasional supervision, upright posture during meals and upright posture for greater than 30 minutes after meals by Speech Therapy. Record review of Resident #1's orders as of 4/28/26 reflected an active order dated 4/7/25 Dining Room Preference: In room, active order dated 3/12/26 for EATING with assist x 1; SET UP ASSISTANCE and active order dated 3/13/26 Consistent Carb, Mechanical Soft Special Instructions: NAS, double protein. Further review revealed the orders did not include Resident #1's need for occasional supervision, upright posture during meals and upright posture for greater than 30 minutes after meals. Record review of Resident #1's progress note written by Agency LVN G dated 3/7/26 reflected During lunch time was called to the resident's room (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that she was choking, arrived in the room to see the resident was sitting upright, face red to color with no cyanosis nor loss of oxygen. Oxygen saturations 97 percent on right arm, pulse equals 01. No respiratory distress noted. Resident able to cough and clear her airway well. Resident is alert and responsive times 4. After some time with this resident, told her would like to change her diet to mechanical soft. Her response was I would like to keep my diet the same, this happened because I was talking to my roommate while eating. Resident's total lung field check and is clear bilaterally. Resident's Nurse Practitioner made aware. X-ray was done to resident's knee that she earlier complaint of. Nebulizer treatment given times 1. After 20 minutes pulse equals 77 and peripheral oxygen saturation equals 97percent , Continuing to monitor status Record review of Resident #1's progress note written by ADON H dated 3/13/26 reflected This nurse was on the hallway at approximate 12:40pm when a visitor from room XXX called out stating the resident in YYY was choking. This nurse immediately responded and entered the room. Upon arrival, resident was noted to be sitting upright at 30 degree angle in bed with facial flushing and signs of distress. Resident was awake, responsive and nodding head appropriately when asked if she was choking. Audible vocalization present. Resident appeared to have food lodged in throat and was attempting to cough. Head of bed was at once elevated to approximately 50 degrees and resident was encouraged to cough. Within approximately 30 secs resident was able to expel a piece of food measuring approximately a half dollar size piece of food, identified as cauliflower. Resident denied further difficulty breathing or choking at that time. No immediate respiratory distress noted. Charge nurse on hall was notified immediately notified and was instructed to respond to the room to perform a full nursing assessment and obtain vital signs. Speech therapist was notified at once of choking at bedside and responded to room as well. After consultation with Speech therapist and residents nurse practitioner residents diet was downgraded to mech soft pending further evaluation by speech therapist. A new meal tray of downgraded diet was taken to patients room with speech therapist at bedside. This nurse notified the Nurse Practitioner and Nurse Practitioner has ordered chest x-ray to rule out possible aspiration. Nurse Practitioner additionally instructed that is resident is to eat meals in dining room for closer supervision during meals. Representative notified via phone, message left, awaiting call back at this time. Resident remained awake and responsive following event and was left in the care of the assigned charge nurse for continued monitoring and assessment. This nurse returned to room [ROOM NUMBER] additional times in 20 min and patient verbally responsive, alert and oriented X 4 and no symptoms/signs of pain or distress at this time. Able to make needs and wants known to staff. Bed placed in lowest position, call light within reach and door to room left open. Record review of Resident of Resident #1's Speech Therapy Discharge Summary date 4/21/26 reflected discharge recommendations .Diet recommendations - Solids = Mechanical Soft textures; diet recommendations - liquids = all liquids; comprehensive strategies/positions: to facilitate safety and efficiently, it is recommended the patient use the following strategies and/or maneuvers during oral intake: general swallow techniques/precautions and alternations of liquids/solids upright posture during meals and upright posture for greater than 30 minutes after meals; Supervision for oral intake = occasional supervision; Discharge recommendations: to facilitate optimal cognitive-communicative performance, the following strategies are recommended: eliminate background noise. An interview with Resident #1 on 4/28/26 at 9:26am revealed she had been at the facility for over a year. Resident #1 reported she had two incidents in which she choked on food while eating in her room. Resident #1 was unable to provide the dates of the incidents but stated they had occurred in 2026. Resident #1 stated because of the 2nd incident her diet was changed to mechanical soft. Resident #1 stated mechanical soft food was working well for her and she had no other incidents of choking. Resident #1 stated they also provided her speech therapy, and the speech therapist watched her eat several times. Resident #1 reported no other staff had watched her eat. Resident #1 stated she prefers to eat in her room and had told staff she did not want to eat in the dining room. An interview with Resident #1's Roommate on 4/28/26 at 9:32am revealed she heard Resident #1 choking twice and both times (continued on next page)

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