

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 04/18/2024
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 0577</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>49640</p> <p>Based on observation, interview, and record review the facility failed to ensure that the residents' right to review survey results were readily accessible to residents, family members and legal representatives of residents reviewed for resident rights.</p> <p>The facility failed to ensure survey results were located and placed in a readily accessible location where individuals wishing to examine survey results without having to ask to review them. The facility failed to ensure residents were informed of their right to view survey results.</p> <p>This failure could affect residents who reside in the facility and could result in a lack of awareness for visitors, family, and residents regarding the survey results and the plan of correction submitted by the facility.</p> <p>The findings were:</p> <p>The confidential group meeting at 11:00 a.m. on 4/17/24, revealed residents were not aware of the location of the results of Federal or State surveys nor were they aware of their right to review the results of these surveys.</p> <p>In an interview at 2:07 p.m. on 04/17/24, the Activities Director said he thought the results of the state surveys were located at the nurse's station, but he was not sure. He stated he was responsible for informing residents of their rights during resident council meetings.</p> <p>In an interview at 3:03 p.m., on 04/18/24, the Administrator said the notebook containing the state survey results were temporarily on his desk. The Administrator walked towards a drawer on a table in the lobby and pointed where the results of State surveys were located when not temporarily on his desk. Observation revealed the drawer was marked with a Facility Postings and Survey Results sticker. The Administrator stated he thought the Activities Director informed residents during Resident's Council of the location of the results of the state inspection. The Administrator stated he would inform residents going forward of the location.</p> <p>Record review of Social Services Policies and Procedures: Subject: Complaints/Grievances Process, Section: Postings and Notifications #4) The facility's leadership will furnish a written description of the patients/resident's legal rights which include: 1) state survey, licensure, and certification agency. Complete Revision: 6/9/2023, Policy Revision: 11/6/2023.</p>

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 04/18/2024
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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690</p> <p>Resident #270</p> <p>48560</p> <p>Based on interview and record review, the facility failed to ensure all alleged violation of abuse and neglect were thoroughly investigated for 2 (Resident #370 and Resident # 270) of 17 residents reviewed for abuse, neglect, and misappropriation of property, in that;</p> <p>1- The facility failed to conduct investigation following self-report of neglect allegation for unwitnessed fall for Resident #370.</p> <p>2- The facility failed to conduct investigation following self-report of neglect allegation report to the administrator attention by Resident #270's family member.</p> <p>This failure could affect residents by placing them at risk for neglect by not having their incidents investigated.</p> <p>The findings were:</p> <p>1- Resident #370</p> <p>Review of Resident #370's Quarterly MDS assessment dated [DATE] reflected Resident #370 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Diabetes (high blood glucose), cancer (abnormal increase in number of cells), end stage renal disease, and dysphagia (difficulty swallowing). She had a BIMS of 15 indicating she was cognitively intact. Resident #370 needed Supervision for transfers and set up help only for ADL support.</p> <p>Record review of Resident #370's Care Plan last updated 4/17/2024 reflected, Problem: Resident #370 is at risk for falling related to impaired mobility, unsteadiness on feet, blindness left eye. Goal: Resident will remain free from injury for 90days. Approach: Give resident verbal reminders not to ambulate/transfer without assistance; Keep call light in reach at all times; Keep personal items and frequently used items within reach; Observe frequently and place in supervised area when out of bed; Provide resident an environment free of clutter.</p> <p>Record review of Resident #370 's Nurses' Note, dated 10/7/2023 at 5:08 am reflected , Heard resident yelling in pain and went to room. Resident lying on floor half on left side with walker on right side of body. Assessment done with pain observed when palpating left hip. Unable to sit up or move leg.</p> <p>Record review of the facility's accident report , dated 10/7/2023, revealed Resident #370's fall to have occurred at 5:08 a.m. in the resident's room. Further review revealed. RN heard resident yelling and went to the room; found on the floor, lying partially on left side. [NAME] on right side of the resident. Finding and analysis: found on floor and complained of left hip pain. Follow-up steps: to emergency room for assessment.</p> <p>(continued on next page)</p>

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 04/18/2024
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the hospital discharge report for Resident #370 dated 10/10/2023 reflected [AGE] year-old female with history of end-stage renal disease on hemodialysis admitted from nursing home after a fall. Imaging revealed fracture of the left pelvis. Patient was evaluated by orthopedics and recommended weightbearing as tolerated and nonoperative management PT OT and outpatient follow-up. Patient overall doing better today pain is controlled and is wanting to go back to nursing home. Patient blood pressure was found to be elevated patient was continued on hemodialysis while in the hospital. CT of the head no acute intracranial abnormality noticed.</p> <p>Record review in TULIP (an online system for submitting long-term care licensure applications) revealed a self-report was made regarding Resident #370's fall with allegation of neglect by the facility dated 10/7/2023. The narrative of the incident included, Heard resident yelling in pain and went to room. Resident lying on floor half on left side with walker on right side of body. Per family member resident reports 'she was getting ready for dialysis and tripped over something in her room.</p> <p>In an interview with Resident #370 on 4/17/2024 at 10:10 AM revealed that she had a fall in October 2023. She said it happened in the morning when she was getting ready for dialysis, and she tripped over a walker in the room. Resident stated she went to the hospital for a few days and recovered well after the incident. Resident #370 stated she had no concerns about her falls and staff checked on her often.</p> <p>In an interview with CNA A on 4/17/2024 at 12:04 PM regarding resident #370's fall revealed she has been working with the facility for the last 2 years. She stated Resident #370 had a history of falls and they had interventions for falls in place for the resident. CNA A stated that she was not questioned about Resident #370's falls and does not know whether an investigation was done. She stated she received multiple in-services on fall prevention and abuse/neglect. She stated she knew to contact the current facility administrator for any allegation of abuse and neglect immediately.</p> <p>In an interview with LVN B regarding Resident #370's fall in October 2023 stated that she was not working on the day of the fall; however Resident #370 had a history of falls. She also stated that Resident #370 had issues with left eye vision, ambulated by herself, and the facility had fall prevention intervention in place. LVN B stated she was not interviewed for the falls and did not know if an investigation was conducted. She stated she had received multiple in-services for fall prevention as well as abuse and neglect. She stated she would report any allegation of abuse and neglect to the current facility administrator immediately.</p> <p>2- Resident#270</p> <p>Review of Resident #270's Admission MDS assessment dated [DATE] reflected he was an [AGE] year-old male admitted to the facility on [DATE]. He had diagnoses of heart failure, hypertension (high blood pressure), peripheral vascular disease, renal failure, diabetes mellitus (High blood sugar). Resident #270 had a BIMS of 14 indicating he was cognitively intact. He required extensive assistance of one-person physical assist with ADLS of bed mobility, toileting, personal hygiene, and bathing. He required extensive assistance of two-person physical assist of ADL of transfers. Resident #270 is occasionally incontinent of bowel and had an indwelling foley catheter.</p> <p>Review of Resident #270's Comprehensive Care Plan dated 08/23/23 reflected Resident #270 required assistance with ADLs. Interventions included Bed mobility: limited to extensive x1. Dressing: assist of limited to extensive. Toileting: assist of extensive. Bathing: of extensive to total.</p> <p>(continued on next page)</p>		

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 04/18/2024
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review in TULIP revealed a self-report was made regarding Resident #270's allegation of neglect made by the resident's family member on 09/07/23. The narrative of the incident included, [Family member] presented in Administrator office asking for admission inventory sheet because they were moving [Resident #270] to new facility because of neglect and there is poop on his bed. The reporter stated resident did not have feces on his person at the time of the incident. The feces were on his bed sheets; there was no provider incident report, for the self-reported incident by the facility.</p> <p>In an interview with the DON on 4/17/2024 at 2:47 PM revealed that she was new to the facility and started working at the facility in December 2023. She stated she did not have any information regarding Resident #370's fall in October or if investigation for Resident #370 was carried out. She stated that her expectation was that any reportable incident should be reported to state and investigative findings completed within 5 working days of reporting. She stated based on the type of allegation, it was a joint responsibility of the DON and the Administrator to complete incident investigations.</p> <p>In an interview with the Facility Administrator on 4/18/2024 at 8:35 AM revealed that he started working at the facility in December 2023 and he was not aware that the reportable self- incident for Resident #370 submitted to Texas HHSC was not investigated. He stated the facility was not able to find any investigation report for Resident #370, and Resident#270. He stated his expectation was that all incidents should be investigated within 5 working days. He stated that the risk to the resident if it was not investigated was the potential for the incident to happen again and decreased quality of care. He stated that all staff members were aware that any allegation of abuse and neglect should be immediately reported to the Administrator, as abuse coordinator immediately. He also stated the DON and the Administrator were responsible for investigating the reportable incidents.</p> <p>In an interview with Corporate Executive Director on 4/18/2024 at 8:40 AM revealed she reached out to the previous Administrator who no longer worked for the facility. He told them the investigation report for Resident #370 would be on the O Drive on computer if the investigation report was completed. He told them he may or may not have completed these reportable incidents and could not recall any specific information about them. She and the Administrator had no specific information about these reportable incidents and could not find any documentation of the facility investigations.</p> <p>Record review of the facility's policy titled, ABUSE, NEGLECT, EXPLOITATION, OR MISTREATMENT, revised 10/23/2019, revealed, 3. 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. Enforcement agencies include but are not limited to the State's survey and certification agency. NOTE: Copies of internal Incident Reports should not be disclosed to any person or agency without prior approval from the Legal Department (see below).</p> <p>4. Investigations are prompt, comprehensive and responsive to the situation and contain founded conclusions.</p>		

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 04/18/2024
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560</p> <p>Based on observation, interview and record review, the facility failed to develop and implement comprehensive person-centered care plans for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for one (Resident #370) of 4 residents reviewed for comprehensive care plans.</p> <p>The facility failed to develop a comprehensive person-centered care plan to address Resident #370 keeping food in her room in unsanitary conditions.</p> <p>This failure placed residents at risk of not receiving individualized care and services to meet their needs.</p> <p>Findings include:</p> <p>Review of Resident #370's Quarterly MDS assessment dated [DATE] reflected Resident #370 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Diabetes (high blood glucose), cancer (abnormal proliferation of cells), end stage renal disease (complete loss of kidney function), and dysphagia (difficulty swallowing). She had a BIMS of 15 indicating she was cognitively intact. Resident #370 needed Supervision for transfers and set up help only for ADL support.</p> <p>Review of Resident #1's Comprehensive Care Plan last revised on 4/17/24 did not reflect Resident #370 keeping food in her room.</p> <p>Observation of Resident #370's room on 4/17/24 at 10:08 AM revealed that Resident #370 had a plastic container on her bed with 1/3rd box filled with shredded purple cabbage, 2 spring onion, 1 tomato and 3-4 medium size pieces of peeled ginger that was left unopened with fruit flies on the produce. Also observed, an avocado seed left on Resident #370's windowsill with fruit flies on it. Observed Resident #370 also had a table-mounted mini refrigerator in her room.</p> <p>Interview with Resident #370 on 4/17/24 at 10:10 AM revealed that her family likes to bring food that included fresh fruits and vegetables for her, and she disliked the facility's food at times. She stated that the fresh produce left uncovered in the container will be used for making salsa later. Resident #370 stated she had impaired vision and did not see the fruit flies on the produce until the time of the interview. She stated she used the facility microwave to cook her own meals at times. Resident #370 stated that she does not utilize her room refrigerator to store fresh produce because there is not enough space to hold all her produce at times. Resident #370 did not permit the writer to see what was in the refrigerator.</p> <p>(continued on next page)</p>		

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 04/18/2024
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with LVN B on 4/17/2024 at 10:59 AM revealed Resident #370's family brings in fresh produce very frequently such as ginger, carrot, and tomato in the room. LVN stated she had tried telling Resident #370 to keep fresh produce in a sanitary manner (covered, stored in refrigerator) multiple times. LVN B commented that Resident #370 has a mini refrigerator in the room, but she had not seen the resident use it often. LVN B stated Resident #370 will not allow facility staff to throw away spoiled foods and noncompliance to store food in sanitary conditions should be care planned. She stated the risk of not appropriately care planning can lead to increased infection risk to the resident.</p> <p>In an interview with CNA A on 4/17/2024 at 12:04 PM revealed Resident #370's family brings her food often, at least weekly, which includes onions, garlic, avocado, and other fruits and vegetables. CNA A stated she has seen fruit flies in the resident's room earlier, however Resident #370 is reluctant and does not allow to clean her room frequently. CNA A stated that the previous facility director and Nurses knew the resident stores fresh produce in her room. CNA A stated since Resident #370 has fresh produce in her room that is often stored in unsanitary condition, it should be care planned so staff was aware of it.</p> <p>In an interview with MA D on 4/17/2024 at 12:07 pm revealed that MA D had seen multiple instances of fresh produce left uncovered in Resident #370's room. She stated that Resident #37 had vision issues and was not sure if she could see the fruit flies in her room. As a medication aide, MA D bought a fresh cup of yogurt and Nepro drinks to Resident #370 each day. MA D stated Resident 370 storing fresh produce in her room should be care planned appropriately to improve quality of care for the resident.</p> <p>In an interview with MDS Coordinator LVN on 4/17/2024 at 12:21 pm stated she was aware Resident #370's family brought packaged snacks for the resident; however, she was not aware resident had fresh produce in her room. She stated Resident #370's care plan did not include her keeping food in her room. She stated that risk of not care planning was staff would not be aware of it and the risk of not appropriately care planning would be decreased quality of care for the resident. She stated that MDS Coordinator and the DON were responsible for care planning and care plans are revised every 92 days and on an as needed basis.</p> <p>In an interview with the DON on 4/17/2024 at 2:47 PM revealed Resident #370's care plan did not include her keeping food in her room and she was not aware that family was bringing in fresh produce for the resident. The DON stated that unsanitary storage of produce should be care planned and the risk of not care planning was that staff will not know about how to take care of the resident and possible risk of infection to the resident. She stated that comprehensive care planning was the responsibility of MDS Coordinator.</p> <p>Review of facility's policy Care Plan Process, Person-Centered Care revised 5/5/2023 reflected The facility will develop and implement a baseline and comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.</p>		

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 04/18/2024
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971</p> <p>Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 (Resident #59) of 8 residents reviewed for ADLs.</p> <p>The facility failed to ensure Resident #59 had his fingernails cleaned and trimmed.</p> <p>This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life.</p> <p>Findings include:</p> <p>Record review of Resident #59's Comprehensive MDS assessment dated [DATE] reflected Resident #59 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including dementia, muscle wasting and atrophy, and cognitive communication deficit. Resident #59's BIMS score of 99 indicated Resident #59 was unable to complete the interview. The MDS assessment indicated Resident #59 required maximal assistance with toileting and personal hygiene.</p> <p>Record review of Resident #59's Care Plan dated 02/19/24, reflected the following: Goal: current Resident #59 functional status will be identified . Approach: . personal hygiene and toileting: dependent - 2 persons assist .</p> <p>In an observation on 04/16/24 at 10:38 AM revealed Resident #59 was laying in his bed. The nails on both hands were approximately 0.4cm in length extending from the tip of his fingers. The nails were discolored tan and had dark brown colored residue on the underside and on the nails' bed. Resident #59 did not answer questions.</p> <p>In an interview on 04/16/24 at 10:50 AM, CNA A stated CNAs were allowed to cut the residents' nails if they were not diabetic. CNA A stated she did not see Resident #59's nails this morning. She stated she would clean and trim Resident #59's finger nails right then.</p> <p>In an Interview on 04/18/24 at 08:47 AM, the DON stated nail care should be completed as needed and every time aides wash the residents' hands. The DON stated nails should be observed daily. The DON stated nurses were responsible for trimming the nails of residents who were diabetic, and CNAs could trim other residents' nails. The DON stated she expected CNAs to offer to cut and clean nails if they were long and dirty. The DON stated the ADON and the DON would do the routine rounds to monitor. The DON stated residents having long and dirty could be an infection control issue.</p> <p>Record review of the facility's policy Activities of Daily Living, Optimal Function revised 05/05/23, reflected the following: . The Facility provides necessary care to all residents that are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition, grooming, and hygiene .</p>		

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 04/18/2024
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one (Resident #59) of two residents reviewed for incontinence care.</p> <p>The facility failed to ensure CNA A provided appropriate perineal (genital and rectal areas) care for Resident #59 after an incontinent episode when she failed to clean from front to back.</p> <p>This failure could place residents at risk for the development and/or worsening of urinary tract infections and skin breakdown.</p> <p>Findings included:</p> <p>Record review of Resident #59's Comprehensive MDS assessment dated [DATE] reflected Resident #59 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including dementia, muscle wasting and atrophy, and cognitive communication deficit. Resident #59's BIMS score of 99 indicated Resident #59 was unable to complete the interview. The MDS assessment indicated Resident #59 required maximal assistance with toileting and personal hygiene.</p> <p>Record review of Resident #59's Care Plan dated 02/17/24, reflected the following: Problem: Resident #59 experiences bladder incontinence. Goal: Resident #59 will be kept clean, dry, and odor free . Approach: . Provide incontinence care after each incontinent episode .</p> <p>Observation on 04/16/24 at 10:38 AM revealed CNA A entered Resident #59's room to provide incontinence care. CNA A had gloves in her hands. She unfastened Resident #59's brief and rolled him on his side. CNA A wiped the resident's buttock area with peri-wipes, back to front , removing a small amount of fecal material. CNA A then removed the soiled brief and with soiled gloves, and placed the clean brief under the resident. CNA A rolled the resident on his back onto the clean brief. CNA A then provided peri-care to the resident, wiping across the resident's pubis bone and then down each groin downward toward the clean brief. Once finished, she fastened the resident's brief.</p> <p>In an interview on 04/16/24 at 10:50 AM, CNA A stated she supposed to clean from front to back and acknowledged she did not do that. CNA A stated she should change her gloves and perform hand hygiene when she went from dirty to clean. CNA A stated failing to provide proper care exposed the resident to infections.</p> <p>In an interview on 04/18/24 at 08:47 AM, the DON stated when providing incontinent care staff were to clean from front to back, cleaning the peri area then moving toward the buttocks. She stated by not providing accurate incontinent care it placed residents at risk for urinary tract infections, skin breakdown and overall poor hygiene.</p> <p>Record review of the facility's policy titled, Perineal and Incontinent Care, revised 05/05/23. The policy did not address the concern.</p>		

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 04/18/2024
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>42971</p> <p>Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 (Med Aide Cart hall 200) of 3 carts reviewed for pharmacy services.</p> <p>The facility failed to ensure MA C, responsible for Med Aide cart hall 200, removed medications in unsecure containers from the Med Aide Cart.</p> <p>This failure could place residents at risk of not having the medication available due to possible drug diversion and at risk of not receiving the intended therapeutic benefit of the medication.</p> <p>Findings Included:</p> <p>Record review and observation on 04/17/24 at 12:00 PM of Med Aide Cart Hall 200, with MA C revealed the blister pack for Resident #61's Hydroco/APAP 7.5 - 325 mg tablet (controlled medication used for pain) had 1 blister seal broken and the pill still inside the broken blister and taped over.</p> <p>Interview on 04/17/24 at 12:05 PM, MA C stated she was unaware when the blister pack seal was broken, and she was not aware of who might have damaged the blister. She stated the risk would be a potential for drug diversion. She stated the nurses and med aides were responsible to check the medication blister packs for broken seals during the count of narcotics during the change of the shift. She stated the count was done at shift change and the count was correct. She stated she did not see the broken blister during the count. She stated when a broken seal was observed, she would report it to the charge nurse.</p> <p>Interview on 04/18/24 at 8:47 AM, the DON stated she expected if a blister pack medication seal was broken the pill should be discarded. The DON stated it would not be acceptable to keep a pill in a blister pack that was opened. The DON stated the risk would be potential for drug diversion and infection control issue. She stated nurses were responsible for checking the medication blister packs for broken seals during the count on the change of shifts. The DON stated the ADON , and the DON were supposed to check the cart randomly.</p> <p>Record review of the facility's policy Medication Storage revised 04/01/22, reflected the following: . 12. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the pharmacy if replacements are needed .</p>		

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 04/18/2024
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>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971</p> <p>Based on observation, interview and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 2 resident (Resident #59 and Resident #46) of 8 residents observed for infection control.</p> <p>The facility failed to ensure:</p> <p>1- CNA A performed hand hygiene and changed gloves during incontinent care for Resident #59.</p> <p>2- LVN B performed hand hygiene after performing FSBS (finger stick blood sugar) checks on Resident #46 and cleaning the glucometer, before re-entering the medication cart and drawing the Resident's Insulin.</p> <p>These failures could place residents at risk for infection and cross contamination of pathogens and illness.</p> <p>Findings include:</p> <p>1- Record review of Resident #59's Comprehensive MDS assessment dated [DATE] reflected Resident #59 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including dementia, muscle wasting and atrophy, and cognitive communication deficit. Resident #59's BIMS score of 99 indicated Resident #59 was unable to complete the interview. The MDS assessment indicated Resident #59 required maximal assistance with toileting and personal hygiene.</p> <p>Record review of Resident #59's Care Plan dated 02/17/24, reflected the following: Problem: Resident #59 experiences bladder incontinence. Goal: Resident #59 will be kept clean, dry, and odor free . Approach: . Provide incontinence care after each incontinent episode .</p> <p>Observation on 04/16/24 at 10:38 AM revealed CNA A entered Resident #59's room to provide incontinence care. CNA A had gloves in her hands. She unfastened Resident #59's brief and rolled him on his side. CNA A wiped the resident's buttock area with peri-wipes, front to back, removing a small amount of fecal material. CNA A then removed the soiled brief and with soiled gloves, placed the clean brief under the resident. CNA A rolled the resident on his back onto the clean brief. CNA A then provided peri-care to the resident, wiping across the resident's pubis bone and then down each groin downward toward the clean brief. Once finished, she fastened the resident's brief.</p> <p>In an interview on 04/16/24 at 10:50 AM, CNA A stated she supposed to clean from front to back and acknowledged she did not do that. CNA A stated she should change her gloves and perform hand hygiene when she went from dirty to clean. CNA A stated failing to provide proper care exposed the resident to infections.</p> <p>2- Record review of Resident #46's Optional State Assessment MDS assessment dated [DATE] reflected Resident #46 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including diabetes mellitus, muscle wasting and atrophy, and cognitive communication deficit. Resident #46's BIMS score of 15 indicated Resident #46 was cognitively intact.</p> <p>(continued on next page)</p>		

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 04/18/2024
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>An observation of LVN B on 04/16/24 at 11:09 AM revealed LVN B gathered supplies from the medication cart, performing hand hygiene and putting on clean gloves. She entered Resident #46's room and pricked the resident's finger with a lancet needle. LVN B squeezed the pricked finger to collect blood for glucose testing, and then she wiped off blood from her finger using a small alcohol wipe. Once finished, she picked up the supplies she had brought into the room and returned to the medication cart, where she placed the dirty glucometer on a piece of wax paper. LVN B discarded the lancet and strip she used on Resident #46, removed her gloves, and then put on clean gloves without performing hand hygiene. LVN B then pulled out a Sani-cloth (germicidal disposable wipe) and wiped down the glucometer and returned it to the Medication cart. LVN B removed her gloves and put on clean gloves without performing hand hygiene and opened the Medication cart. She then pulled out the resident's insulin pen of Novolog. She cleaned the top of the pen with an alcohol wipe and re-entered the resident's room. Without changing her gloves or performing hand hygiene she wiped the resident's upper right abdomen with a small alcohol wipe and administered the insulin. LVN B returned to the medication cart, discarded the needle, removed her gloves and sanitized her hands.</p> <p>In an interview on 04/16/24 at 11:20 AM, LVN B stated she sanitized her hands before she performed the FSBS and after she gave the Insulin. She stated she realized she should have sanitized her hands after she had cleaned the glucometer. She stated the risk would be cross contamination and spread of infection.</p> <p>In an interview with on 04/18/24 at 8:47 AM, the DON stated she expected the staff to remove their gloves and sanitize their hands when going from dirty to clean. She stated the nurse should have sanitized her hands before giving any medication and should have sanitized her hands after cleaning the glucometer, since it was considered contaminated after use.</p> <p>Record review of the facility's policy, Hand Hygiene/Hand Washing, revised May 15, 2023, reflected, . Hand Hygiene/Hand Washing is done . Before taking part in a medical or surgical procedure . After contact with soiled or contaminated articles such as articles that are contaminated with body fluids . After removal of medical/surgical or utility gloves.</p>		