Printed: 11/20/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676319	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2023	
NAME OF PROVIDER OR SUPPLIER  Corinth Rehabilitation Suites on the Parkway		STREET ADDRESS, CITY, STATE, ZI 3511 Corinth Parkway Corinth, TX 76208	P CODE	
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 0580  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	SUMMARY STATEMENT OF DEFICIENCIES		on on the first of the hospital with a blood sugars greater than 300 mg/dL) on multiple as and symptoms of hyperglycemia. The first of the hospital with a blood and blood sugars greater than 300 mg/dL) on multiple as and symptoms of hyperglycemia. The first of the hospital with a blood and blood sugars greater than 300 mg/dL) on multiple as and symptoms of hyperglycemia. The first of the hospital with a blood and blood sugars greater than 300 mg/dL) on 2/28/23 at 4:23 PM Resident #5 mg/d face, and clammy skin). Resident on 2/28/23 at 6:14 PM.  The ADM was notified, and a me facility remained out of	

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

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 676319

If continuation sheet Page 1 of 59

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X3) PADE INFORMATION NUMBER: 676319  Resident September 1				No. 0936-0391
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)  This (aliure could place residents by full regulatory or LSC identifying information)  This (aliure could place residents of the facility at risk for life-threatening medical conditions due to the facility's failure to notify the physician of a resident change in condition.  The findings included:  Observation of Resident #5 on 2/28/23 at 9.45 AM revealed that resident was lying in bed. Her husband sitting in a hair next to her. Resident #5 fall difficulty answering questions due to confusion. Resident #5 husband expressed concern and said that this was not normal for the resident.  Review of Resident #5's quarterly MDS assessment dated [DATE] reflected she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted to the facility from the hospital and on 1/2/7/23. She diagnoses of sepsis (blood infection), hypertension (high blood pressure), blobsed was a [AGE] year-old female admitted to the facility on [DATE] and readmitted to the facility on the hospital injections. Review revealed the resident had a BIMS soor of 13 which meant the resident was cognitive intact. The resident required extensive assistance to total dependence with all ADLs except eating only needed supervisor. Resident #6's was incontinent of bovel and blooder.  Review of the care plan dated 2/20/23 revealed that there was a care plan for diabetes with the gas statement. Diabetic status will remain stable as evidenced by resident blood sugary staying within the resident #5's had been discharged with an order for insulin isling scale that read, fill Blood Sugar is 10 to 200 give 2 Units. [If] Blood Sugar is 20 to 200 give 2 Units. [If] Blood Sugar is 20 to 200 give 2 Units		IDENTIFICATION NUMBER:	A. Building	COMPLETED
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.  [XA) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES [(Each deficiency must be preceded by full regulatory or LSC identifying information)  This failure could place residents of the facility at risk for life-threatening medical conditions due to the facility's failure to notify the physician of a resident change in condition.  The findings included:  Observation of Resident #5 on 2/28/23 at 9.45 AM revealed that resident was lying in bad. Her husband stiting in a chair next to her. Resident #5 had difficulty answering questions due to confusion. Resident #6 husband was trying to get the resident to eat breakfast, but Resident #6 related the husband expressed concern and said that this was not normal for the resident because of sepais (blood infection), hyperbreation (high blood pressure). Disease to entire the said in the said in DATE; reflected she was a [AGE] year-old female admitted to the facility from the hospital on or 1/27/23. And diagnoses of sepais (blood infection), hyperbreation (high blood pressure). Disease is diagnosed of sepais (blood infection), hyperbreation (high blood pressure). Disease is diagnosed of sepais (blood infection), hyperbreation (high blood pressure). Disease is diagnosed of sepais (blood infection), hyperbreation (high blood pressure). Disease is diagnosed the resident had a BIMS score of 33 which means with the resident was cognitive intact. The resident required extensive assistance to total dependence with all ADLs except eating only needed supervison. Resident #5 was incontinent of bowel and bladder.  Review of the care plan dated 2/20/23 revealed that there was a care plan for diabetes with the goal statement, Diabetic status will remain stable as evidenced by residents (blood sugar) statement. Diabetic status will remain stable as evidenced by residents (blood sugar) statement. Diabetic status will remain stable as evidenced by residents (blo			3511 Corinth Parkway	P CODE
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some  The findings included: Safety of the Resident #5 on 2/28/23 at 9.45 AM revealed that resident was lying in bed. Her husband sitting in a chair next to her. Resident #5 had difficulty answering questions due to confusion. Resident #5 husband was trying to get the resident to eat breakfast, but Resident #5 refused to eat. Resident #5's husband expressed concern and said that this was not normal for the resident.  Review of Resident #5's quarterly MDS assessment dated [DATE] reflected she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted to the facility from the hospital on 01/27/23. She diagnoses of sepsis (blood infection), hypertension (high blood pressure), Diabetes, Multiple Sclerosis (edegenerative neurological diseases), and Kidney Failure. It reflected she did not recieve any insulin injections. Review revealed the resident had a BIMS score of 13 which tent the resident was cognitive intact. The resident required extensive assistance to total dependence with all ADLs except eating only needed supervison. Resident #5's use incontinent of bowel and bladder.  Review of the care plan dated 2/20/23 revealed that there was a care plan for diabetes with the goal statement, Diabetic status will remain stable as evidenced by residents [blood sugar] staying within the resident's normal limits for Resident #5's had been discharge orders dated 1/27/23 (resident was admitted [DATE]) indicated that Resident #5's had been discharged with an order for Insulin Lispro high dose stiding scale. A written note the bottom of the orders read, New orders added by [MD T]: check blood sugar BID. There were no orders for the treatment of diabetes (insuli	For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some  The findings included:  Observation of Resident #5 on 2/28/23 at 9:45 AM revealed that resident was tying in bed. Her husband stiting in a chair next to her. Resident #5 had difficulty answering questions due to confusion. Resident #husband was trying to get the resident to eat breaks, but Resident #5 refused to eat. Resident #shusband was trying to get the resident to eat breaksts, but Resident #5 refused to eat. Resident #5 husband expressed concern and said that this was not normal for the resident.  Review of Resident #5's quarterly MDS assessment dated [DATE] reflected she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted to the facility from the hospital on 01/27/23. She diagnoses of sepsis (blood infection), hypertension (high blood pressure), Diabetes, Multiple Sclerosis (a degenerative neurological disease), and Kidney Failaire. It reflected did not recieve any insulin injections. Review revealed the resident had a BIMS score of 13 which meant the resident was cognitive intact. The resident required extensive assistance to total dependence with all ADLs except eating only needed supervison. Resident #5 was incontinent of bowel and bladder.  Review of the care plan dated 2/20/23 revealed that there was a care plan for diabetes with the goal statement, Diabetic status will remain stable as evidenced by residents [blood sugar] staying within the residents formal limits for Resident #5.  Review of the hospital discharge orders dated 1/27/23 (resident was admitted [DATE]) indicated that Resident #5 had been discharged with an order for Insulin Lispro high dose sliding scale. A written note the bottom of the orders read, New orders added by [MD T]: check blood sugar BID. There were no order for ror all medication for diabetes.  Review of Resident #5's January and February physician orders dated 03/02/23 revealed that the progress is 301 to 300, give 8 Units, [If] Blood Sugar is 70 to 150, g	(X4) ID PREFIX TAG			
	Level of Harm - Immediate jeopardy to resident health or safety	This failure could place residents of facility's failure to notify the physicial. The findings included:  Observation of Resident #5 on 2/26 sitting in a chair next to her. Reside husband was trying to get the reside husband expressed concern and some service of Resident #5's quarterly female admitted to the facility on [Ediagnoses of sepsis (blood infection degenerative neurological disease) injections. Review revealed the resintact. The resident required extensineeded supervison. Resident #5 work Review of the care plan dated 2/20 statement, Diabetic status will remain resident's normal limits thru the nethormal limits for Resident #5.  Review of the hospital discharge on Resident #5 had been discharged the bottom of the orders read, Newfor oral medication for diabetes.  Review of Resident #5's January and orders for the treatment of diabetes.  Review of Resident #5's January and orders for the treatment of diabetes.  Review of Physician order dated 03 Sugar [is] less than 70, call MD. [Iff give 2 Units. [Iff] Blood Sugar is 20' Sugar is 301 to 350, give 8 Units. [Ithan 400, call MD.  Review of TAR for Resident #5 ind 324 mg/dL. No medication was giverevealed no documentation that the Review of TAR for Resident #5 ind 332 mg/dL. No medication was giverevealed no documentation that the	this deficiency, please contact the nursing home or the state survey agency.  Y STATEMENT OF DEFICIENCIES  Iency must be preceded by full regulatory or LSC identifying information)  el could place residents of the facility at risk for life-threatening medical conditions due illure to notify the physician of a resident change in condition.  gs included:  on of Resident #5 on 2/28/23 at 9:45 AM revealed that resident was lying in bed. Her chair next to her. Resident #5 had difficulty answering questions due to confusion. Resident #5 refused to eat. Resident expressed concern and said that this was not normal for the resident.  Resident #5's quarterly MDS assessment dated [DATE] reflected she was a [AGE] y mitted to the facility on [DATE] and readmitted to the facility from the hospital on 01/2 sof sepsis (blood infection), hypertension (high blood pressure), Diabetes, Multiple Sc ive neurological disease), and Kidney Failure. It reflected she did not recieve any ins Review revealed the resident had a BIMS score of 13 which meant the resident was a resident required extensive assistance to total dependence with all ADLs except eat upervison. Resident #5 was incontinent of bowel and bladder.  If the care plan dated 2/20/23 revealed that there was a care plan for diabetes with the picates tatus will remain stable as evidenced by residents [blood sugar] staying w normal limits thru the next review date. Review of care plan revealed no statement as intis for Resident #5.  If the hospital discharge orders dated 1/27/23 (resident was admitted [DATE]) indicate #5 had been discharged with an order for Insulin Lispro high dose sliding scale. A writ of the orders read, New orders added by [MD T]: check blood sugar BID. There were dication for diabetes.  Resident #5's January and February physician orders dated 03/02/23 revealed there the treatment of diabetes (insulin sliding scale or oral medication) from 01/27/23 to 05 physician orders dated 03/01/23 revealed an order for insulin sliding scale that read, [1 less than 70,	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0580  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	335 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind mg/dL. No medication was given for revealed no documentation that the Review of TAR for Resident #5 ind 397 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 309 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 377 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 384 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 306 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 306 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 306 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 306 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 306 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 306 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 306 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 306 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 306 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 306 mg/dL Review of TAR for Resident #5 ind 306 mg/dL Review of TAR fo	icated that on 2/10/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/14/23 at 4:00 PM DON or this high blood sugar. Review of the exphysician was notified of the elevated icated that on 2/17/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/18/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/20/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/21/23 at 4:00 PM ADO en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/22/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/23/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/23/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/24/23 at 7:00 AM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/24/23 at 7:00 AM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/24/23 at 7:00 AM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/24/23 at 7:00 AM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/24/23 at 7:00 AM LVN en for this high blood sugar.	the progress notes dated 2/10/23 blood sugar of 335 mg/dL.  I documented a blood sugar of 356 progress notes dated 2/14/23 blood sugar of 356 mg/dL.  E documented a blood sugar of the progress notes dated 2/17/23 blood sugar of 397 mg/dL.  E documented a blood sugar of the progress notes dated 2/18/23 blood sugar of 399 mg/dL.  E documented a blood sugar of the progress notes dated 2/18/23 blood sugar of 309 mg/dL.  E documented a blood sugar of the progress notes dated 2/20/23 blood sugar of 377 mg/dL.  N documented a blood sugar of the progress notes dated 2/21/23 blood sugar of 400 mg/dL.  E documented a blood sugar of the progress notes dated 2/22/23 blood sugar of 384 mg/dL.  E documented a blood sugar of the progress notes dated 2/23/23 blood sugar of 400 mg/dL.  R documented a blood sugar of the progress notes dated 2/24/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	ion)
F 0580  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	375 mg/dL. No medication was give revealed no documentation that the Review of TAR for Resident #5 ind mg/dL. No medication was given for revealed no documentation that the Review of TAR for Resident #5 ind mg/dL. No medication was given for revealed no documentation that the Review of TAR for Resident #5 ind 406 mg/dL. No medication was given revealed no documentation that the Review of TAR for Resident #5 ind 305 mg/dL. No medication was givent revealed no documentation that the Review of TAR for Resident #5 ind 397 mg/dL. No medication was givent revealed no documentation that the Review of TAR for Resident #5 ind 477 mg/dL. No medication was givent revealed no documentation that the Review of TAR for Resident #5 ind 477 mg/dL. No medication was givent revealed no documentation that the Review of nursing progress notes of facility nurses who documented Reference TAR for Resident #5 ind 537 mg/dL. No medication was givent that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was givent that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was givent that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was givent that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was givent that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was givent that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was givent that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was givent that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was givent that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was givent that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was givent that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was givent that the Review of TAR for Resident #5 ind 537 mg/dL.	icated that on 2/24/23 at 4:00 PM LVN en for this high blood sugar. Review of en physician was notified of the elevated icated that on 2/25/23 at 7:00 AM RN of this high blood sugar. Review of the en physician was notified of the elevated icated that on 2/25/23 at 4:00 PM RN of this high blood sugar. Review of the en physician was notified of the elevated icated that on 2/26/23 at 4:00 PM LVN en for this high blood sugar. Review of en physician was notified of the elevated icated that on 2/27/23 at 7:00 AM LVN en for this high blood sugar. Review of en physician was notified of the elevated icated that on 2/27/23 at 4:00 PM LVN en for this high blood sugar. Review of en physician was notified of the elevated icated that on 2/28/23 at 7:00 AM LVN en for this high blood sugar. Review of en physician was notified of the elevated icated that on 2/28/23 at 7:00 AM LVN en for this high blood sugar. Review of en physician was notified of the elevated icated that on 2/28/23 at 7:00 AM LVN en for this high blood sugar. Review of en physician was notified of the elevated for the period of 1/27/23 through 2/27/2 esident #5's high blood sugar. Review of the for this high blood sugar.	the progress notes dated 2/24/23 I blood sugar of 375 mg/dL.  2 documented a blood sugar of 304 progress notes dated 2/25/23 I blood sugar of 304 mg/dL.  2 documented a blood sugar of 421 progress notes dated 2/25/23 I blood sugar of 421 mg/dL.  N documented a blood sugar of the progress notes dated 2/26/23 I blood sugar of 406 mg/dL.  R documented a blood sugar of the progress notes dated 2/27/23 I blood sugar of 305mg/dL.  E documented a blood sugar of the progress notes dated 2/27/23 I blood sugar of 397 mg/dL.  P documented a blood sugar of the progress notes dated 2/28/23 I blood sugar of 477mg/dL.  3 revealed that none of the seven ted these high blood sugar of progress notes dated 2/28/23  E documented a blood sugars to MD

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F 0580  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	sugar check this morning 477 . NPI At about 1pm this nurse noted individed checked blood sugar which was 48 that the physician was notified of the was notified that Resident #5 was seen to hospital as requested be about the change in condition and the linterview with LVN R on 03/02/23 as because she had a really high bloo	or Resident #5 dated 2/28/23 at 6:14 PN by both DON and [NP 5] . Review revea	order for Lispro on [sliding scale] . hyperglycemia . shaky . clammy . 28/23 revealed no documentation of documentation that the physician  M by LVN E read in part, Resident aled the physician was not notified  admitted to the hospital on 2/28/23 s not receiving insulin. LVN R
	ordered insulin for Resident #5 on the #5] wasn't on insulin. When asked to No.  In an interview on 03/02/23 at 12:10 hospitalization . MD T said, I think I something I think that was disconting the hospital due to kidney failure. I scale as well as accu-checks AC at by medical records . I was under the about the high blood sugars that lether #5 had been having high blood sugars. The admitted to the hospital. NP AA saik knowledge that Resident #5 had not an interview on 03/02/23 at 12:4 2/28/23. I found that [on 2/28/23] the insulin per sliding scale. I gave [Resugar again . I checked it, and it was didn't have a sliding scale. I called else intervened when the blood sugary, when she looked flushe saying she's hospice and the hospital.	of PM MD T was unaware of the decline her sugars are usually well-controlled? nued in the hospital. I remember that he know that I gave the order for Metformind HS on February 3, 2023. The progrete impression that the orders I gave weld to Resident #5's hospitalization, MD gars and did not know that Resident #5 1 PM with NP AA (MD T's nurse practite he first I heard of [the high blood sugared that MD T usually reviewed the laboration or orders in her chart for diabetic medical 1 PM, LVN P said she first discovered the blood sugar was 477, I notified the disident #5] 10 units before lunch. She lose 397. When I re-checked it and the nather doctor because she was trending high gar was high. I didn't see no sliding scald, cool and clammy, I stayed in contact ince nurse was saying to contact the doctor here.	I don't know why she [Resident during the interview, LVN R stated be that led to Resident #5's  I think she was on metformin or her metformin was discontinued in in and for Novolog Lispro sliding less notes that I write are received be re put into the chart. When asked T said that she knew that Resident had been sent to the hospital.  Sicioner), NP AA denied knowledge of signature was altory results and denied attorn from 1/27/23 to 2/28/23.  Resident #5's high blood sugar on octor who ordered 10 units of booked flushed so I checked her machine just said 'high'. To me, she ligh. I was shocked that nobody le, so I reached out to the twith the doctors . the doctor was core. her blood sugars were fine

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F 0580  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	In an interview on 03/02/23 at 01:0 #5's physician, MD 2. She stated, I me not to worry about it. Per nurse she learned how to monitor blood sthe facility policy for notifying the double of the facility of	1 PM LVN E denied reporting Resident didn't know I had to. I asked another now, she had graduated from nursing schools ugar in nursing school, nurse said yes octor for high blood sugars.  5 PM ADON denied reporting Resident or is, what the parameters are . Each do dentify what the blood sugar parameters policy for notifying the doctor for high bloods and the facility. He stated, .I go onc LVN O said he remembered admitting I would try . I tried to enter the order, be definished finishing the orders. I told [LVN also to be done by the ADON and DON and DON and DON and and the DON and ADON would finish the admitted the DON and ADON would finish the admitted the DON and ADON would finish the	t #5's high blood sugars to Resident turse what I should do and she told tol 2 months ago. When asked if . LVN E stated she did not know to the stated she did not know the stated she did not know the stated she did not know the stated she to the stated she did not know the stated she to the stat

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For information on the nursing nome's	plan to correct this deliciency, please con	tact the nursing home or the state survey	адепсу.
(X4) ID PREFIX TAG			on)
F 0580  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	SUMMARY STATEMENT OF DEFICIENCIES ((Each deficiency must be preceded by full regulatory or LSC identifying information)  In an interview on 03/04/23 at 02:46 PM LVN N said she was not sure when to notify the physician of resident's high blood sugar. I wasn't educated on that. I don't know if there's a policy. LVN N went on know that [a blood sugar of] 50 bis dangerous. I know that 400 is of some concern, but we would mo signs and symptoms. LVN N denied contacting the physician on 2/26/23 when she documented a blo sugar level of 406 for Resident #5.1 monitored for signs and symptoms. LVN N confirmed that there wilding scale in place for Resident #5.1 monitored for signs and symptoms. LVN N confirmed that there wilding scale in place for Resident #5. There was only an order for blood sugar checks BID. LVN N althat she did not see any orders for diabetes medication on Resident #5's chart. LVN N said that if a dresident didn't receive any orders for diabetes medication on Resident #5's chart. LVN N said that if a dresident didn't receive any orders for diabetes medication on Resident #5's chart. LVN N said that if a dresident didn't receive any orders for diabetes medication in would think that it would be life-threatening in an interview on 03/04/23 at 3:00 PM MD T said that if a resident had high blood sugar. MD T said she first became a Resident #5's bigh blood sugar sand subsequent hospital admission, When the surveyor called me [a 3/02/23]. MD T said that she saw Resident #5 on approximately February 3 or 4, 2023, I gave an ord Metformin around February 4th, when I saw her after she got back from the hospital. Her creatinine w normal, so I wrote the order for Metformin . I thought she was on sliding scale, because I think that she back from the hospital on sliding scale. MD T said she gave we orders for Metformin but could not remember which runses he gave them to. The second time is pecially second to diabetes medication. MD T said her next visit to Resident #5 was on February 10 or 11, I gave orders Metformi		e's a policy. LVN N went on to say, I a concern, but we would monitor for when she documented a blood /N N confirmed that there was no ugar checks BID. LVN N also said chart. LVN N said that if a diabetic at it would be life-threatening.  Igh blood sugar, I would expect [the sted to be notified of any resident of T said she first became aware of an the surveyor called me [on a or 4,, 2023, I gave an order for the hospital. Her creatinine was cale, because I think that she came to see if Resident #5 had orders for the second time I specifically computer, so I was going to give sow she would know when to report to keep the the Resident's orders. If they also or below 70. When a resident doctor and make sure that they lity protocol for making sure sometimes the doctor enters the steep give a verbal order. If a N said, There's a possibility they m DON also said that a resident is not being medically managed.  The second time I specifically they m DON also said that a resident as not being medically managed.  The second time I specifically they m DON also said that a resident as not being medically managed.  The second time I specifically they m DON also said that a resident didn't for the wasn't ordered. LVN BB to be is responsible for making sure and right before her shift, LVN BB to to make sure their medication is econciled, and then I gotta put the and and wake them up. LVN BB ctor but she hates being woken up.

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

(continued on next page)

Facility ID: 676319

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			NO. 0936-0391
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 03/07/2023
NAME OF PROVIDER OR SUPPLIER  Corinth Rehabilitation Suites on the Parkway		STREET ADDRESS, CITY, STATE, ZI 3511 Corinth Parkway Corinth, TX 76208	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0580  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	documented high blood sugar for FADON) had no documented trainin personnel files of 2 nurses (Wound checking blood glucose, but the for had skills check off forms for check Review of job descriptions for LVN report a resident's change in condition of the property of a resident's change in condition of the property of a resident's change in condition of the property of a resident's change in condition of the property of a resident not using insulin sliding so diabetic residents using an insulin series of the physician reflected to improve communication care, provide nursing staff with guid of medical staff regarding patient's patients/residents and their responsion change in medical condition (The pacceptable notification timeframes. patient's/resident's condition in the time frame, the Medical Director armedical orders as necessary to tree member/legal representative will be hospital.  An Immediate Jeopardy (IJ) situation of the poor was requested. The POR was The accepted POR reflected the form of the poor of Nursing resigned and not proceed to the poor of Nursing resigned and not proceed to the poor of Nursing will start 3/6/23.  Agency checklist will be reviewed as a poor of the poor of Nursing will start 3/6/23.	16/17) titled Physician and Other Commific physician orders if present; or > 300. (or machine registers high) in diabetic to be notified of blood sugars greater ale and 450 mg/dL (or blood glucose residing scale.  In and Other Communication/Change in the between physicians and nursing staff delines for making decisions regarding fresident's condition, and provide guidates is party regarding changes in conditionly sible party regarding changes in condition of the physician notification grid may be used in Director of Nursing will be notified. The physician does not the resident's/patient's condition regarded of any change in condition regarded on 03/04/23 at 4:15 Per saccepted on 03/04/23 at 4.15 Per saccepted on 03/04/23 at	AN P, LVN E, RN Q, DON, and exporting change in condition. The distance in a skills check off form regarding enurse's personnel file (LVN CC) age in condition to the physician. Ited that each required the nurse to inunication/Change in Condition Dimg/dL in diabetic patient not using a patient using sliding scale insulin. Ithan 300 mg/dL in a diabetic monitoring registers high) in  Condition revised 10/16/17 It opromote optimal patient/resident appropriate and timely notification nee for the notification of ion .3. Notify the physician of the as a reference tool regarding ents and changes in the sont respond within an acceptable he Medical Director will provide Patient's/residents family quired an emergent transfer to the  M. The ADM was notified, and a  of condition or Diabetic have the tor of Nursing in place and Mobile ocess, order entry, change in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
	676319	A. Building B. Wing	03/07/2023
NAME OF PROVIDER OR SUPPLIE	NAME OF PROVIDER OR SUPPLIER		P 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 con	tact 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 0580  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	(Each deficiency must be preceded by full regulatory or LSC identifying information)  A house wide audit of admission or readmission orders on current residents admitted or readn to 3/2/23 will be conducted by Director of Nursing / designee to validate that orders were trans into matrix as ordered from the discharge summary or hospital discharge orders.		at orders were transcribed /entered orders.  sing / designee to validate that ed into matrix and implemented will be reviewed to validate that sulin have been ordered. If no notification of physician for further for blood glucose to validate that etion. This will be completed by the 23 be audited by the Director of of condition and validate that the ty has been notified. This will be etor of Nursing and the consulting consultant regarding the following ered into matrix completely and eric from the discharge summary or effect order entry.  The grand management as part of the validation of accurate and complete the facility a second nurse will on orders have been entered into rn the Mobile Director of Nursing or ately identify, assess and

			10. 0930-0391	
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 03/07/2023	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, Z	IP CODE	
Corinth Renabilitation Suites on the	rinth Rehabilitation Suites on the Parkway  3511 Corinth Parkway  Corinth, TX 76208			
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0580  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	Licensed nurses, including agency nurses and new hires should identify the signs and symptoms of hyper and hypoglycemia and blood sugars out of the range of ordered parameters or above 300 per policy and notify the physician for further direction  Notification of responsible party for acute change in condition and significant order change  When a change of condition is identified the medical record will be reviewed by the clinical management team for any opportunities for training and education.  Mobile Director of Nursing and Interim Director of Nursing and Nursing Managers will be individually trained as train the trainer on Matrix order entry in order to complete training going forward on licensed nurses including prn and agency nurses. This will be completed on 3/3/23 by the Clinical Consultant.  Licensed nurses including agency Nurses and new hires will be re-educated by the Interim Director of Nursing/Designee on the following:  Admission policy including the requirement that orders are to be entered into matrix completely and accurately  Admission and readmission orders are to be transcribed/entered into Matrix from the discharge summary or hospital admission orders that have been verified by the physician  Matrix physician order entry training will be completed on each licensed nurse including agency nurses and new hires for proficiency on physician order entry. No nurse shall admit a resident or receive a new order from a physician without completing this training.  When admitting a resident without nursing management or supervisor in facility a second nurse is to validate that orders on discharge summary/hospital admission orders have been entered into matrix completely and accurately and if any concern the Mobile Director of Nursing or Interim Director of Nursing is to be notified for further direction			
	Residents displaying a change of condition should be assessed to identify the signs and symptoms of hyper and hypoglycemia and notify the physician for further direction  The physician should be notified of blood sugars out of the range of ordered parameters or above 300 per			
Any blood glucose monitoring when nursing management not in facility signed as validated that it is within range or out of ordered parameters on notified.				
	Notification of responsible party fo	r acute change in condition		
	Abuse Neglect and Misappropriati	on training		
	(continued on next page)			

			NO. 0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676319	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2023
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, Z	IP 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 con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informat	ion)
F 0580  Level of Harm - Immediate jeopardy to resident health or safety	This re-education will be initiated on 3/3/23 by the Interim Director of Nursing/designee. Any licensed nurse including Agency Nurses not receiving this education by the end 3/7/23 will receive prior to next scheduled shift. An employee roster will be utilized to track education compliance. Scheduled agency personnel will receive this re-education prior to		
Residents Affected - Some			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND I DAN OF COMMENTAL	676319	A. Building	03/07/2023		
	070010	B. Wing			
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P 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 con	tact 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 0600	Protect each resident from all types and neglect by anybody.	s of abuse such as physical, mental, se	exual abuse, physical punishment,		
Level of Harm - Immediate jeopardy to resident health or safety	**NOTE- TERMS IN BRACKETS H	IAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 34399		
Residents Affected - Some	40316				
Nesidento Affected - Soffie	neglect when the facility failed to pr	and record review, the facility failed to e rovide care and services for treatment of wed for neglect. Resident # 5 did not re	of diabetes for one resident		
	for treatment of diabetes from 01/2	S .	serve oral medications and insulin		
	The facility failed to have a system	in place to ensure:			
	1) Physician orders were in place for medications to control blood sugar for				
	more than one month (1/27/23 2/28/23) for Resident #5 (diagnosed with Diabetes Type 2).				
	2) Treatment was provided for elev	ated blood sugars equal to or greater t	han		
	300 mg/dL on multiple occasions f	or Resident #5.			
	3) Their policy of notifying the phys	ician for elevated blood sugars			
	equal to or greater than 300 mg/dl	for Resident #5.			
	,	tesident #5 showed signs and sympton	ns of		
	hyperglycemia.				
	This failure resulted in Resident #5 having high blood sugars for one month (1/27/23-2/28/23), which were not treated by nursing staff, and not reported to Resident #5's physician. On 2/28/23 at 4:23 PM Resident # showed signs and symptoms of hyperglycemia (profuse sweating, flushed face, and clammy skin). Resider #5 was transferred to the hospital for elevated blood sugar on 2/28/23 at 6:14 PM.				
	This failure could place residents o impairment, pain, mental anguish a	f the facility at risk for neglect and could death.	d lead to serious injury, serious		
	An Immediate Jeopardy (IJ) situation was identified on 03/02/23 at 4:15 PM. The ADM was notified, and a POR was requested. While the IJ was removed on 3/07/23 at 2:52 PM, the facility remained out of compliance at a scope of pattern at the severity level of actual harm because the facility was still monitoring the effectiveness of their Plan of Removal (POR).				
	The findings included:				
	(continued on next page)				

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 03/07/2023	
NAME OF PROVIDER OR SUPPLIE	NAME OF DROVIDED OR SURDUED		P CODE	
	Corinth Rehabilitation Suites on the Parkway		FCODE	
For information on the nursing home's plan to correct this deficiency, please cont		tact 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)		on)	
F 0600  Level of Harm - Immediate jeopardy to resident health or safety	Observation of Resident #5 on 2/28/23 at 9:45 AM revealed that resident was lying in bed. Her husband was sitting in a chair next to her. Resident #5 had difficulty answering questions due to confusion. Resident #5's husband was trying to get the resident to eat breakfast, but Resident #5 refused to eat. Resident #5's husband expressed concern and said that this was not normal for the resident.			
Residents Affected - Some	According to the National Library of Medicine (https://www.ncbi.nlm.nih.gov/books/NBK482142/), Hyperosmolar hyperglycemic syndrome (HHS) is a clinical condition that arises from a complication of diabetes mellitus. This problem is most commonly seen in type 2 diabetes. HHS is a serious and potentially fatal complication of type 2 diabetes. The mortality rate in HHS can be as high as 20%, which is about 10 times higher than the mortality seen in diabetic ketoacidosis.			
	Review of Resident #5's quarterly MDS assessment dated [DATE] reflected she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted to the facility from the hospital on 01/27/23. She had diagnoses of sepsis (blood infection), hypertension (high blood pressure), Diabetes, Multiple Sclerosis (a degenerative neurological disease), and Kidney Failure. It reflected she did not recieve any insulin injections. Review revealed the resident had a BIMS score of 13 which meant the resident was cognitively intact. The resident required extensive assistance to total dependence with all ADLs except eating only needed supervison. Resident #5 was incontinent of bowel and bladder.			
	stable as evidenced by residents [b	/23 revealed the following goal statemolood sugar] staying within the resident no statement as to the normal limits for	's normal limits thru the next review	
	Review of hospital discharge orders dated 1/27/23 indicated that Resident #5 had been discharged with an order for Insulin Lispro high dose sliding scale. A written note at the bottom of the orders read, New orders added by [MD T]: check blood sugar BID. There were no orders for oral medication for diabetes.			
	Review of Resident #5's January and February physician orders dated 03/02/23 revealed there were no orders for the treatment of diabetes (insulin sliding scale or oral medication) from 01/27/23 to 02/28/23. Review of physician order dated 03/01/23 revealed an order for insulin sliding scale that read, [If] Blood Sugar [is] less than 70, call MD. [If] Blood Sugar is 70 to 150, give 0 Units. [If] Blood Sugar is 151 to 200, give 2 Units. [If] Blood Sugar is 201 to 250, give 4 Units. [If] Blood Sugar is 251 to 300, give 6 Units. [If] Blood Sugar is 301 to 350, give 8 Units. [If] Blood Sugar is 351 to 400, give 10 Units. [If] Blood Sugar is greater than 400, call MD.			
	Review of the physician orders for Resident #5 revealed an order dated 2/03/23 that read, Check blood sugar BID. There was no order to notify the physician for high blood sugars.			
	Review of TAR for Resident #5 indicated that on 1/28/23 at 5:00 PM LVN E documented a blood sugar of 324 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 1/28/23 revealed no documentation that the physician was notified of the elevated blood sugar of 324 mg/dL.			
	(continued on next page)			

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 03/07/2023
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 con	Lact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFI (Each deficiency must be preceded by		CIENCIES full regulatory or LSC identifying information)	
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	332 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 335 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind mg/dL. No medication was given for revealed no documentation that the Review of TAR for Resident #5 ind 397 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 309 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 377 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 384 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 384 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 400 mg/dL.	icated that on 2/09/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/10/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/14/23 at 4:00 PM DON or this high blood sugar. Review of the exphysician was notified of the elevated icated that on 2/17/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/18/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/20/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/21/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/21/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/22/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/23/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/23/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/23/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/23/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/23/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/23/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/23/23 at 4:00 PM LVN en for this high blood sugar.	the progress notes dated 2/09/23 blood sugar of 332 mg/dL.  E documented a blood sugar of the progress notes dated 2/10/23 blood sugar of 335 mg/dL.  I documented a blood sugar of 356 progress notes dated 2/14/23 blood sugar of 356 mg/dL.  E documented a blood sugar of the progress notes dated 2/17/23 blood sugar of 397 mg/dL.  E documented a blood sugar of the progress notes dated 2/18/23 blood sugar of 309 mg/dL.  E documented a blood sugar of the progress notes dated 2/18/23 blood sugar of 377 mg/dL.  E documented a blood sugar of the progress notes dated 2/20/23 blood sugar of 377 mg/dL.  N documented a blood sugar of the progress notes dated 2/21/23 blood sugar of 400 mg/dL.  E documented a blood sugar of the progress notes dated 2/22/23 blood sugar of 384 mg/dL.  E documented a blood sugar of the progress notes dated 2/23/23 blood sugar of 384 mg/dL.

			NO. 0930-0391
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 03/07/2023
NAME OF PROVIDER OR SUPPLIER  Corinth Rehabilitation Suites on the Parkway		STREET ADDRESS, CITY, STATE, ZI 3511 Corinth Parkway Corinth, TX 76208	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	Lact 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)		ion)
F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	306 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 375 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind mg/dL. No medication was given for revealed no documentation that the Review of TAR for Resident #5 ind mg/dL. No medication was given for revealed no documentation that the Review of TAR for Resident #5 ind 406 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 305 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 397 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 477 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 477 mg/dL. No medication was giver revealed no documentation that the Review of nursing progress notes facility nurses who documented Review of TAR for Resident #5 ind 537 mg/dL. No medication was giver to the revealed revealed resident #5 ind 537 mg/dL. No medication was giver to the revealed revealed resident #5 ind 537 mg/dL. No medication was giver to the revealed reveal	icated that on 2/24/23 at 7:00 AM LVN en for this high blood sugar. Review of en physician was notified of the elevated dicated that on 2/24/23 at 4:00 PM LVN en for this high blood sugar. Review of en physician was notified of the elevated dicated that on 2/25/23 at 7:00 AM RN of the physician was notified of the elevated dicated that on 2/25/23 at 4:00 PM RN of this high blood sugar. Review of the en physician was notified of the elevated dicated that on 2/25/23 at 4:00 PM LVN en for this high blood sugar. Review of the en physician was notified of the elevated dicated that on 2/26/23 at 4:00 PM LVN en for this high blood sugar. Review of the en physician was notified of the elevated dicated that on 2/27/23 at 7:00 AM LVN en for this high blood sugar. Review of the physician was notified of the elevated dicated that on 2/27/23 at 4:00 PM LVN en for this high blood sugar. Review of the physician was notified of the elevated dicated that on 2/28/23 at 7:00 AM LVN en for this high blood sugar. Review of the physician was notified of the elevated dicated that on 2/28/23 at 7:00 AM LVN en for this high blood sugar. Review of the physician was notified of the elevated dicated that on 2/28/23 at 7:00 AM LVN en for this high blood sugar. Review of the physician was notified of the elevated dicated that on 2/28/23 at 4:00 PM LVN en for this high blood sugar. Review of the physician was notified of the elevated dicated that on 2/28/23 at 4:00 PM LVN en for this high blood sugar. Review of the physician was notified of the elevated dicated that on 2/28/23 at 4:00 PM LVN en for this high blood sugar. Review of the physician was notified of the elevated dicated that on 2/28/23 at 4:00 PM LVN en for this high blood sugar. Review of the physician was notified of the elevated blood sugar. Review of the for this high blood sugar. Review of the for this high blood sugar.	the progress notes dated 2/24/23 delood sugar of 306 mg/dL.  E documented a blood sugar of the progress notes dated 2/24/23 delood sugar of 375 mg/dL.  Q documented a blood sugar of 304 progress notes dated 2/25/23 delood sugar of 304 mg/dL.  Q documented a blood sugar of 421 progress notes dated 2/25/23 delood sugar of 421 mg/dL.  N documented a blood sugar of the progress notes dated 2/26/23 delood sugar of 406 mg/dL.  R documented a blood sugar of the progress notes dated 2/27/23 delood sugar of 305mg/dL.  E documented a blood sugar of the progress notes dated 2/27/23 delood sugar of 305mg/dL.  E documented a blood sugar of the progress notes dated 2/27/23 delood sugar of 397 mg/dL.  P documented a blood sugar of the progress notes dated 2/28/23 delood sugar of 477mg/dL.  3 revealed that none of the seven the delood sugar of progress notes dated 2/28/23

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For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		ion)
F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	sugar check this morning 477 . NP At about 1pm this nurse noted indichecked blood sugar which was 48 that the physician was notified of the was notified that Resident #5 was a Review of nursing progress note for was sent to hospital as requested the about the change in condition and linterview with LVN R on 03/02/23 at she had a really high blood sugar. facility just ordered insulin for Resident resident wasn't on insulin.  In an interview on 03/02/23 at 12:1 Metformin (a diabetes pill) was disc for Metformin and for Novolog Lisp was under the impression that the lin an interview on 03/02/23 at 12:3 Resident #5's high blood sugars, Tadmitted to the hospital. NP AA saik knowledge that Resident #5 had not lin an interview on 03/02/23 at 12:4 found that [on 2/28/23] the blood sustiding scale. I gave [Resident #5] checked it, 397 . When I re-checke scale. I called the doctor because as the blood sugar was high. I didn't selushed, cool and clammy, I stayed hospice nurse was saying to contain an interview on 03/02/23 at 01:0 #5's physician, MD T. I didn't know worry about it. Per nurse, she had how to monitor blood sugar in nurse In an interview on 03/02/23 at 01:0 saying, .depends on who the doctor follow. The ADON was unable to incomplete the sugar process.	or Resident #5 dated 2/28/23 at 6:14 PM by both DON and [NP 5]. Review reveal transfer to the hospital.  at 11:07 AM revealed Resident #5 was LVN R stated the resident was not recedent #5 on the morning of 02/28/23. LV 0 PM with MD T, the doctor said, I remonitioned in the hospital due to kidney ro sliding scale as well as accu-checks orders I gave were put into the chart.  1 PM with NP AA (MD T's nurse practified the first I heard of [the high blood sugarided that MD T usually reviewed the labor or orders in her chart for diabetic medical PM, LVN P said she first discovered ugar was 477, I notified the doctor who 10 units before lunch. She looked flushed it and the machine just said 'high'. The she was trending high. I was shocked to in contact with the doctors. the doctor of the doctor. her blood sugars were fill PM LVN E denied reporting Resident I had to. I asked another nurse what I graduated from nursing school 2 month.	order for Lispro on [sliding scale] . hyperglycemia . shaky . clammy . 28/23 revealed no documentation y documentation that the physician of documentation that the physician of the physician was not notified admitted to the hospital because eving insulin. Interview revealed the NR stated she did not know why the stated she stated she stated she she did not she did not she she did not she

			No. 0936-0391
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 03/07/2023
NAME OF PROVIDER OR SUPPLIER  Corinth Rehabilitation Suites on the Parkway		STREET ADDRESS, CITY, STATE, ZI 3511 Corinth Parkway Corinth, TX 76208	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	stact 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)		<u>-</u>
F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	1/27/23) said he did not frequently there in three weeks. LVN O said hadmission and I said I would try. I hadn't done an admission for a whi yet and I needed help finishing the is what needs to be done by the Al came in at about 8pm. I stayed late report assuming that the DON and to make sure everything is up to da In an interview on 03/02/23 at 01:2 for ensuring orders on newly admit DON are supposed to review the deverything is correct. The DON sair resident's physician but was unsurnotes. The DON said that the staff was.  In an interview on 03/02/23 at 02:1 Receiving nurse sees orders, clarif Interdisciplinary Team meeting and responsible for making sure new or recognizing that there has been a conormal, the nursing staff should repaddressed. The administrator said In an interview on 03/04/23 at 02:1 week. The nurse who was suppose supposed to be still on orientation happened on 2/25/23, when she do In an interview on 03/04/23 at 02:4 resident's high blood sugar: I wasn know that [a blood sugar of] 500 is signs and symptoms. LVN N denie sugar level of 406 for Resident #5. sliding scale in place for Resident #5. sliding scale in place for Resident #5. sliding scale in place for Resident #5.	1 PM LVN O (the nurse who admitted work at the facility. I go once a month, or eremembered admitting Resident #5, tried to enter the order, but I was having ite. I passed on in report to [LVN BB] the orders. I told [LVN BB] this is what I report and DON and DON and can you please passe to finish the admission to do as much ADON would finish the admission. The late and correct.  2 PM the DON said, The nurses, the Dotted residents are entered into the eMA ischarge orders. Every morning, we red that a blood sugar level of 200 would be why she did not contact the physician had been trained on neglect but was undersome and that nurses should be a contact with physician, and they go it during care planning. The ADM said the redersome of condition. When there is some or port it to the physician. I recognize the he was not sure when the staff had last 4 PM with RN Q, the nurse said she had to be training her (LVN N) just left me training, and I don't know these people occumented a blood sugar of 305 mg/dL for PM LVN N said she wasn't sure when the dangerous. I know that 400 is of some of contacting the physician on 2/26/23 of I monitored for signs and symptoms. L'#5, There was only an order for blood sidiabetes medication on Resident #5's or diabetes medication I would think the	once every 2 weeks. I haven't been The DON asked me if I could do an g trouble with the eMAR because I hat I wasn't done with the admission eviewed, and this is what I did. This is it on in the morning.' The patient as I could do. I passed it on in ey are supposed to review the chart of the contact the co

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676319	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2023
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P 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 con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	X TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	facility] to inform me if anyone has who had a blood sugar over 400, a Resident #5's high blood sugars an 3/02/23]. MD T said that she saw R Metformin around February 4th, whormal, so I wrote the order for Meback from the hospital on sliding so diabetes medication. MD T said he Metformin then as well because I sorders for Metformin but couldn't retalked to the nurse and told her I dianother order.  In an interview on 3/04/23 at 03:18 high blood sugar to the resident's p don't have an order, I would call the gets admitted from the hospital, I lowant to continue the orders. The In physician orders are entered into the orders in the computer. Sometimes diabetic resident doesn't receive arketoacidosis, which is a life-threate pressure ulcers (bed sores) if the rewas able to explain what neglect whave a sliding scale, I'd have to cal stated that when the resident is addorders get entered into the compute said, If it's my resident I make sure on the way before I leave. First, I gorders in. If the admission happens said that she had experienced diffice She will snap at you but if you gottamedication, Well, eventually they we Review of job descriptions for LVN, report neglect to the appropriate au Review of facility policy (dated 10/1 read in part, Glucose. Follow spec	, RN, DON, and ADON positions revea	and the dot be notified of any resident of T said she first became aware of the the surveyor called me [on 3 or 4,, 2023, I gave an order for the hospital. Her creatinine was cale, because I think that she came to see if Resident #5 had orders for the hospital. Her creatinine was cale, because I think that she came to see if Resident #5 had orders for the hospital that the gave verbal of the second time I specifically computer, so I was going to give thow she would know when to report to the at the Resident's orders. If they said the Resident's orders. If they said the Resident's orders. If they said that a resident doctor and make sure that they litty protocol for making sure. Sometimes the doctor enters the set they give a verbal order. If a cossibility they could go into diabetic said that a resident could developed cally managed. The Interim DON aff had last been trained on neglect. The wasn't ordered. LVN BB se is responsible for making sure and right before her shift, LVN BB at to make sure their medication is acconciled, and then I gotta put the anj and wake them up. LVN BB cor but she hates being woken up. stabetes didn't get diabetes.

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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 03/07/2023
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 con	tact 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)		on)
F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	ne's plan to correct this deficiency, please contact the nursing home or the state survey agency.  SUMMARY STATEMENT OF DEFICIENCIES		DON reflected staff were LVN P, LVN S, ADON, Wound Care nunication/Change in Condition Omg/dL in diabetic patient not using a patient using sliding scale insulin . Ithan 300 mg/dL in a diabetic monitoring registers high) in  M. The ADM was notified, and a sulfing thoroughly investigated, and a sulfing thoroughly investigated. It is sulfing the investigation will be completed of condition or Diabetic have the tor of Nursing in place and Mobile ocess, order entry, change in en out of parameters or above 300.

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 03/07/2023		
NAME OF PROVIDER OR SUPPLI	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 con	tact 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 0600  Level of Harm - Immediate jeopardy to resident health or safety	Residents with diagnosis of diabetes will be audited by the Director of Nursing / designee to validate that orders for sliding scale, diabetic medications have been transcribed/entered into matrix and implemented accurately per physician orders. Any resident with a diagnosis of diabetes will be reviewed to validate that appropriate monitoring of blood sugars and oral diabetic medications or insulin have been ordered. If no orders noted, the physician will be notified for further direction.				
Residents Affected - Some	Any concern identified will be addre direction. This will be completed by	essed at the time of discovery including v 3/7/23.	notification of physician for further		
	A house wide audit will be completed of sliding scale results and lab tests for blood glucose to validate that any result out of range has been reported to the physician for further direction. This will be completed by the Interim Director of Nursing or Mobile Director of Nursing/ designee by 3/7/23				
	The facility activity report and the 24-hour report for the past 72 hours will be audited by the Director of Nursing/ designee to identify any documentation that indicates a change of condition and validate that the physician has been contacted for further direction and the responsible party has been notified. This will be completed by 3/7/23				
	The administrator and members of nursing management, the Mobile Director of Nursing and the consulting Director of Nursing will be re-educated as a train the trainer by the clinical consultant regarding the followin expectations: This will be completed on 3/3/23				
	The admission policy including the accurately	e requirement that orders are to be ente	ered into matrix completely and		
	Abuse and Neglect				
	Admission and readmission orders hospital admission orders and verification	s are to be transcribed/entered into Ma ried by the physician	trix from the discharge summary or		
	Matrix physician order entry trainir	ng will be done for accurate and comple	ete order entry.		
		s are to be validated by members of nu arge nurse on the weekends including	0 0 1		
	ent without nursing management or supervisor in the facility a second nurse will lischarge summary/hospital admission / readmission orders have been entered into ccurately and verified by a physician. If any concern the Mobile Director of Nursing or ng is to be notified for further direction.				
		nurses and new hires should appropronand notify the physician for further di	•		
Licensed nurses, including agency nurses and new hires should identify the signs and syr and hypoglycemia and blood sugars out of the range of ordered parameters or above 300 notify the physician for further direction  (continued on next page)					

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 03/07/2023	
NAME OF PROVIDER OR SUPPLIE	NAME OF PROVIDER OR SUPPLIER		P CODE	
	Corinth Rehabilitation Suites on the Parkway		. 6652	
Commit Nonabilitation Guites on the Fairway		Corinth, TX 76208		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey a	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)	
F 0600	Notification of responsible party for	r acute change in condition and signific	ant order change	
Level of Harm - Immediate jeopardy to resident health or safety	When a change of condition is identified the medical record will be reviewed by the clinical management team for any opportunities for training and education.			
Residents Affected - Some	Mobile Director of Nursing and Interim Director of Nursing and Nursing Managers will be individually trained as train the trainer on Matrix order entry in order to complete training going forward on licensed nurses including prn and agency nurses. This will be completed on 3/3/23 by the Clinical Consultant.			
	Licensed nurses including agency Nursing/Designee on the following:	Nurses and new hires will be re-educat	ed by the Interim Director of	
	Admission policy including the requirement that orders are to be entered into matrix completely and accurately.			
	Admission and readmission orders are to be transcribed/entered into Matrix from the discharge summary or hospital admission orders that have been verified by the physician			
	Matrix physician order entry training will be completed on each licensed nurse including agency nurses ar new hires for proficiency on physician order entry. No nurse shall admit a resident or receive a new order from a physician without completing this training.			
	When admitting a resident without nursing management or supervisor in facility a second nurse is to validate that orders on discharge summary/hospital admission orders have been entered into matrix completely and accurately and if any concern the Mobile Director of Nursing or Interim Director of Nursing is to be notified further direction.			
		nge of condition should be assessed to dition and notify the physician for furthe		
	Residents displaying a change of and hypoglycemia and notify the pl	condition should be assessed to identify hysician for further direction	y the signs and symptoms of hyper	
	The physician should be notified o policy.	f blood sugars out of the range of order	red parameters or above 300 per	
	Any blood glucose monitoring when nursing management not in facility will be reviewed by 2nd nurse signed as validated that it is within range or out of ordered parameters or above 300 and that physiciar notified.			
	Notification of responsible party for	r acute change in condition		
	Abuse Neglect and Misappropriation	on training.		
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			No. 0938-0391
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 03/07/2023
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Corinth Rehabilitation Suites on the Parkway		3511 Corinth Parkway Corinth, TX 76208	
For information on the nursing home's p	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
Evel of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	including Agency Nurses not receive shift. An employee roster will be util receive this re-education prior to we Licensed Nurses including agency tracked by the Mobile Director of Noscheduled to work has had the trained completed by the Mobile Director of The next 6 shift changes a member	in 3/3/23 by the Interim Director of Nursing this education by the end 3/7/23 which is education compliance. So orking scheduled shift. This will also be Nurses will not work until training compursing or Interim Director of Nursing to hing and education and if not, training a f Nursing or Interim Director of Nursing or of nursing management (Nurse Assessing, Mobile Director of Nursing, Assisting, Mobile Director of Nursing, Assisting).	ill receive prior to next scheduled cheduled agency personnel will presented in new hire orientation. Deted. Agency nurse training will be validate that the agency nurse and education will be arranged or .  ssment Coordinator, RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676319	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2023
NAME OF PROVIDER OR SUPPLIE	NAME OF PROVIDED OR CURRULED		P CODE
Corinth Rehabilitation Suites on the Parkway		STREET ADDRESS, CITY, STATE, ZI 3511 Corinth Parkway	PCODE
Connun Renabilitation Suites on the	e raikway	Corinth, TX 76208	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC)			on)
F 0635	Provide doctor's orders for the resid	dent's immediate care at the time the re	esident was admitted.
Level of Harm - Immediate jeopardy to resident health or	**NOTE- TERMS IN BRACKETS H	IAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 34399
safety	40316		
Residents Affected - Some	Based on observation, interview and record review, the facility failed to ensure residents had admission physician orders for their immediate care for two residents (Resident #5 and Resident #173) of 24 residents reviewed for admitting physician orders.		
	The facility failed to reconcile hose Resident #5's readmission to the facility.	spital discharge orders for diabetes me cility from the hospital on 1/27/23.	dication (insulin sliding scale) upon
	2. The facility failed to have any physician orders for medications to control blood sugar for more than one month (1/27/23-2/28/23) for Resident #5 (diagnosed with Diabetes Type 2).		
		an orders for treatment of high blood so een 1/28/23-2/28/23 for Resident #5.	ugar levels (greater than 300
	4. The facility failed to physician or	ders when Resident #5 showed signs a	and symptoms of hyperglycemia.
	This failure resulted in Resident #5 having no orders for diabetes medication, and no orders for the physical notification in the case of very high blood sugar for one month (1/27/23-2/28/23). This failure resulted in Resident #5 having frequent high blood sugars, which were not treated by staff and not reported to Resident #5's physician. On 2/28/23 at 4:23 PM Resident #5 showed signs and symptoms of hyperglycemia (profus weating, flushed face, and clammy skin). Resident #5 was transferred to the hospital for elevated blood sugar on 2/28/23 at 6:14 PM.  An Immediate Jeopardy (IJ) situation was identified on 03/02/23 at 4:15 PM. While the IJ was removed of 3/07/23 at 2:52 PM, the facility remained out of compliance at a scope of pattern at the severity level of actual harm that is not immediate jeopardy because the facility was still monitoring the effectiveness of the Plan of Removal (POR).		
	5. The facility failed to ensure Residulcer when she was admitted on [D	dent #173 had admitting physician orde ATE] from the hospital.	ers for wound care for her pressure
		ents of the facility at risk for life-threate an of a resident change in condition.	ning medical conditions due to the
	The findings included:		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676319	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2023	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P 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 con	tact 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)		on)	
F 0635  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	1. Review of Resident #5's quarterly MDS assessment dated [DATE] reflected she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted to the facility from the hospital on 01/27/23. She had diagnoses of sepsis (blood infection), hypertension (high blood pressure), Diabetes, Multiple Sclerosis (a degenerative neurological disease), and Kidney Failure. It reflected she did not receive any insulin injections. Review revealed the resident had a BIMS score of 13 which meant the resident was cognitively intact. The resident required extensive assistance to total dependence with all ADLs except eating only needed supervision. Resident #5 was incontinent of bowel and bladder.			
	Review of the care plan dated 2/20/23 revealed that there was a care plan for diabetes with the goal statement, Diabetic status will remain stable as evidenced by residents [blood sugar] staying within the residents normal limits thru the next review date. Review of care plan revealed no statement as to the limits for Resident #5.			
	order for Insulin Lisper high dose s	s dated 1/27/23 indicated that Resident liding scale. A written note at the bottor ar BID. There were no orders for oral m	n of the orders read, New orders	
	Review of the January and February physician orders dated 03/02/23 revealed there were no ordereatment of diabetes (insulin sliding scale or oral medication) from 01/27/23 to 02/28/23. Review physician order dated 03/01/23 revealed an order for insulin sliding scale that read, Blood Sugar 70, call MD. Blood Sugar is 70 to 150, give 0 Units. Blood Sugar is 151 to 200, give 2 Units. Blood 201 to 250, give 4 Units. Blood Sugar is 251 to 300, give 6 Units. Blood Sugar is 301 to 350, give Blood Sugar is 351 to 400, give 10 Units. Blood Sugar is greater than 400, call MD.			
	Review of the physician orders rev was no order to notify the physician	ealed an order dated 2/03/23 that read, n for high blood sugars.	Check blood sugar BID. There	
	Review of TAR for Resident #5 ind 324 mg/dL. (Normal range is 70-11	icated that on 1/28/23 at 5:00 PM LVN 0 mg/dL)	E documented a blood sugar of	
	Review of TAR for Resident #5 ind 332 mg/dL. (Normal range is 70-11	icated that on 2/09/23 at 4:00 PM LVN 0 mg/dL).	E documented a blood sugar of	
	Review of TAR for Resident #5 indicated that on 2/10/23 at 4:00 PM LVN E documented a blood sugar of 335 mg/dL. (Normal range is 70-110 mg/dL).			
	Review of TAR for Resident #5 indicated that on 2/14/23 at 4:00 PM DON documented a blood sugar of 356 mg/dL. (Normal range is 70-110 mg/dL).			
	Review of TAR for Resident #5 ind mg/dL. (Normal range is 70-110 mg	icated that on 2/17/23 at 4:00 PM docug/dL).	mented a blood sugar of 397	
	Review of TAR for Resident #5 ind 309 mg/dL. (Normal range is 70-11	icated that on 2/18/23 at 4:00 PM LVN 0 mg/dL).	E documented a blood sugar of	
	(continued on next page)			

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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 03/07/2023
NAME OF PROVIDER OR SUPPLIE	-R	STREET ADDRESS, CITY, STATE, ZI	P CODE
Corinth Rehabilitation Suites on the		3511 Corinth Parkway Corinth, TX 76208	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0635	Review of TAR for Resident #5 ind 377 mg/dL. (Normal range is 70-11	icated that on 2/20/23 at 4:00 PM LVN 0 mg/dL).	E documented a blood sugar of
Level of Harm - Immediate jeopardy to resident health or safety	Review of TAR for Resident #5 ind 400 mg/dL. (Normal range is 70-11	icated that on 2/21/23 at 4:00 PM ADO 0 mg/dL).	N documented a blood sugar of
Residents Affected - Some	Review of TAR for Resident #5 ind 384 mg/dL. (Normal range is 70-11	icated that on 2/22/23 at 4:00 PM LVN 0 mg/dL).	E documented a blood sugar of
	Review of TAR for Resident #5 ind 400 mg/dL. (Normal range is 70-11	icated that on 2/23/23 at 4:00 PM LVN 0 mg/dL).	E documented a blood sugar of
	Review of TAR for Resident #5 ind 306 mg/dL. (Normal range is 70-11	icated that on 2/24/23 at 7:00 AM LVN 0 mg/dL).	R documented a blood sugar of
	Review of TAR for Resident #5 ind 375 mg/dL. (Normal range is 70-11	icated that on 2/24/23 at 4:00 PM LVN 0 mg/dL).	E documented a blood sugar of
	Review of TAR for Resident #5 ind mg/dL. (Normal range is 70-110 mg	icated that on 2/25/23 at 7:00 AM RN 0g/dL).	Q documented a blood sugar of 304
	Review of TAR for Resident #5 ind mg/dL. (Normal range is 70-110 mg	icated that on 2/25/23 at 4:00 PM RN 0g/dL).	documented a blood sugar of 421
	Review of TAR for Resident #5 ind 406 mg/dL. (Normal range is 70-11	icated that on 2/26/23 at 4:00 PM LVN 0 mg/dL).	N documented a blood sugar of
	Review of TAR for Resident #5 ind 305 mg/dL. (Normal range is 70-11	icated that on 2/27/23 at 7:00 AM LVN 0 mg/dL).	R documented a blood sugar of
	Review of TAR for Resident #5 ind 397 mg/dL. (Normal range is 70-11	icated that on 2/27/23 at 4:00 PM LVN 0 mg/dL).	E documented a blood sugar of
	Review of TAR for Resident #5 ind 477 mg/dL. (Normal range is 70-11	icated that on 2/28/23 at 7:00 AM LVN 0 mg/dL).	P documented a blood sugar of
	Review of TAR for Resident #5 ind 537 mg/dL. (Normal range is 70-11	icated that on 2/28/23 at 4:00 PM LVN 0 mg/dL).	E documented a blood sugar of
		or the period of 1/27/23 through 2/27/2 esident #5's high blood sugar, reported	
	sugar check this morning 477 . [NF At about 1pm this nurse noted indiv	r Resident #5 dated 2/28/23 at 4:23 PN PAA] informed of blood sugar with new vidual having [signs and symptoms] of I 11 . Review revealed the physician was	order for Lispro on [sliding scale] . hyperglycemia . shaky . clammy .
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NAME OF PROVIDER OR SUPPLIE	I ER	STREET ADDRESS, CITY, STATE, ZI	P CODE
Corinth Rehabilitation Suites on the	e Parkway	3511 Corinth Parkway Corinth, TX 76208	
For information on the nursing home's	plan to correct this deficiency, please con	l tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0635  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	was sent to hospital as requested to about the change in condition.  Interview with LVN R on 03/02/23 as she had a really high blood sugar. I facility just ordered insulin for Resident was not on insulin. LVI sure if she had been trained by add In an interview on 03/02/23 at 01:1 1/27/23) said he did not frequently there in three weeks. LVN O said he admission and I said I would try. I hadn't done an admission for a while yet and I needed help finishing the is what needs to be done by the AE came in at about 8pm. I stayed late report assuming that the DON and to make sure everything is up to do on physician order entry.  In an interview on 03/02/23 at 12:1 Metformin (a diabetes pill) was disc for Metformin and for Novolog Lisp was under the impression that the In an interview on 03/02/23 at 12:3 Resident #5's high blood sugars, T admitted to the hospital. NP AA sait that Resident #5 had no orders in he In an interview on 03/02/23 at 12:4 found that [on 2/28/23] the blood sugars sliding scale. I gave [Resident #5] checked it, 397. When I re-checke scale. I called the doctor because sthe blood sugar was high. I didn't sflushed, cool and clammy, I stayed hospice nurse was saying to contain	r Resident #5 dated 2/28/23 at 6:14 PM by both DON and [NP 5]. Review reveal at 11:07 AM revealed Resident #5 was LVN R stated the resident was not receivent #5 on the morning of 02/28/23. LVN R was unsure of the facility policy for ministration on physician order entry.  1 PM LVN O (the nurse who admitted R work at the facility. I go once a month, or the remembered admitting Resident #5, tried to enter the order, but I was having le. I passed on in report to [LVN BB] the orders. I told [LVN BB] 'this is what I responsible to a more than a more than a more to finish the admission to do as much a more than a mor	admitted to the hospital because eiving insulin. Interview revealed the N R stated she did not know why admission orders and was not  Resident #5 from the hospital on once every 2 weeks. I haven't been The DON asked me if I could do an g trouble with the eMAR because I at I wasn't done with the admission viewed, and this is what I did. This is it on in the morning.' The patient as I could do. I passed it on in ey are supposed to review the chart eceived training from administration  ember that [Resident #5's] failure. I know that I gave the order AC and HS on February 3, 2023. I incore), NP AA denied knowledge of s] was the day [Resident #5] was atory results and denied knowledge /27/23 to 2/28/23.  Resident #5's high blood sugar: I ordered 10 units of insulin per ed so I checked her sugar again. I one, she didn't have a sliding nat nobody else intervened when the physician. When she looked was saying she's hospice and the

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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 03/07/2023
NAME OF PROVIDER OR SUPPLII Corinth Rehabilitation Suites on the		STREET ADDRESS, CITY, STATE, ZI 3511 Corinth Parkway Corinth, TX 76208	P CODE
For information on the nursing home's	plan to correct this deficiency please con	tact the nursing home or the state survey	agency
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC		
F 0635  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	In an interview on 03/02/23 at 01:0 Resident #5's physician, MD 2. I di she told me not to worry about it. P asked if she learned how to monitor received training from administration In an interview on 03/02/23 at 01:0 T, saying, .depends on who the do follow. The ADON said she was not entry. The ADON was unable to sta question, What would you consider In an interview on 03/02/23 at 01:2 for ensuring orders on newly admit DON are supposed to review the d everything is correct. The DON sair resident's physician but was unsur notes. The DON said she was not entry.  In an interview on 03/02/23 at 02:1 orders with physician, and they go during care planning. The ADM sai entered, and that nurses should co condition. When there is somethin physician. I recognize there are th received training from administration In an interview on 03/04/23 at 02:1 week. The nurse who was suppose supposed to be still on orientation th happened on 2/25/23, when she do training from administration on phy In an interview on 03/04/23 at 02:4 resident's high blood sugar: I wasn know that [a blood sugar: I wasn know that [a blood sugar of] 500 is signs and symptoms. LVN N denie sugar level of 406 for Resident #5. sliding scale in place for Resident #5.	1 PM, LVN E denied reporting Resider dn't know I had to. I asked another nurser blood sugar in nursing school, nurse on on physician order entry.  5 PM, the ADON denied reporting Resident is, what the parameters are. Each of sure if staff had received training from the what MD T's parameters were. The had highly a hold a highly a hold sugar level?  2 PM the DON said, The nurses, the Dated residents are entered into the eMA ischarge orders. Every morning, we red that a blood sugar level of 200 would be why she did not contact the physician sure if staff had received training from a sure if staff had received training from a sure if staff had received training from a that the DON or ADON is responsible intact the physician upon recognizing the gath that the tool on the physician upon recognizing the gath at continues to be not normal, the resident is that need to be addressed. ADM so no on physician order entry.  4 PM with RN Q, the nurse said she had to be training her (LVN N) just left materianing, and I don't know these people occumented a blood sugar of 305 mg/dL	at #5's high blood sugars to see [LVN R] what I should do and sing school 2 months ago. When said yes. LVN E said she had not doctor has parameters that they madministration on physician order ADON chose not to answer the ADON and the ADON are responsible R. The nurses, and ADON and the view the charts to make sure prompt her to contact the n, saying, I would have to check my administration on physician order deceiving nurse sees orders, clarifies disciplinary Team meeting and the for making sure new orders are not there has been a change of nursing staff should report it to the said he was not sure if staff had and been working at the facility for 1 to alone without any guidance. I'm and the RN Q was unable to recall what are RN Q said she had not received then to notify the physician of a se's a policy. LVN N went on to say, I se concern, but we would monitor for when she documented a blood VN N confirmed that there was no sugar checks BID. LVN N also said chart. LVN N said that if a diabetic that it would be life-threatening. LVN

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676319	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2023
ER .	STREET ADDRESS, CITY, STATE, ZI	P CODE
е Рагкway	Corinth, TX 76208	
plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
		on)
facility] to inform me if anyone has who had a blood sugar over 400, a Resident #5's high blood sugars an 3/02/23]. MD T said that she saw R Metformin around February 4th, whormal, so I wrote the order for Metback from the hospital on sliding so diabetes medication. MD T said he Metformin then as well because I s orders for Metformin but couldn't retalked to the nurse and told her I dianother order.  In an interview on 3/04/23 at 03:18 report high blood sugar to the resident gets admitted from the hosthey want to continue the orders. T physician orders are entered into the orders in the computer. Sometimes diabetic resident does not receive a diabetic ketoacidosis, which is a life develop pressure ulcers (bed sores DON said she was not sure if staff.  In an interview on 3/06/23 at 4:51 F to call the resident's physician: It's have a sliding scale, I'd have to cal stated that when a resident is admi orders get entered into the compute said, If it's my resident I make sure on the way before I leave. First, I gorders in. If the admission happenes aid that she had experienced diffice She will snap at you but if you gottamedication, Well, eventually they we physician order entry.  Review of personnel files for nurse documented high blood sugar for RADON) had no documented training	a high blood sugar. MD T said she war coording to the sliding scale orders. MI ad subsequent hospital admission, Whe desident #5 on approximately February nen I saw her after she got back from the formin. I thought she was on sliding scale. MD T denied checking the chart to revert visit to Resident #5 was on February the twasn't entered in Resident #5's commember which nurse she gave them to don't see the order for Metformin in the order to the province of t	anted to be notified of any resident of T said she first became aware of en the surveyor called me [on 3 or 4,, 2023, I gave an order for the hospital. Her creatinine was cale, because I think that she came to see if Resident #5 had orders for uary 10 or 11, I gave orders for that. MD T said she gave verbal to The second time I specifically computer, so I was going to give seed how she would know when to the second time I specifically computer, so I was going to give seed how she would know when to the second time I specifically computer, so I was going to give seed how she would know when to the second time I specifically computer, so I was going to give seed how she would know when to the second time I specifically computer, so I was going to give seed how she would know when to the second time I gotter. If a possibility protocol for making sure set they give a verbal order. If a possibility they could go into DN also said that a resident could being medically managed. Interimental to the second time I gotten to the second time I gotten to the second time I gotten to the second time I gotta put the cian I and wake them up. LVN BB to the to make sure their medication is second and then I gotta put the cian I and wake them up. LVN BB to but she hates being woken up. Tabletes did not get diabetes ived training from administration on that most of the nurses who had the I gotta put the size of the nurses who had the I gotta put the size of the nurses who had the I gotta put the size of the nurses who had the I gotta put the size of the nurses who had the I gotta put the size of the nurses who had the I gotta put the size of the nurses who had the I gotta put the size of the nurses who had the I gotta put the size of the nurses who had the I gotta put the size of the nurses who had the I gotta put the size of the nurses who had the I gotta put the size of the nurses who had the I gotta put the size of the nurses who had the I gotta put the size of the nurses who had the I gotta put the size of the nurses who had th
	IDENTIFICATION NUMBER: 676319  R Parkway  Clan to correct this deficiency, please con  SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by  In an interview on 03/04/23 at 3:00 facility] to inform me if anyone has who had a blood sugar over 400, a Resident #5's high blood sugars ar 3/02/23]. MD T said that she saw R Metformin around February 4th, wh normal, so I wrote the order for Me back from the hospital on sliding so diabetes medication. MD T said he Metformin then as well because I s orders for Metformin but couldn't re talked to the nurse and told her I di another order.  In an interview on 3/04/23 at 03:18 report high blood sugar to the resid they don't have an order, I would concerned to the computer. Sometimes diabetic resident does not receive a diabetic ketoacidosis, which is a life develop pressure ulcers (bed sores DON said she was not sure if staff In an interview on 3/06/23 at 4:51 F to call the resident's physician: It's have a sliding scale, I'd have to cal stated that when a resident is admi orders get entered into the compute said, If it's my resident I make sure on the way before I leave. First, I g orders in. If the admission happene said that she had experienced diffic She will snap at you but if you gotte medication, Well, eventually they w physician order entry.  Review of personnel files for nurse documented high blood sugar for R ADON) had no documented trainin Review of job descriptions for LVN enter physician orders.	R Parkway  STREET ADDRESS, CITY, STATE, ZI 3511 Corinth Parkway Corinth, TX 76208  SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying informati In an interview on 03/04/23 at 3:00 PM, MD T said that if a resident had h facility] to inform me if anyone has a high blood sugar. MD T said she war who had a blood sugar over 400, according to the sliding scale orders. MI Resident #5's high blood sugars and subsequent hospital admission, Wh 3/02/23). MD T said that she saw Resident #5 on approximately February Metformin around February 4th, when I saw her after she got back from th normal, so I wrote the order for Metformin. I thought she was on sliding s back from the hospital on sliding scale. MD T denied checking the chart to diabetes medication. MD T said her next visit to Resident #5's was on Febr Metformin then as well because I saw it wasn't entered in Resident #5's c orders for Metformin but couldn't remember which nurse she gave them to talked to the nurse and told her I didn't see the order for Metformin in the nanother order.  In an interview on 3/04/23 at 03:18 PM with the Interim DON, she explain- report high blood sugar to the resident's physician: I look at the paramete they don't have an order, I would call the physician if the blood sugar was resident gets admitted from the hospital, I look at the hospital orders and they want to continue the orders. The Interim DON was unable to describ physician orders are entered into the e-chart, Well that's in development. orders in the computer. Sometimes they give us written orders. Sometime diabetic ketoacidosis, which is a life-threatening condition. The Interim DO develop pressure ulcers (bed sores) if the resident's blood sugar was not DON said she was not sure if staff had received training from administrati In an interview on 3/06/23 at 4:51 PM, LVN BB explained what resident b to call the resident's physician: It's between 400 and 450, whichever the s have a sliding scale, I'd have to call the physic

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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 03/07/2023
NAME OF PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZI	P CODE
Corinth Rehabilitation Suites on the	е Рагкway	3511 Corinth Parkway Corinth, TX 76208	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0635  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	Review of facility In-service Admissica pt [patient] is here and send med additional labs they want ordered, that day, meds will not arrive at mic too pleased about missed meds eit prior physician orders have to be do that needed to be confirmed with the electronic record and included instructional record in the record and included instructional record in the record in the record and included instructional record in the record in part, Glucose . Follow special record in part record in part record in par	sion Compliance dated 12/09/22 reflect in a total of seven nurses that received ons Instructions about a new resident to list to the physician. Physician may has so be ready to make notes. 2. Input the dright, and will be delayed until the next ther Under medication orders it reflected iscontinued and would have medication at attending physician. It reflected all muctions on how to input orders into the retrainer dated 12/12/22 by Regional Macaded shift including agency. 3. Instructional and would have medicated the trainer dated 12/12/22 by Regional Macaded shift including agency. 3. Instructional and would have admits within 24 hours Macaded shift including agency. 3. Instructional and the work of the state o	ed LVN I, LVN P, LVN S, Wound this facility in-service. The o Alert the DON and physician that we changes to the med orders, or a med orders - if not done by 8 pm at day. [patients] generally aren't diabout readmitted patients that in list in admittance/hospital pack pedications must be entered into electronic record.  Nurse reflected 2. All nurses must atted on Audit tools and Admission onday through Friday. Weekend will address concerns and provide clinical meeting from M - F. assigned by DON. It reflected 3/22.  Please follow the attached pelicy All medication should be put in mission process including the state orders verified and validated by included ADON, Wound Care  The qualified licensed nurse will mission: 1. The qualified licensed or other entity. 2. A call is placed to preder the resident's functional abilities repriate care plan. Under the resident's functional abilities repriate care plan. Under the physician.  The qualified in Gondition of the potential of the potential of the proposed in condition of the physician.
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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 03/07/2023
NAME OF PROVIDER OR SUPPLIE  Corinth Rehabilitation Suites on the		STREET ADDRESS, CITY, STATE, ZI 3511 Corinth Parkway Corinth, TX 76208	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0635  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	The accepted POR for admission procession and the feet of the series of	chysician orders reflected the following: facility.  Idmitted to the facility or have a change ged deficient practice.  Indice accepted on 3/3/23. Interim Direct and revised to include the admission program and notification of physician who consultants by 3/7/23  In readmission orders on current resider ctor of Nursing / designee to validate the charge summary or hospital discharge as will be audited by the Director of Nursing years and oral diabetic medications or innotified for further direction.  In research at the time of discovery including ya/7/23.  In readmission orders on current resider ctor of Nursing years and oral diabetic medications or innotified for further direction.  In the provided Health of the provided Health of the physician for further direction and the physician for further direction and the responsible parameter of the past 72 hours will ocumentation that indicates a change of the physician for further direction and the responsible parameter direction and the responsible parameter direction and the responsible parameter direction and the trainer by the clinical and on 3/3/23  In requirement that orders are to be entered as a train the trainer by the clinical and on 3/3/23  In requirement that orders are to be entered as a train the trainer by the clinical and on 3/3/23	of condition or Diabetic have the tor of Nursing in place and Mobile ocess, order entry, change in en out of parameters or above 300.  Into admitted or readmitted [DATE] and orders were transcribed /entered orders.  It is admitted or readmitted into matrix and implemented et will be reviewed to validate that it is utilin have been ordered. If no is into motification of physician for further for blood glucose to validate that ettion. This will be completed by the into motification and validate that the etty has been notified. This will be consulting consultant regarding the following ered into matrix completely and

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NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE
Corinth Rehabilitation Suites on the	e Parkway	3511 Corinth Parkway Corinth, TX 76208	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0635	Matrix physician order entry training	ng will be done for accurate and comple	ete order entry.
Level of Harm - Immediate jeopardy to resident health or safety		s are to be validated by members of nu arge nurse on the weekends including	
Residents Affected - Some	validate that orders on discharge s	nursing management or supervisor in ummary/hospital admission / readmissind verified by a physician. If any concenotified for further direction.	on orders have been entered into
	, ,	r nurses and new hires should appropring and notify the physician for further di	
		r nurses and new hires should identify to so out of the range of ordered paramete stion	
	Notification of responsible party fo	r acute change in condition and signific	cant order change
	When a change of condition is idea team for any opportunities for training	ntified the medical record will be review ng and education.	ved by the clinical management
	as train the trainer on Matrix order	rim Director of Nursing and Nursing Ma entry in order to complete training goin his will be completed on 3/3/23 by the	g forward on licensed nurses
	Licensed nurses including agency Nursing/Designee on the following:	Nurses and new hires will be re-educat	ted by the Interim Director of
	Admission policy including the req accurately	uirement that orders are to be entered	into matrix completely and
	Admission and readmission orders hospital admission orders that have	s are to be transcribed/entered into Mate	trix from the discharge summary or
		ng will be completed on each licensed r ian order entry. No nurse shall admit a g this training.	
	that orders on discharge summary/	nursing management or supervisor in hospital admission orders have been e hobile Director of Nursing or Interim Dir	entered into matrix completely and
		nge of condition should be assessed to dition and notify the physician for furthe	
	(continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676319	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2023
NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, Z	IP CODE
Corinth Rehabilitation Suites on the	e Parkway	3511 Corinth Parkway Corinth, TX 76208	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informat	ion)
F 0635  Level of Harm - Immediate jeopardy to resident health or	and hypoglycemia and notify the pl	condition should be assessed to identing a specific probability of the restriction for further direction or the range of order	
safety	policy	r blood ouguro out of the fullge of orde	rea parameters of above our per
Residents Affected - Some		n nursing management not in facility wrange or out of ordered parameters or	
	Notification of responsible party fo	r acute change in condition	
	Abuse Neglect and Misappropriati	on training	
	including Agency Nurses not receive shift. An employee roster will be util receive this re-education prior to we Licensed Nurses including agency tracked by the Mobile Director of Nurses scheduled to work has had the train	n 3/3/23 by the Interim Director of Nursing this education by the end 3/7/23 willized to track education compliance. Sorking scheduled shift. This will also be Nurses will not work until training comursing or Interim Director of Nursing to hing and education and if not, training f Nursing or Interim Director of Nursing	rill receive prior to next scheduled cheduled agency personnel will be presented in new hire orientation. pleted. Agency nurse training will be a validate that the agency nurse and education will be arranged or
	Supervisor, Interim Director of Nurs shift to shift report to validate that a appropriately, physician notified an during the shift will be reviewed to below 300 or physician notified if o	r of nursing management (Nurse Assesing, Mobile Director of Nursing, Assistany resident that has had a change of a dorders implemented promptly. Blood validate that 2nd nurse validated that rut of parameters or above 300. This withis will be done as monitoring in clinical	ant Director of Nursing) will attend condition has been assessed sugars ordered and monitored esults were within parameters or Il begin on 3/3/23 at 11PM and end
	activity report to identify any docun has been assessed appropriately, This includes signs and symptoms Clinical Meeting and Charge Nurse	and/or Manager on Duty will review the nentation regarding a change of condit physician notified, RP/Family notified a of hyper and hypoglycemia. This will be on weekends. When a change of con cal management team for any [NAME]	ion and validate that the resident and orders implemented promptly. se completed Monday -Friday in the dition is identified the medical

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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 03/07/2023
NAME OF PROVIDER OR SUPPLIE	-D	STREET ADDRESS, CITY, STATE, ZI	P CODE
Corinth Rehabilitation Suites on the		3511 Corinth Parkway Corinth, TX 76208	. 6052
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0656  Level of Harm - Minimal harm or potential for actual harm	that can be measured.  **NOTE- TERMS IN BRACKETS H	e care plan that meets all the resident's	ONFIDENTIALITY** 34918
Residents Affected - Few	described the services that were to	nd record review, the facility failed to ended to be furnished to attain or maintain the result well-being for two (Residents #31 and sive care plans.	esident's highest practicable
	The facility failed to care plan Re required to prevent further decline.	esident #31's contractures to her right a	and left shoulders with interventions
	The facility failed to care plan Reprevent further decline.	esident #52's contractures to his right h	and with interventions required to
	These failures could place resident decreased quality of life and care a	es at risk for possible adverse side effect and worsening of contractures.	ets, adverse consequences, and
	Findings include:		
	female with an admitted [DATE]. R interview for mental status. Reside upper and lower extremities. She w was always incontinent of bowel ar	e Quarterly MDS assessment dated [DA esident #31 was severely cognitively in nt #31 had functional limitation in Rangwas totally dependent of one-to-two-pered bladder. Her diagnoses included apted (a nervous system disorder) and Dome (a nervous system disorder)	npaired and unable to complete the e of Motion on both sides in her son assistance with all ADLs and hasia (disorder that affects
	Record review of Resident #31's ca any interventions to help prevent fu	are plan revised on 02/28/23 did not ad urther decline.	dress the residents' contractures or
	for Skilled Services: Patient require	erapy Evaluation and Plan of treatment ed skilled OT services to facilitate tone in oper extremity muscle tone- Rigid .Fine d . Start of care 02/27/23.	n upper extremity in order to
	#31. Resident was observed with a	00 a.m. revealed CNA B and NA C prov n pillow under her left arm, and her right ere unable to raise the resident's right	t hand was observed to be drawn
	(continued on next page)		

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 03/07/2023
NAME OF PROVIDER OR SUPPLIER Corinth Rehabilitation Suites on the P		STREET ADDRESS, CITY, STATE, ZI 3511 Corinth Parkway Corinth, TX 76208	P CODE
For information on the nursing home's pla	an to correct this deficiency, please conf	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	:IENCIES full regulatory or LSC identifying informati	on)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Resident #31's conference last week and had requeshe had requeshed they keep a pillow she stated Resident #31 kept her in never had a splint for her right hand above the Resident's bed to make shelp.  In an interview with CNA B on 03/0 they always kept a pillow under her right shoulder. She stated she was In an interview on 03/01/23 at 1:35 02/27/23. She stated the resident dher left shoulder. She stated the Restated the resident was able to extern hand flat on her stomach to keep her resting splint but stated she would be resting splint but stated she would be resting splint but stated she would be contractures or improve mobility, she progress is made with the staff.  2. Record review of Resident #52's male with an admitted [DATE]. Resinterview for mental status. Resider upper and lower extremities. He was always incontinent of bowel and communication), cerebral vascular and schizoaffective disorders (moodactive, or splint or brace in the last right hand or any interventions to Record review of Resident #52's cahis right hand or any interventions to Record review of the OT Discharge	responsible party on 02/28/23 at 11:25 ested therapy due to the residents decored by under her left arm so she can mainting that had clutched but could still open if but thought that was a good idea. She sure they kept a pillow under her arm but 1/23 at 10:05 a.m. she stated Resident left arm. She stated the resident was not aware of any thing they were supping. In with OT K, she stated she picked id not have a contracture to her right she seponsible party requested they keep a send her right hand, but stated they never from drawing it up in a fist. She stated beconcerned with skin breakdown.  1/01/23 at 1:40 p.m., she stated they mean at 1:40 p.m., she stated they never apply. She stated interventions for the should have been placed on the care play at 1:40 p.m., she stated they mean at 1:40 p.m., she stated	is a.m. she stated they had a care dining range of motion. She stated ain some mobility in that shoulder. It. She stated the Resident had be stated she had to post signs and stated that still did not always that stated that still did not always at \$\frac{4}{3}\$1's responsible party requested very stiff and unable to move her osed to be doing for her right hand. The provided that the staff to lay her end she would evaluate her for a set with nursing and updated them staff to follow to prevent further and to be able to maintain what in communicating those  TE], reflected a [AGE] year-old aired and unable to complete the end of Motion on both sides in his on assistance with all ADLs and asia (disorder that affects is of one side), seizure disorder any Range of motion, passive or other will safely wear a resting attent will safely wear a resting

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676319	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2023
NAME OF PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZI	P CODE
Corinth Rehabilitation Suites on the	e Parkway	3511 Corinth Parkway Corinth, TX 76208	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0656  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	An observation and interview on 03 dressing Resident #52 for the day. Resident #52's right hand was consplint but stated he had not been a She stated his hand often smells a attempted to place a washcloth in his hand to place a washcloth in his hand to doing any type of exercises with Resupposed to be care planned and of interventions, other than placing In an interview with MDS D on 03/0 comprehensive care plan. She stated the contracture on Resishould document what prevention resident's intervention were no long supposed to be a comprehensive a were.  An interview with the DON on 03/0 updating the care plan. She stated place. She stated if a resident had stated if a resident refused the requisiting to have interventions in place and by not updating the care plan, resident's decline.  Review of the facility's policy titled facility will develop and implement the instructions needed to provide standards of quality of care. develor includes measurable objectives an psychosocial needs that are identificated in the review for effectiveness and revise facility will initiate care plans when person centered care plan will include.	8/01/23 at 9:15 a.m. revealed Hospice A Resident's Responsible Party was pre- tracted. Resident's Responsible Party s ble to wear if for some time due to his o nd stated she wished they would try an	Aide L providing ADL care and sent in the room. Observed stated he used to wear a hand decline and increased behaviors. d keep in clean. Hospice aide L pted to do exercise on Resident he stated the staff should be trying adown. She stated they were not e stated contractures were de. She stated she was not aware responsible for updating the quality of life rounds every quarter. The been care planned and they e care plan should reflect when a e stated the care plan was lent were or what their wished to ordinator was responsible for a planned with interventions in the physician's orders. The DON ted on the care plan. She stated the and decreased range of motion had been made to prevent a lated October 2017, reflected, The an for each resident that meet professional son-centered care plan that MEJ, nursing, and mental and the Interdisciplinary Team will Thru ongoing assessment, the of condition dictates the need. The specific services, and frequency.

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 03/07/2023  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]  Provide care and assistance to perform activities of daily living for any resident who is unable.  Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some  Provide care and assistance to perform activities of daily living for any resident who is unable.  "NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY" 34918 Based on observation, interview, and record review, the facility failed to ensure residents who were unable carry out activities of daily living, received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two (Residents #64, and #65, of ten residents reviewed for ADL care.  The facility failed to ensure staff provided consistent showers/baths and shaving to Residents #64 and #65 This failure could place residents at risk of not receiving needed hygiene care which could cause skin breakdown, a loss of dignity and self-worth.  Findings included:  1. Record review of Resident #64's Quarterly MDS assessment, dated 0/2/7/23, reflected a [AGE] year-old male admitted to the facility on [DATE]. He had a BIMS score of 14 which indicated he was cognitively intal His active diagnoses included quadriplegia (paralysis of all four limbs). He was totally dependent for bath and required extensive work of the callity on [DATE]. He had a BIMS score of 14 which indicated he was cognitively intal His active diagnoses included
Corinth Rehabilitation Suites on the Parkway  S111 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)  Provide care and assistance to perform activities of daily living for any resident who is unable.  **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918  Based on observation, interview, and record review, the facility failed to ensure residents who were unable carry out activities of daily living, received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two (Residents #64, and #65,) of ten residents reviewed for ADL care.  The facility failed to ensure staff provided consistent showers/baths and shaving to Residents #64 and #65  This failure could place residents at risk of not receiving needed hygiene care which could cause skin breakdown, a loss of dignity and self-worth.  Findings included:  1. Record review of Resident #64's Quarterly MDS assessment, dated 0/27/23, reflected a [AGE] year-old male admitted to the facility on [DATE]. He had a BIMS score of 14 which indicated he was cognitively inta His active diagnoses included quadriplegia (paralysis of all four limbs). He was totally dependent for bathin and required extensive two-person assistance of personal hygiene, dressing, foilet use and transfers. He was always incontinent of bowel and had a foley catheter. Resident #64 did not have a history of refusal of care.  Review of Resident #64's care plan revised on 03/01/23 reflected, [Resident #64] has an ADL Self Care Deficit RT DX of quadriplegia, contractures. Goal. Will maintain a sense of dignity by being clean, dry, odd free and well groomed. Approach. Bathing: Assist of total one person.  Record review of the undated shower schedule for hall 200, reflected Resident #64 was sche
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F 0677  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some  **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918  Based on observation, interview, and record review, the facility failed to ensure residents who were unable carry out activities of daily living, received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two (Residents #64, and #65,) of ten residents reviewed for ADL care.  The facility failed to ensure staff provided consistent showers/baths and shaving to Residents #64 and #65  This failure could place residents at risk of not receiving needed hygiene care which could cause skin breakdown, a loss of dignity and self-worth.  Findings included:  1. Record review of Resident #64's Quarterly MDS assessment, dated 0/27/23, reflected a [AGE] year-old male admitted to the facility on [DATE]. He had a BIMS score of 14 which indicated he was cognitively inta His active diagnoses included quadriplegia (paralysis of all four limbs). He was totally dependent for bathin and required extensive two-person assistance of personal Pigene, dressing, toilet use and transfers. He was always incontinent of bowel and had a foley catheter. Resident #64 did not have a history of refusal of care.  Review of Resident #64's care plan revised on 03/01/23 reflected, [Resident #64] has an ADL Self Care Deficit R/T DX of quadriplegia, contractures. Goal. Will maintain a sense of dignity by being clean, dry, odo free and well groomed. Approach. Bathing: Assist of total one person.  Record review of Resident #64's Cnit of Care history report for February 2023 reflected he had not receive a shower on his scheduled days for 02/02/23, 02/04/23, 02/09/23, 02/11/23, 02/21/23, 02/21/23, 02/25/23, and 02/27/23.  Review of Resident #64's CNA Shower Review sheet reflected Resident #65 was provided a shower on files.
F 0677  Level of Harm - Minimal harm or potential for actual harm Provide care and assistance to perform activities of daily living for any resident who is unable.  ***NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918  Based on observation, interview, and record review, the facility failed to ensure residents who were unable carry out activities of daily living, received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two (Residents #64, and #65,) of ten residents reviewed for ADL care.  The facility failed to ensure staff provided consistent showers/baths and shaving to Residents #64 and #65  This failure could place residents at risk of not receiving needed hygiene care which could cause skin breakdown, a loss of dignity and self-worth.  Findings included:  1. Record review of Resident #64's Quarterly MDS assessment, dated 0/27/23, reflected a [AGE] year-old male admitted to the facility on [DATE]. He had a BIMS score of 14 which indicated he was cognitively inta His active diagnoses included quadriplegia (paralysis of all four limbs). He was totally dependent for bathin and required extensive two-person assistance of personal hygiene, dressing, toilet use and transfers. He was always incontinent of bowel and had a foley catheter. Resident #64 did not have a history of refusal of care.  Review of Resident #64's care plan revised on 03/01/23 reflected, [Resident #64] has an ADL Self Care Deficit R/T DX of quadriplegia, contractures. Goal. Will maintain a sense of dignity by being clean, dry, ode free and well groomed. Approach. Bathing: Assist of total one person.  Record review of the undated shower schedule for hall 200, reflected Resident #64 was scheduled for a shower on Tuesdays, Thursdays, and Saturdays on the 2 p.m. to 10 p.m. shift.  Record review of Resident #64's CNA Shower Review sheet reflected Resident #65 was provided a shower on a shower on his scheduled days for 02/02/23, 02/04/23, 02/09/23, 02/11/23, 02/18/23, 02/21/23, 0
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sheets 02/02/23, 02/04/23, 02/09/23, 02/11/23, 02/18/23, 02/21/22, 02/23/22,02/25/23 and 02/27/23 which indicated why the shower was not provided.
Review of the Grievance reports dated 09/28/23 filed by Resident #64, reflected, I have been her a month and 4 days and have not gotten a shower. I have received bed baths but would like a shower,
In an interview with Resident #64 on 03/01/23 at 11:25 a.m., he stated he did not get his showers as scheduled. He stated he had only been offered a shower on Tuesday and Thursdays and had never been offered a shower on Saturdays. He stated the only reason he got shaved today (03/01/23) was because State was in the building. He stated he had made complaints to management about the inconsistency in getting his showers.
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(X4) ID PREFIX TAG	X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a follow up interview with Reside with him getting his showers. He st the shower. He stated they used to with the shower aide. He stated the even aware he was supposed to be 2. Record review of Resident #65's male admitted to the facility on [DA impaired. His active diagnoses incl one side) and dementia. He was to of personal hygiene, dressing, toile incontinent of bowel. Resident #65's carisk for pressure ulcers R/T decrea intact. Approach. Keep clean and odry and wrinkle free.  Record review of Resident #65's Prescheduled days for 02/01/23, 02/08/23, 02/15/23, and 02/03/22, 02/10/23, 02/15/23, and 02/01/23, 02/08/23, 02/15/23, and 02/01/23, 02/01/23, 02/08/23, 02/15/23, and 02/01/23, 02/01/23	ent #64 on 03/02/23 at 8:30 a.m., he stated he would occasionally get a bed by have a shower aide, but since the first ey usually have a lot of agency staff on a getting a shower on Saturdays.  **Quarterly MDS assessment, dated 01.** TE]. He had a BIMSs of 8 which indicated cerebrovascular accident (stroke) tally dependent for bathing and require to use and transfers. He was frequently did not have a history of refusal of care plan, with a revision date of 01/18/2 sed mobility, wakens, incontinence. Gother as possible. Minimize skin exposure over schedule for hall 200 reflected Resident and Fridays on the 2 p.m. to 10 p.m. storict of Care history report for February 23/23, and 02/15/23.  **Dower Review sheet reflected Resident #7/23, 02/20/23, 02/22/23 and 02/24/23.  **Object of Care history of the stated he was a shower at all this week. Resident #65 on 03/02/23 at 08:35 a.m., he stated a shower at all this week. Resident #65 on 03/02/23 at 08:35 a.m., he stated a shower at all this week. Resident #65 on 03/02/23 at 08:35 a.m., he stated a shower at all this week. Resident #65 on 03/02/23 at 08:35 a.m., he stated a shower at all this week. Resident #65 on 03/02/23 at 08:35 a.m., he stated he shower at all this week. Resident #65 on 03/02/23 at 08:35 a.m., he stated he shower at all this week. Resident #65 on 03/02/23 at 08:35 a.m., he stated he shower at all this week. Resident #65 on 03/02/23 at 08:35 a.m., he stated he shower at all this week. Resident #65 on 03/02/23 at 08:35 a.m., he stated he shower at all this week. Resident #65 on 03/02/23 at 08:35 a.m., he stated he shower at all this week. Resident #65 on 03/02/23 at 08:35 a.m., he stated he was the property for the p	ated it had been an ongoing issue bath, but stated he wanted to go to of the year they had done away the weekend. He stated he was not was moderately cognitively hemiplegia right side (paralysis on dextensive one person assistance incontinent of bladder and always and always set.  3, reflected, [Resident #65] is at all Resident's skin will remain to moisture. Keep linens clean, dent #65 was scheduled for a shift.  2023 reflected no showers on there were no shower sheets for ver was not provided.  red clean shaven with no apparent was only getting a shower once a dated he had been shaved dent #65 stated he wanted his one on the facility for met to 2:00 p.m. shift and the 2:00 p.m. shower book. She stated they is and turn it into the charge nurse. It to the charge nurse. She stated
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For information on the nursing home's	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)		ion)
F 0677  Level of Harm - Minimal harm or potential for actual harm	In an interview with CNA H on 03/01/23 at 9:00 a.m. she stated Resident #64 and Resident #65 were on the 2:00 p.m. to 10:00 p.m. shower schedule. She stated they used to have a shower aide, but they changed that a month or so ago. She stated they were supposed to turn in a shower sheet on every shower or bed bath they gave.		
Residents Affected - Some	In an interview with CNA F on 03/02/23 at 9:00 a.m., she stated she worked 6 a.m. to 2 p.m. shift. She stated Residents #65 and #64 were a 2-10 p.m. shift shower She stated she shaved both Resident #65 and Resident #64 on 03/01/23 because no one had shaved them or given them a shower. She stated she did not give them a shower. She stated she used to be the shower aide but asked to step down from the position because she could not get anyone to assist her with the residents who were 2-person transfers, or help dressing and grooming the residents. She stated there was still a problem with all the residents getting their showers. She stated the biggest problem had been on the to 2:00 to 10:00 p.m. shift. She stated she had reported the concern to the DON over a month ago.		
	Attempted to reach weekend Agen	cy CNA J on 03/02/23 at 9:20 a.m.	
	In an interview with the Staffing Coordinator on 03/02/23 at 9:37 a.m., she stated the CNAs were supposed to complete a shower sheet on every shower they gave and turn it into the Charge Nurse. She stated the Charge Nurses were supposed to review it for skin issues and sign off they had reviewed it and then turn the shower sheets into her. She stated she had noticed there were still issues with the CNAs not completing shower sheets on all the residents. She stated there had been issues with residents not getting showers, so they had started the shower sheets with the nurse's checking off the showers. She stated she reported to the ADON and the DON there were still some missing showers on some of the residents, and they said they would take care of it.		
	short time. She stated she was aw to 10:00 p.m. shift. She stated they expectation of the Charge Nurses to were getting the Charge Nurses to 2:00 to 10:00 p.m. was a brand new	03/02/23 at 9:40 a.m., she stated she hare there had been issues with residen had in serviced the staff on the use of to review those shower sheets. She stated the warmse and stated she was not sure if not been able to follow up with the resider nurse frequently.	t's getting their showers on the 2:00 the shower sheets and the ated the biggest challenge they had be Charge Nurse for the 200 hall on she was holding the CNAs
	not getting their showers, so they in supposed to check the shower she wanted one. She stated the nurses been completed. She stated she washowers as scheduled. She stated scheduled or when they preferred showers and this could cause a lost	8/02/23 at 10:00 a.m., she stated there implemented the shower sheets. She states and make sure all the residents has were supposed to text her at the end was not aware Resident #65 and Resident was her expectation that all residents them. She stated it was not acceptable as of dignity and overall cleanliness.	ated the Charge Nurses were d received their showers if they of their shifts that all showers had ent #64 were still not receiving their s received their showers as
	(continued on next page)		

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 03/07/2023	
NAME OF DROVIDED OR SURDIUS			D CODE	
NAME OF PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZI	PCODE	
Corinth Rehabilitation Suites on the	e Parkway	3511 Corinth Parkway Corinth, TX 76208		
For information on the nursing home's	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	X TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)	
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with LVN E on 03/02 2023. She stated she was the Chair Friday. She stated the CNAs brougensured all the scheduled showers showers. She stated she had not a was surprised Resident #64 had not was not being showered. She stated had been completed.  In an interview with Agency CNA J weekend of 02/25/23 and 02/26/23 stated she had not seen a shower suchedule and stated she did not co some of the residents but stated she had not seen a shower suchedule and stated she had not seen a shower suchedule and stated she had not seen a shower suchedule and stated she had not seen a shower suchedule and stated she had not seen a shower suchedule and stated she had not seen a shower suchedule and stated she had not seen a shower suchedule and stated she had not seen a shower suchedule and stated she had not seen a shower suchedule and stated she had not could stated she had not seen a shower suchedule and stated she had not seen a shower suchedule and stated she had not could stated she had not seen a shower suchedule and stated she had not seen a shower suchedule and stated she had not could stated she had not seen a shower suchedule and stated she had not could stated she had not seen a shower suchedule and stated she had not could stated she had not seen a shower suchedule she had not seen a shower sh	2/23 at 10:13 p.m., she stated she work ge Nurse for the 200 hall on the 2:00 the theorem the theorem the theorem the stated she trusted sked the residents if they had gotten the total her he was not getting his showed she had been texting the DON at the con 03/06/23 at 12:27 p.m. she stated she stated she did not provide any she schedule. She stated she did not ask the mplete any shower sheets. She stated she could not recall who they were.  It is a total she work at the could not recall who they were.	ked at the facility since January to 10:00 p.m. shift Monday through of the shift. When asked how she her CNAs to give their scheduled eir showers or not. She stated she er. She stated she had no idea he end of shift that all the showers when the had worked at the facility on the lowers on either of those days. She he Charge nurse about a shower she did provide a few bed baths to reflected, .Shower sheets need to harry action .NO bed baths unless action, dated August 2017, reflected, arry out activities of daily living on .Facility staff develop and goals for care, preferences and ability to perform ADLs .Facility staff	

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. Building	COMPLETED	
	676319	B. Wing	03/07/2023	
NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZI	P 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 con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIT  (Each deficiency must be preceded by for		CIENCIES full regulatory or LSC identifying informati	on)	
F 0684	Provide appropriate treatment and care according to orders, resident's preferences and goals.			
Level of Harm - Immediate jeopardy to resident health or	**NOTE- TERMS IN BRACKETS H	HAVE BEEN EDITED TO PROTECT C	ONFIDENTIALITY** 40316	
safety  Residents Affected - Some	treatment and care in accordance v	and record review, the facility failed to with professional standards of practice (Resident #5) of 24 residents reviewed	and the resident's comprehensive	
		ysician orders for medications to contro ent #5 (diagnosed with Diabetes Type 2		
	2. The facility failed to notify the ph occasions between 1/28/23-2/28/23	ysician of high blood sugar levels (grea 3 for Resident #5.	ater than 300 mg/dL) on multiple	
	3. The facility failed to notify the ph	ysician when Resident #5 showed sign	s and symptoms of hyperglycemia.	
	4. The facility failed to notify the physician when Resident #5 was transferred to the hospital with a blood sugar of 537 mg/dL (normal range is 70-110 mg/dL).			
	5. The facility failed to follow their pmg/dL.	policy of physician notification of elevate	ed blood sugars great than 300	
	This failure resulted in Resident #5 having high blood sugars for one month (1/27/23-2/28/23), which were not treated by nursing staff, and not reported to Resident #5's physician. On 2/28/23 at 4:23 PM Resident # showed signs and symptoms of hyperglycemia (profuse sweating, flushed face, and clammy skin). Residen #5 was transferred to the hospital for elevated blood sugar on 2/28/23 at 6:14 PM.  An Immediate Jeopardy (IJ) situation was identified on 03/02/23 at 4:15 PM. The ADM was notified, and a POR was requested. While the IJ was removed on 3/07/23 at 2:52 PM, the facility remained out of compliance at a scope of pattern at the severity level of actual harm because the facility was still monitoring the effectiveness of their Plan of Removal (POR).			
		s of the facility at risk for life-threatenin an of a resident change in condition.	g medical conditions due to the	
	The findings included:			
	Observation of Resident #5 on 2/28/23 at 9:45 AM revealed that resident was lying in bed. Her husband sitting in a chair next to her. Resident #5 had difficulty answering questions due to confusion. Resident # husband was trying to get the resident to eat breakfast, but Resident #5 refused to eat. Resident #5's husband expressed concern and said that this was not normal for the resident.			
	(continued on next page)			

			No. 0936-0391
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 03/07/2023
NAME OF PROVIDER OR SUPPLIER  Corinth Rehabilitation Suites on the Parkway		STREET ADDRESS, CITY, STATE, ZI 3511 Corinth Parkway Corinth, TX 76208	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		ion)
F 0684  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	Review of Resident #5's quarterly MDS assessment dated [DATE] reflected she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted to the facility from the hospital on 01/27/23. She had diagnoses of sepsis (blood infection), hypertension (high blood pressure), Diabetes, Multiple Sclerosis (a degenerative neurological disease), and Kidney Failure. It reflected she did not receive any insulin injections. Review revealed the resident had a BIMS score of 13 which meant the resident was cognitively intact. The resident required extensive assistance to total dependence with all ADLs except eating only needed supervision. Resident #5 was incontinent of bowel and bladder.		
	Review of the care plan dated 2/20/23 revealed that there was a care plan for diabetes with the goal statement, Diabetic status will remain stable as evidenced by residents [blood sugar] staying within the residents normal limits thru the next review date. Review of care plan revealed no statement as to the norm limits for Resident #5.		
	Review of hospital discharge orders dated 1/27/23 indicated that Resident #5 had been discharged with an order for Insulin Lispro high dose sliding scale. A written note at the bottom of the orders read, New orders added by [MD T]: check blood sugar BID. There were no orders for oral medication for diabetes.  Review of the January and February physician orders dated 03/02/23 revealed there were no orders for the treatment of diabetes (insulin sliding scale or oral medication) from 01/27/23 to 02/28/23. Review of physician order dated 03/01/23 revealed an order for insulin sliding scale that read, Blood Sugar less than 70, call MD. Blood Sugar is 70 to 150, give 0 Units. Blood Sugar is 151 to 200, give 2 Units. Blood Sugar is 201 to 250, give 4 Units. Blood Sugar is 251 to 300, give 6 Units. Blood Sugar is 301 to 350, give 8 Units. Blood Sugar is 351 to 400, give 10 Units. Blood Sugar is greater than 400, call MD.  Review of the hospital discharge orders dated 1/27/23 (resident was admitted [DATE]) indicated that Resident #5 had been discharged with an order for Insulin Lispro high dose sliding scale. A written note at the bottom of the orders read, New orders added by [MD T]: check blood sugar BID. There were no orders for oral medication for diabetes.  Review of Resident #5's January and February physician orders dated 03/02/23 revealed there were no orders for the treatment of diabetes (insulin sliding scale or oral medication) from 01/27/23 to 02/28/23. Review of physician order dated 03/01/23 revealed an order for insulin sliding scale that read, [If] Blood Sugar is 151 to 200, give 2 Units. [If] Blood Sugar is 201 to 250, give 4 Units. [If] Blood Sugar is 251 to 300, give 6 Units. [If] Blood Sugar is greater than 400, call MD.		
		Resident #5 revealed an order dated 2 notify the physician for high blood suga	· · · · · · · · · · · · · · · · · · ·
	324 mg/dL. No medication was giv	icated that on 1/28/23 at 5:00 PM LVN en for this high blood sugar. Review of e physician was notified of the elevated	the progress notes dated 1/28/23
	(continued on next page)		

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 03/07/2023
NAME OF PROVIDER OR SUPPLIER  Corinth Rehabilitation Suites on the Parkway		STREET ADDRESS, CITY, STATE, ZI 3511 Corinth Parkway Corinth, TX 76208	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0684  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	332 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 335 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind mg/dL. No medication was given for revealed no documentation that the Review of TAR for Resident #5 ind 397 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 309 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 377 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 384 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 384 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver the Review of TAR for Resident #5 ind 400 mg/dL. No medication was giver the Review of TAR for Resident #5 ind 400 mg/dL #5 ind 400 mg/dL #5 ind 400 mg/dL #5 ind 400 mg	icated that on 2/09/23 at 4:00 PM LVN en for this high blood sugar. Review of e physician was notified of the elevated icated that on 2/10/23 at 4:00 PM LVN en for this high blood sugar. Review of e physician was notified of the elevated icated that on 2/14/23 at 4:00 PM DON or this high blood sugar. Review of the period physician was notified of the elevated icated that on 2/17/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/18/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/20/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/21/23 at 4:00 PM ADO en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/21/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/22/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/23/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/23/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/23/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/23/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/23/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/23/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/23/23 at 4:00 PM LVN en for this high blood sugar.	the progress notes dated 2/09/23 blood sugar of 332 mg/dL.  E documented a blood sugar of the progress notes dated 2/10/23 blood sugar of 335 mg/dL.  I documented a blood sugar of 356 progress notes dated 2/14/23 blood sugar of 356 mg/dL.  E documented a blood sugar of the progress notes dated 2/17/23 blood sugar of 397 mg/dL.  E documented a blood sugar of the progress notes dated 2/18/23 blood sugar of 309 mg/dL.  E documented a blood sugar of the progress notes dated 2/18/23 blood sugar of 309 mg/dL.  E documented a blood sugar of the progress notes dated 2/20/23 blood sugar of 377 mg/dL.  N documented a blood sugar of the progress notes dated 2/21/23 blood sugar of 400 mg/dL.  E documented a blood sugar of the progress notes dated 2/22/23 blood sugar of 384 mg/dL.  E documented a blood sugar of the progress notes dated 2/23/23 blood sugar of 384 mg/dL.

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NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Corinth Rehabilitation Suites on the	e Parkway	3511 Corinth Parkway Corinth, TX 76208	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	X TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0684  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	306 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 375 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind mg/dL. No medication was given for revealed no documentation that the Review of TAR for Resident #5 ind mg/dL. No medication was given for revealed no documentation that the Review of TAR for Resident #5 ind 406 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 305 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 397 mg/dL. No medication was giver revealed no documentation that the Review of TAR for Resident #5 ind 477 mg/dL. No medication was giver revealed no documentation that the Review of nursing progress notes ffacility nurses who documented Retaility nurses who documented Retaility nurses who documented #5 ind 537 mg/dL. No medication was giver that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was giver that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was giver that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was giver that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was giver that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was giver that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was giver that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was giver that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was giver that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was giver that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was giver that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was giver that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was giver that the Review of TAR for Resident #5 ind 537 mg/dL. No medication was giver that the Review of TAR for Resident #5 ind 537 mg/dL.	icated that on 2/24/23 at 7:00 AM LVN en for this high blood sugar. Review of e physician was notified of the elevated icated that on 2/24/23 at 4:00 PM LVN en for this high blood sugar. Review of e physician was notified of the elevated icated that on 2/25/23 at 7:00 AM RN Cor this high blood sugar. Review of the period of the elevated icated that on 2/25/23 at 4:00 PM RN Cor this high blood sugar. Review of the period of the elevated icated that on 2/25/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/26/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/27/23 at 7:00 AM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/27/23 at 4:00 PM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/28/23 at 7:00 AM LVN en for this high blood sugar. Review of exphysician was notified of the elevated icated that on 2/28/23 at 7:00 AM LVN en for this high blood sugar. Review of exphysician was notified of the elevated for the period of 1/27/23 through 2/27/2 esident #5's high blood sugar. Review of iffied of the elevated blood sugar of 537	the progress notes dated 2/24/23 blood sugar of 306 mg/dL.  E documented a blood sugar of the progress notes dated 2/24/23 blood sugar of 375 mg/dL.  Q documented a blood sugar of 304 progress notes dated 2/25/23 blood sugar of 304 mg/dL.  Q documented a blood sugar of 421 progress notes dated 2/25/23 blood sugar of 421 mg/dL.  N documented a blood sugar of the progress notes dated 2/26/23 blood sugar of 406 mg/dL.  R documented a blood sugar of the progress notes dated 2/27/23 blood sugar of 305 mg/dL.  E documented a blood sugar of the progress notes dated 2/27/23 blood sugar of 397 mg/dL.  E documented a blood sugar of the progress notes dated 2/27/23 blood sugar of 397 mg/dL.  P documented a blood sugar of the progress notes dated 2/28/23 blood sugar of 477 mg/dL.  3 revealed that none of the seven ted these high blood sugar of progress notes dated 2/28/23

(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676319	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2023
NAME OF PROVIDER OR SUPPLIER  Corinth Rehabilitation Suites on the Parkway		P CODE
an to correct this deficiency, please conf	tact the nursing home or the state survey	agency.
SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
Review of nursing progress note for sugar check this morning 477. NP[At about 1pm this nurse noted individence of blood sugar which was 48 that the physician was notified of the was notified that Resident #5 was sure Review of nursing progress note for was sent to hospital as requested be notified about the change in conditional linterview with LVN R on 03/02/23 as she had a really high blood sugar. If acility just ordered insulin for Resident resident wasn't on insulin. LVN elevated blood sugars.  In an interview on 03/02/23 at 12:10 Metformin (a diabetes pill) was discordered insulin for Resident wasn't on insulin. LVN elevated blood sugars.  In an interview on 03/02/23 at 12:11 Metformin (a diabetes pill) was discordered in the impression that the control of the impression	r Resident #5 dated 2/28/23 at 4:23 PM (AA) informed of blood sugar with new indual having [signs and symptoms] of 1. Review of progress notes dated 2/2 in elevated blood sugar of 477, nor any showing signs of hyperglycemia.  r Resident #5 dated 2/28/23 at 6:14 PM (and the property of the hospital).  r Resident #5 dated 2/28/23 at 6:14 PM (and tanner of the hospital).  at 11:07 AM revealed Resident #5 was LVN R stated the resident was not received the property of the hospital.  At 11:07 AM revealed Resident #5 was LVN R stated the resident was not received the following the facility por the stated she didn't know the facility por the stated she didn't know the facility por the first I heard of [the high blood sugar did that MD T usually reviewed the labor or orders in her chart for diabetic medical PM, LVN P said she first discovered fugar was 477, I notified the doctor who follow units before lunch. She looked flushed it and the machine just said 'high'. To she was trending high. I was shocked the eno sliding scale, so I reached out to in contact with the doctors. The doctor of the doctor her blood sugars were find the first of the sugar was 477. In the sugar was 477, I notified the doctor who in contact with the doctors. The doctor of the d	M by LVN P read in part, blood order for Lispro on [sliding scale] . hyperglycemia . shaky . clammy . 28/23 revealed no documentation of documentation that the physician of by LVN E read in part, Resident ealed the physician was not admitted to the hospital because eiving insulin. Interview revealed the N R stated she did not know why dicy on notifying the MD for ember that [Resident #5's] failure. I know that I gave the order AC and HS on February 3, 2023 . I dioner), NP AA denied knowledge of sign was the day [Resident #5] was ratory results and denied ation from 1/27/23 to 2/28/23.  Resident #5's high blood sugar: I ordered 10 units of insulin per ed so I checked her sugar again . I or me, she didn't have a sliding nat nobody else intervened when the physician. When she looked was saying she's hospice and the ne until recently. LVN P stated she should do and she told me not to its ago. When asked if she learned
	Parkway  an to correct this deficiency, please consumants of the correct this morning 477. NPI At about 1pm this nurse noted individuals of the charm of the c	A. Building B. Wing  STREET ADDRESS, CITY, STATE, ZI 3511 Corinth Parkway Corinth, TX 76208  an to correct this deficiency, please contact the nursing home or the state survey.  SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information of the state survey of the state of the survey of the survey of the state of the survey of the sur

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676319	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2023
NAME OF PROVIDER OR SUPPLIE	-p	STREET ADDRESS, CITY, STATE, ZI	P CODE
Corinth Rehabilitation Suites on the Parkway		3511 Corinth Parkway	r CODE
Commit Nonabilitation Calco on the	o r dirkway	Corinth, TX 76208	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0684  Level of Harm - Immediate jeopardy to resident health or safety	In an interview on 03/02/23 at 01:05 PM ADON denied reporting Resident #5's high blood sugars to MD 2, saying, .depends on who the doctor is, what the parameters are . Each doctor has parameters that they follow. The ADON was unable to identify what the blood sugar parameters were for Resident #5. The ADON stated she didn't know the facility policy on notifying the MD for elevated blood sugars.		
Residents Affected - Some	1/27/23) said he did not frequently there in three weeks. LVN O said h admission and I said I would try. I hadn't done an admission for a whi yet and I needed help finishing the what needs to be done by the ADC came in at about 8pm. I stayed late report assuming that the DON and to make sure everything is up to dathe MD for elevated blood sugars.  In an interview on 03/02/23 at 01:2 for ensuring orders on newly admit DON are supposed to review the deverything is correct. The DON sair resident's physician but was unsure notes. DON stated she didn't know.  In an interview on 03/02/23 at 02:1 Receiving nurse sees orders, clarif Interdisciplinary Team meeting and responsible for making sure new on recognizing that there has been a commal, the nursing staff should repaddressed. ADM stated he didn't know.  In an interview on 03/04/23 at 02:1 week. The nurse who was suppose supposed to be still on orientation to	1 PM LVN O (the nurse who admitted I work at the facility. I go once a month, are remembered admitting Resident #5, tried to enter the order, but I was havin le. I passed on in report to [LVN 7] that orders. I told [LVN 7] 'this is what I revival and DON and can you please pass is to finish the admission to do as much ADON would finish the admission. The ste and correct. LVN O stated he didn't are and correct. LVN O stated he didn't exist a blood sugar level of 200 would be why she did not contact the physician the facility policy on notifying the MD for the are entered, and that nurses show that a blood sugar level of 200 would be why she did not contact the physician the facility policy on notifying the MD for the state are entered, and that nurses show that a blood sugar level of 200 would be why she did not contact the physician and they go in a during care planning. The ADM said the facility policy on notifying the MD for the same of condition and the said to the physician and they go in the facility policy on notifying the MD for the same of the physician and they go in the facility policy on notifying the MD for the physician and they go in the facility policy on notifying the MD for the physician and I don't know these people. The properties of the physician and I don't know these people on the physician and I don't know these people on the physician and I don't know these people on the physician and I don't know these people on the physician and I don't know these people on the physician and I don't know these people on the physician and I don't know these people on the physician and I don't know these people on the physician and I don't know these people on the physician and I don't know these people on the physician and I don't know these people on the physician and I don't know these people on the physician and I don't know these people on the physician and I don't know the phy	once every 2 weeks. I haven't been The DON asked me if I could do an g trouble with the eMAR because I I wasn't done with the admission ewed, and this is what I did. This is it on in the morning.' The patient as I could do. I passed it on in ey are supposed to review the chart know the facility policy on notifying  ON, and the ADON are responsible R. The nurses, and ADON and the view the charts to make sure prompt her to contact the a, saying, I would have to check my or elevated blood sugars.  When a resident is admitted is: noto effect. Best practice is during that the DON or ADON is all did contact the physician Upon mething that continues to be not be are things that need to be MD for elevated blood sugars.  In the facility for 1 all the facility for 1 all the all the continue and guidance. I'm RN Q was unable to recall what

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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 03/07/2023
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Corinth Rehabilitation Suites on th	Corinth Rehabilitation Suites on the Parkway		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0684  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	In an interview on 03/04/23 at 02:4 resident's high blood sugar: I wasn know that [a blood sugar of] 500 is signs and symptoms. LVN N denie sugar level of 406 for Resident #5. sliding scale in place for Resident # that she did not see any orders for resident didn't receive any orders for N stated she didn't know the facility.  In an interview on 03/04/23 at 3:00 facility] to inform me if anyone has who had a blood sugar over 400, a Resident #5's high blood sugars ar 3/02/23]. MD T said that she saw F Metformin around February 4th, whormal, so I wrote the order for Me back from the hospital on sliding so diabetes medication. MD T said he Metformin then as well because I sorders for Metformin but couldn't retalked to the nurse and told her I dianother order.  In an interview on 3/04/23 at 03:18 high blood sugar to the resident's product the dianother order. I would call the gets admitted from the hospital, I lowant to continue the orders. The In physician orders are entered into the orders in the computer. Sometimes diabetic resident doesn't receive arketoacidosis, which is a life-threate pressure ulcers (bed sores) if the resident's product of the physician orders are entered into the orders in the computer. Sometimes diabetic resident doesn't receive arketoacidosis, which is a life-threate pressure ulcers (bed sores) if the resident of the physician orders are producted and the product of the	6 PM LVN N said she wasn't sure whee 't educated on that. I don't know if there dangerous. I know that 400 is of some d contacting the physician on 2/26/23 v. I monitored for signs and symptoms. LV #5, There was only an order for blood's diabetes medication on Resident #5's or diabetes medication I would think that policy on notifying the MD for elevated. PM MD T said that if a resident had his a high blood sugar. MD T said she was coording to the sliding scale orders. MI and subsequent hospital admission, Whe resident #5 on approximately February then I saw her after she got back from the formin. I thought she was on sliding stale. MD T denied checking the chart for next visit to Resident #5 was on February it wasn't entered in Resident #5's commber which nurse she gave them to the drift see the order for Metformin in the element of the physician: I look at the parameters. I look at the hospital orders and I call the terim DON was unable to describe facing e-chart, Well that's in development. It should be sugar was not being medication for diabetes, There's a penning condition. The Interim DON also sesident's blood sugar was not being medication for diabetes, There's a penning condition. The Interim DON also sesident's blood sugar was not being medication for diabetes, There's a penning condition. The Interim DON also sesident's blood sugar was not being medication for diabetes, There's a penning condition. The Interim DON also sesident's blood sugar was not being medication for diabetes, There's a penning condition.	In to notify the physician of a be's a policy. LVN N went on to say, I be concern, but we would monitor for when she documented a blood vN N confirmed that there was no sugar checks BID. LVN N also said chart. LVN N said that if a diabetic at it would be life-threatening. LVN d blood sugars.  In the surveyor called me [on a or 4, 2023, I gave an order for the surveyor called me [on a or 4, 2023, I gave an order for the hospital. Her creatinine was cale, because I think that she came to see if Resident #5 had orders for the surveyor called the surveyor called the surveyor that the same to see if Resident #5 had orders for the second time I specifically computer, so I was going to give the second that the Resident's orders. If they also the surveyor of making sure sometimes the doctor enters the set they give a verbal order. If a cossibility they could go into diabetic said that a resident could develop edically managed. Interim DON

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 03/07/2023
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P.CODE
Corinth Rehabilitation Suites on the		3511 Corinth Parkway	r CODE
Commit Rendemnation Cares on the	o r dirkway	Corinth, TX 76208	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0684  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	In an interview on 3/06/23 at 4:51 F to call the resident's physician: It's have a sliding scale, I'd have to cal stated that when the resident is add orders get entered into the computs said, If it's my resident I make sure on the way before I leave. First, I gorders in. If the admission happens said that she had experienced diffices She will snap at you but if you gotte medication, Well, eventually they were MD for elevated blood sugars.  Review of personnel files for nurse documented high blood sugar for FADON) had no documented trainin physician. The personnel files of 2 form regarding checking blood glucefile (LVN CC) had skills check off for physician.  Review of job descriptions for LVN report a resident's change in conditional Review of facility In-service Admissional Care Nurse M were in-serviced with in-service reflected under Admissional pt [patient] is here and send med additional labs they want ordered, shat day, meds will not arrive at mice too pleased about missed meds eit prior physician orders have to be don't the electronic record and included instruction of a facility in-service Train the complete training prior to next sche process and follow up. 4. ADONs we supervisor/Designees will audit Sa education redirection of clinical if no Weekend Supervisor or Designee were sident to call the supervisor or Designee were sident to call the service of the supervisor or Designee were sident supervisor or Designee.	PM LVN BB explained what resident blobetween 400 and 450, whichever the soll the physician and get a sliding scale is mitted to the facility, the resident's nurser. If a resident on her hall gets admitted the orders are entered, because I wan gotta call the doctor to get everything resident at night, I have to call [the physiciculty contacting MD T: Well, she's a docated a call you gotta call. If a resident with divould die. LVN BB stated she didn't know as who cared for Resident #5 revealed the Resident #5 (LVN R, LVN O, LVN N, LVR gin either checking blood glucose or requires (Wound Care Nurse M and LVN cose, but the form was not signed by either checking blood glucose and resident, RN, DON, and ADON positions reveals.	cood sugar levels would prompt her liding scale is. If the resident didn't fone wasn't ordered. LVN BB is expressible for making sure and right before her shift, LVN BB at to make sure their medication is acconciled, and then I gotta put the an and wake them up. LVN BB at the state of the hates being woken up. It is abetes didn't get diabetes ow the facility policy on notifying the state of the nurses who had a proving change in condition to the NBB contained a skills check off ther nurse. One nurse's personnel apporting a change in condition to the led that each required the nurse to led LVN I, LVN P, LVN S, Wound this facility in-service. The loader the DON and physician that we changes to the med orders, or a med orders - if not done by 8 pm at day. [patients] generally aren't did about readmitted patients that a list in admittance/hospital pack hedications must be entered into electronic record.  Nurse reflected 2. All nurses must atted on Audit tools and Admission conday through Friday. Weekend will address concerns and provide clinical meeting from M - F. assigned by DON. It reflected

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NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Corinth Rehabilitation Suites on the Parkway		3511 Corinth Parkway	r CODE
Commit Rondomation Cuitos on the	o r anway	Corinth, TX 76208	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		ion)
F 0684  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	Review of facility In-service Admiss guidelines when new admission an system before end of shift. License expectation that orders are to be tradmission check list for guidance of another nurse on the shift. This inservices M, LVN I, LVN P and LVN S.  Review of facility policy (dated 10/1 read in part, Glucose . Follow specialiding scale insulin; or >450 mg/dL. Review revealed the physician was resident not using insulin sliding scale diabetic residents using an insulin series of medical staff regarding patient's/ patients/residents and their responschange in medical condition (The pacceptable notification timeframes. patient's/resident's condition in the time frame, the Medical Director and medical orders as necessary to treamenber/legal representative will be hospital.  Review of facility's policy Physician obtain and transcribe orders accord nurse reviews orders from the transthe physician to confirm the orders Facility has physician orders for the B. Medications, if necessary C. Rountil staff can conduct a comprehenate in the physician orders and the resident of the conduct a comprehenate medical orders and Verbal section it references.	sions dated 12/12/22 by DON reflected rives. Assessment completed immediated Nurse will be re-educated on the adranscribed and implemented as ordered in completion and will have admission service reflected a sign-in sheet which sife physician orders if present; or > 30 to be notified of blood sugars greater ale and 450 mg/dL (or blood glucose is sliding scale.  In and Other Communication/Change in a between physicians and nursing staff delines for making decisions regarding dresident's condition, and provide guidates is ble party regarding changes in conditionly size of the nurse will document all assessment and birector of Nursing will be notified. The physician does not be resident's/patient's condition reflected of any change in condition reflected of any change in condition reflected as trevised 10/27/17 reflected ding to Facility Practice Guidelines. Addisfer record from an acute care hospital and request any additional orders as reflected 2. Record the actual order received on was identified on 03/02/23 at 4:15 Person was identified on 03/02/23 at 4:15 Person was identified on 03/04/23 at 4pm.  The reflected the following:	Please follow the attached tely All medication should be put in mission process including the d. Licensed Nurse will utilize orders verified and validated by included ADON, Wound Care nunication/Change in Condition Omg/dL in diabetic patient not using a patient using sliding scale insulin than 300 mg/dL in a diabetic monitoring registers high) in  Condition revised 10/16/17 for to promote optimal patient/resident appropriate and timely notification independent of the notification of the as a reference tool regarding ents and changes in the sont respond within an acceptable the Medical Director will provide Patient's/residents family quired an emergent transfer to the Interpretation of the notification of the notification of the Medical Director will provide Patient's/residents family quired an emergent transfer to the Interpretation of the notification of the notification of the notification of the mission: 1. The qualified licensed or other entity. 2. A call is placed to needed .3. Upon admission, the pout not limited to: A. Dietary orders the tresident's functional abilities repriate care plan. Under the physician.
		dmitted to the facility or have a change	of condition or Diabetic have the
	(continued on next page)		

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 03/07/2023
NAME OF PROVIDER OR SUPPLIER  Corinth Rehabilitation Suites on the Parkway		STREET ADDRESS, CITY, STATE, ZI 3511 Corinth Parkway Corinth, TX 76208	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	Lact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0684  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	Director of Nursing will start 3/6/23.  Agency checklist will be reviewed a condition and monitoring of blood so This will be completed by clinical condition and monitoring of blood so This will be completed by clinical condition and monitoring of blood so to 3/2/23 will be conducted by Directinto matrix as ordered from the disconders for sliding scale, diabetic meaccurately per physician orders. An appropriate monitoring of blood sugorders noted, the physician will be addredirection. This will be completed by A house wide audit will be completed by A house wide audit will be completed by A house wide audit will be completed by The facility activity report and the 2 Nursing/ designee to identify any diphysician has been contacted for furcompleted by 3/7/23  The administrator and members of Director of Nursing will be re-educed expectations: This will be completed.	and revised to include the admission programs and notification of physician where productions are admission orders on current resider corrector of Nursing / designee to validate the charge summary or hospital discharge as will be audited by the Director of Nursing / designee to validate the charge summary or hospital discharge as will be audited by the Director of Nursing resident with a diagnosis of diabetes gars and oral diabetic medications or innotified for further direction.  Bessed at the time of discovery including a 377/23.  Bed of sliding scale results and lab tests apported to the physician for further direction being the Director of Nursing designee by 377/4-hour report for the past 72 hours will coumentation that indicates a change of curther direction and the responsible parameter as a train the trainer by the clinical	ocess, order entry, change in en out of parameters or above 300.  Into admitted or readmitted [DATE] that orders were transcribed /entered orders.  It is admitted or readmitted [DATE] that orders were transcribed /entered orders.  It is admitted or readmitted [DATE] that orders were transcribed /entered orders.  It is admitted or readmitted [DATE] that orders were transcribed /entered orders.  It is admitted or readmitted [DATE] that orders were transcribed /entered orders.  It is admitted or readmitted [DATE] that orders were transcribed /entered orders.  It is admitted or readmitted [DATE] that orders were transcribed /entered orders.  It is admitted or readmitted [DATE] that orders were transcribed /entered orders.  It is admitted or readmitted [DATE] that orders were transcribed /entered orders.  It is admitted or readmitted [DATE] that orders were transcribed /entered orders.  It is admitted or readmitted [DATE] that orders were transcribed /entered orders.  It is admitted or readmitted [DATE] that orders were transcribed /entered orders.  It is admitted or readmitted [DATE] that orders were transcribed /entered orders.  It is admitted or readmitted [DATE] that orders were transcribed /entered orders.  It is admitted or readmitted [DATE] that orders were transcribed /entered orders.  It is admitted or readmitted [DATE] that orders were transcribed /entered orders.  It is admitted or readmitted [DATE] that orders were transcribed /entered orders.  It is admitted or readmitted [DATE] that orders were transcribed /entered orders were transcribed /entered orders.  It is admitted or readmitted [DATE] that orders were transcribed /entered orders were transcribed orders were transcribed /entered orders were transcribed /e

			No. 0936-0391
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 03/07/2023
NAME OF PROVIDER OR SUPPLIE Corinth Rehabilitation Suites on the		STREET ADDRESS, CITY, STATE, ZI 3511 Corinth Parkway Corinth, TX 76208	IP CODE
For information on the country to be seed		,	
For information on the nursing nomes	pian to correct this deliciency, please con	stact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	ion)
F 0690  Level of Harm - Minimal harm or potential for actual harm	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.  **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918		
Residents Affected - Few	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 and to restore continence to the extent possible for one (Resident #31) of two residents reviewed for incontinence care.		vent urinary tract infections and to
	The facility failed to ensure NA C provided appropriate perineal care for Resident #31 after an incontinent episode when she failed to separate the residents' labia and clean down the middle.		
	This failure placed residents at risk breakdown.	for the development and/or worsening	of urinary tract infections and skin
	Findings include:		
	Review of Resident #31's Quarterly MDS assessment dated [DATE], reflected a [AGE] year-old female an admitted [DATE]. Resident #31 was severely cognitively impaired and unable to complete the interv for mental status. She was totally dependent of one-to-two-person assistance with all ADLs and was al incontinent of bowel and bladder. Her diagnoses included aphasia (disorder that affects communication Tourette's syndrome (a nervous system disorder) and Down syndrome (a genetic disorder).		
	incontinence r/t cognition resident incontinence breakdown related to incontinence	n revised on 02/28/23 reflected, . [Resigns is unaware of the need to void .Goal .R .Approach .check for incontinent episodequate bowel elimination .Provide inco	desident will not develop skin odes at least every 2 hours .Apply
	incontinence care. Both staff wash- reveal the resident had been incon perineal area and the groin area. N were held tightly together, toward h separate the labia and clean down	200 a.m. revealed CNA B and NA C entered their hands and put on gloves. NA C litinent of urine and bowel. Fecal matter NA C pushed the soiled brief down between buttocks and cleaned her peri area the middle. With the assistance of CNA incontinence care, wiping from front to be	C unfastened Resident #31's brief to was observed in the Resident's veen the Resident's legs, which from front to back but did not A B, they rolled the resident onto
	missing this step could lead to an i	3 at 10:15 a.m. revealed she failed to s nfection. She stated she was going to g g and knew the importance of hand hyg	go back and re-clean the resident.
	(continued on next page)		

			No. 0938-0391
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 03/07/2023
NAME OF PROVIDER OR SUPPLIER  Corinth Rehabilitation Suites on the Parkway		STREET ADDRESS, CITY, STATE, Z 3511 Corinth Parkway Corinth, TX 76208	IP CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informat	ion)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents during incontinence care residents at risk of urinary tract inference care residents at risk of urinary tract inference care and residents as sumption the CNA would ensure the assumption the CNA would ensure with a more tenured CNA, since Review of CNA B's competency chand on 08/08/22 she had met criter Review of the facility's policy titled, Don glove .Position patient/resider Wash labia majora .Separate labia Wash downward from pubic area to stroke. Retract labia from thigh, was side using separate section of wash position .Clean anal area by first wifemale, wash by wiping from vaging	and wipe downward. She stated by no actions, especially if they did not remove and had not taken her CNA certification and hygiene and could perform these sure the proper steps were followed. See CNA B was also a recent graduate.  Perineal care/incontinent care, revised to expose urethra meatus and vaginal oward rectum in one smooth stroke. Us shing carefully in skin folds from perinencloth. Lower legs and assist or have pring off excessive fecal material with the atoward anus with one stroke). Discareded. Reapply appropriate incontinent.	at following proper peri care it placed by the fecal matter.  Into completed skills check off on NA in yet. She stated she completed the tasks if she were with a CNA with the stated they should had placed she met criteria for hand hygiene  If July 2016, reflected, .Wash hands apart .For female patient/resident . orifice. Apply cleanser as directed. See separate section of cloth for each the se

CTATEMENT OF DEFICIENCIES	(VI) DDO//DED/CUBS/ 155/6/	(V2) MILITIDLE CONSTRUCTION	(VZ) DATE CURVEY
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	03/07/2023
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Corinth Rehabilitation Suites on the	orinth Rehabilitation Suites on the Parkway  3511 Corinth Parkway  Corinth, TX 76208		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0812  Level of Harm - Minimal harm or potential for actual harm	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.		, prepare, distribute and serve food
·	34399		
Residents Affected - Some		and record review, the facility failed to s al standards in one of one kitchen revie	
	1. Facility failed to ensure fryer was	s cleaned after use and grease was cha	anged.
	2. Dietary Cook Z failed to wash ha	ands during lunch meal preparation on	02/28/23.
	These failures could place resident	s at risk for food contamination and foo	od-borne illness.
	Findings included:		
	1	on 02/28/23 at 9:43 AM revealed grease se with food particles and crumbs on fry	•
	yesterday evening. She stated she Manager stated the grease in the fi the company had not come out to d	02/28/23 at 9:45 AM revealed Dietary Manager stated the fryer was last used for dinner ening. She stated she expected the fryer should have been cleaned off after use. Dietary ted the grease in the fryer had not been changed due to grease container was full. She stated had not come out to dispose of the used grease in 4 months. She stated she had called thems. She stated the grease was last changed last week.	
		AM and 03/01/23 at 12:54 PM revealed evealed it was closed but full to the top	
	Observation on 03/01/23 at 12:54 FO Operations stated they could put the	PM revealed barrel from company was ne grease in this barrel.	empty and Regional Director of
	notified of any issues with company container being full and not being of	with Regional Director of Plant Operati y not picking up grease disposal for fac disposed of could attract flies. He would apany and let Dietary Manager know the	ility. He stated the used grease I follow-up with Dietary Manager to
2. Observation on 02/28/23 at 12:24 PM Dietary Cook Z took her surgical mask off and drank not wash her hands. She scooped food on plates for resident meals and touched her hands cinner part of the plates. At 12:28 PM Dietary Cook Z went to sink and ran hot water on cloth. I did not wash her hands. She went back to plating food on lunch plates. She wiped her hands cloth. Dietary Cook Z went back to plating food on lunch plates.		ouched her hands on top of the hot water on cloth. Dietary Cook Z	
	Interview on 02/28/23 at 12:35 PM have washed her hands more.	12:35 PM with Dietary Cook Z revealed she washed her hands one time but sho more.	
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676319	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2023
NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE
Corinth Rehabilitation Suites on the	orinth Rehabilitation Suites on the Parkway  3511 Corinth Parkway  Corinth, TX 76208		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0812  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	the relief cook and this was the firs when she took her mask off and dr her hands appropriately. She state have stopped to wash her hands be Review of facility's policy Hand hyg most important component for prevexposed portions of arms clean .1. used for food preparation or ware washed to the cook and the cook and the cook arms clean arms clean and the cook arms clean	and 1:30 PM with Dietary Manager revitime she was observed by the state. Sank water. She stated Dietary Cook Zid she should not have used a wash cloefore going back to plating food.  giene/Hand Washing revised 08/01/202 venting the spread of infection .Employed Clean hands in a hand washing sink. It washing or in a service sink used for dissoiled .D. Before handling or eating foo	She should have washed her hands was nervous and usually did wash the to wash her hands and should  O reflected Hand hygiene is the ees will keep their hands and Hands may not be cleaned in a sink sposal of mop water. 2. Wash

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	03/07/2023
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P 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		tact 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)		on)
F 0814	Dispose of garbage and refuse pro	perly.	
Level of Harm - Minimal harm or potential for actual harm	34399		
Residents Affected - Many		nd record review, the facility failed to dis and used grease disposal container for	
	1. Facility failed to ensure used gre	ease disposal container was disposed o	of by contract company.
	2. Facility failed to ensure dumpster did not have items of recliner, wheelchairs, mattress and used PPE gloves on the ground behind dumpster.		
	This deficient practice could place and rodents.	residents at risk for exposure to germs	and diseases carried by vermin
	Findings included:		
		AM and 03/01/23 at 12:54 PM revealed evealed it was closed but full to the top	
		on 02/28/23 at 9:50 AM of behind exterior dumpster revealed a recliner, four wheelchairs and ind it with used gloves and trash debris on ground. There was a sticky substance on ground ster. Dumpster was open.	
		PM of behind exterior dumpster reveale cy substance on ground behind the dun	
		PM revealed barrel from Company was tary staff could put the used grease in	
	Interview on 03/01/23 at 12:58 PM with Regional Director of Plant Operations revealed he had notified of any issues with company not picking up grease disposal for facility. He stated the us container being full and not being disposed of could attract flies and other bugs. He stated to be to step in the substance behind the dumpster. He stated he was covering for the facility's Main Director today. He stated there should not be items behind the dumpster and he would have to substance on the ground. He stated the items should go in the dumpster so they can be disposed.		ility. He stated the used grease bugs. He stated to be careful not for the facility's Maintenance and he would have to clean up the
	up with Dietary Manager and found	11:03 AM with Regional Director of Pla I out she had contacted the disposal co grease. He stated last time the disposa	ompany 4 times since January 2023
	(continued on next page)		

Level of Harm - Minimal harm or due to service hold due to lack of payment for October 2022 service call and could not be scheduled until payment was received. He stated the facility should call them when they need disposal containers to be		.a.a 55.7.555		No. 0938-0391
Corinth Rehabilitation Suites on the Parkway  Sorinth, 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)  Interview on 03/02/23 at 11:14 AM with Representative from Disposal Company revealed the facility had contacted them four times starting in January 2023. He stated when facility first called it was not schedule due to service hold due to lack of payment for October 2022 service call and could not be scheduled until payment for October 2022 service call and could not be scheduled until payment for October 2022 service call and could not be scheduled until payment for October 2022 service call and could not be scheduled until payment for October 2022 service call and could not be scheduled until payment for October 2022 service call and could not be scheduled until payment for October 2022 service call and could not be scheduled until payment for October 2022 service call and could not be scheduled until payment for October 2022 service call and could not be scheduled until payment for October 2022 service call and could not be scheduled until payment for October 2022 service call and could not be scheduled until payment for October 2022 service call and could not be scheduled until payment for October 2022 service call and could not be scheduled until payment for October 2022 service call and could not be scheduled until payment for October 2022 service call and could not be scheduled until payment for October 2022 service call and could not be scheduled until payment for October 2022 service call and could not be scheduled until payment for October 2022 service call and could not be scheduled until payment for October 2022 service call and could not be scheduled until payment for October 2022 service call and could not be scheduled until payment for October 2022 service call and c		IDENTIFICATION NUMBER:	A. Building	COMPLETED
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)  Interview on 03/02/23 at 11:14 AM with Representative from Disposal Company revealed the facility had contacted them four times starting in January 2023. He stated when facility first called it was not scheduled until due to service hold due to lack of payment for October 2022 service call and could not be scheduled until payment was received. He stated the facility should call them when they need disposal containers to be picked up. He stated the facility had paid the outstanding balance and was currently on the list to come of the stated the facility did not have a regular scheduled pickup time.  Interview on 03/03/23 at 5:15 PM with ADM revealed there was not a facility policy for dumpster or used	NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)  Interview on 03/02/23 at 11:14 AM with Representative from Disposal Company revealed the facility had contacted them four times starting in January 2023. He stated when facility first called it was not scheduled until payment was received. He stated the facility should call them when they need disposal containers to be picked up. He stated the facility had paid the outstanding balance and was currently on the list to come of the stated the facility did not have a regular scheduled pickup time.  Interview on 03/03/23 at 5:15 PM with ADM revealed there was not a facility policy for dumpster or used	Corinth Rehabilitation Suites on the	e Parkway		
F 0814  Interview on 03/02/23 at 11:14 AM with Representative from Disposal Company revealed the facility had contacted them four times starting in January 2023. He stated when facility first called it was not scheduled upto the to service hold due to lack of payment for October 2022 service call and could not be scheduled until payment was received. He stated the facility should call them when they need disposal containers to be picked up. He stated the facility had paid the outstanding balance and was currently on the list to come of the stated the facility did not have a regular scheduled pickup time.  Interview on 03/03/23 at 5:15 PM with ADM revealed there was not a facility policy for dumpster or used	For information on the nursing home's	plan to correct this deficiency, please con	l tact the nursing home or the state survey	agency.
contacted them four times starting in January 2023. He stated when facility first called it was not schedule due to service hold due to lack of payment for October 2022 service call and could not be scheduled until payment was received. He stated the facility should call them when they need disposal containers to be picked up. He stated the facility had paid the outstanding balance and was currently on the list to come or He stated the facility did not have a regular scheduled pickup time.  Interview on 03/03/23 at 5:15 PM with ADM revealed there was not a facility policy for dumpster or used	(X4) ID PREFIX TAG			on)
	Level of Harm - Minimal harm or potential for actual harm	contacted them four times starting in January 2023. He stated when facility first called it was not scheduled due to service hold due to lack of payment for October 2022 service call and could not be scheduled until payment was received. He stated the facility should call them when they need disposal containers to be picked up. He stated the facility had paid the outstanding balance and was currently on the list to come out. He stated the facility did not have a regular scheduled pickup time.  Interview on 03/03/23 at 5:15 PM with ADM revealed there was not a facility policy for dumpster or used		
		grease disposal.		

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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 03/07/2023
NAME OF PROVIDER OR SUPPLIE	<u> </u> ER	STREET ADDRESS, CITY, STATE, ZI	P 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 con	tact 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)		on)
F 0849 Level of Harm - Minimal harm or potential for actual harm	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.  **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32486		
Residents Affected - Few		ew the facility failed to obtain from hospician certification of the terminal illness records.	
	1.The facility failed to obtain the hospice election form and a physician certification of terminal illness for Resident #21.		
	2.The facility failed to obtain the ho	spice a physician certification of termin	al illness for Resident #4.
	These failures could place resident	s at risk for services and treatments no	t being coordinated.
	Findings included:		
	Record review of Resident #21's electronic face sheet revealed an [AGE] year-old female admitted to facility on [DATE]. Resident #21 had diagnoses which included Rhabdomyolysis, pain, psychosis, cirrhos liver.		
	Record review of Resident #21's M admitted to hospice.	arch 2023 electronic physician's orders	s reflected on 10/25/22 she was
		ectronic clinical record and hospice do ion of terminal illness from Hospice A.	cumentation reflected no hospice
		electronic face sheet revealed a [AGE] I diagnoses which included heart failure	
	Record review of Resident #4's Ma admitted to hospice.	rch 2023 electronic physician's orders	reflected on 01/23/23 she was
	Record review of Resident #4's ele certification of terminal illness from	electronic clinical record and hospice documentation reflected no physician rom Hospice A.	
	Interview on 03/01/23 at 10:15 AM the DON stated it was the Social Worker's responsibility to er the appropriate hospice documentation was in the resident's record. The DON stated the important paperwork was to ensure accurate care was provided to the resident.		
	(continued on next page)		

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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 03/07/2023
NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, Z	P CODE
	tehabilitation Suites on the Parkway  3511 Corinth Parkway  Corinth, TX 76208		
For information on the nursing home's	For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.		agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		ion)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/01/23 at 10:27 AM physician certification of terminal ill clinical record. The Social Worker's from Hospice A in Resident #4's ho would call Hospice A to obtain the Interview on 03/01/23 at 11:42 AM approximately four months and to the ensure the appropriate hospice does hospice election form and physicial certification of terminal illness form it was not available on site.  Interview on 03/01/23 at 1:09 PM vor of care, hospice election form, physicial form to be onsite, he continued by responsibility of the Social Worker forward the ADM would ensure the the paperwork was to ensure accurate interview on 03/01/23 at 1:22 PM vor documentation that was required in Record review of the facility policy established procedures for ongoing care providers, physicians, and face	the Social Worker stated she did not some some from Hospice A in Resident stated she did not see the physician cerespice binder or electronic clinical recommissing information for Resident #21 at the Social Worker stated she had been the best of her knowledge she was not cumentation was in the resident's recommentation was in the resident's recommentation of terminal illness form for Resident #4 from Hospice A which with the ADM revealed he was aware of sician certification of terminal illness are stating he was new to the facility. He some to ensure the appropriate hospice doctore is an appropriate process in place. The resident with the ADON revealed she was not facility the ADON revealed she was not facility the some stating here.	ee the hospice election form and #21's hospice binder or electronic riffication of terminal illness form rd. The Social Worker stated she nd #4.  In working at the facility for aware she was responsible to rd. The Social Worker provided the or Resident #21 and the physician was send over electronically since  If the regulation for the hospice plan rated it would confirm that it was the umentation was on site and moving The ADM stated the importance of milliar with the appropriate hospice reted .Policy:1.The facility has be collaboration between hospice regarding treatment including

			No. 0936-0391
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 03/07/2023
NAME OF PROVIDER OR SUPPLIER  Corinth Rehabilitation Suites on the Parkway  STREET ADDRESS, CITY, STATE, ZIP CODE  3511 Corinth Parkway  Corinth, TX 76208		P CODE	
For information on the nursing home's	For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.		agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		ion)
F 0880  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Provide and implement an infection  **NOTE- TERMS IN BRACKETS IN Based on observation, interview, a Control Program designed to provide velopment and transmission of cresidents observed for infection control program designed to provide velopment and transmission of cresidents observed for infection control perform hand hygiene before lead to perform hand hygiene before lead the period of the perio	n prevention and control program.  HAVE BEEN EDITED TO PROTECT Country and record review, the facility failed to make a safe, sanitary, and comfortable encommunicable diseases and infections introl.	confidential and to help prevent the for one (Resident #31) of five for Resident #31 and CNA B failed for Resident #31 and Was always for that affects communication), genetic disorder).  Ident #31] experiences bladder for Resident will not develop skin for Resident will not develop skin for Resident #31's room to provide the Counfastened Resident #31's brief to was observed in the perineal area for the Solled brief revealing the draw for the soiled brief revealing the draw for the soiled brief revealing the draw for the soiled brief under the soiled and brief under the soiled and brief under the resident. Both and placed a pillow under her left for the line of the line and trash are to the form of the line and trash are to the form of the line and trash are to deposit the linen and trash are to the form of the line and trash are to the form of the line and trash are to the form of the line and trash are to deposit the linen and trash.

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			NO. 0936-0391
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 03/07/2023
NAME OF PROVIDER OR SUPPLIE	:R	STREET ADDRESS, CITY, STATE, ZII	P CODE
Corinth Rehabilitation Suites on the	e Parkway	3511 Corinth Parkway Corinth, TX 76208	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying information	on)
F 0880  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	when they enter a resident's room, room. NA B stated she knew she m dirty to clean. She stated she was training and knew the importance of the animeteries with CNA B on 03/0 when they enter a resident's room, room. CNA B stated she was a new hygiene after she cleaned up the reby not doing this, it could cause an she took off her gloves and before she could spread infection.  Review of CNA B's competency chand on 08/08/22 she had met criter. In an interview with DON A on 03/0 they entered a resident's room, after perform hand hygiene during incon resident's room. She stated by not risk of infections and cross contami. In an interview with the ADON on 0 C because she was still in training a completed the training on incontine with a CNA with the assumption the should had placed her with a more.	11/23 at 02:00 p.m. she stated staff were er contact with any bodily fluid, and they tinent care when they went from dirty to following standard precautions with har	before they leave a resident's d hygiene when she went from and by missing this step could lead dent. She stated she had been in a resident.  Supposed to perform hand hygiene before they leave a resident's anged her gloves perform hand ream on the resident. She stated we performed hand hygiene after linen. She stated by not doing this he met criteria for hand hygiene  e to perform hand hygiene when were to change their gloves and oclean and before leaving a high hygiene it placed residents at not completed skills check off on NA and yet. She stated she had perform these tasks if she were were followed. She stated they recent graduate.  July 2016, reflected, .Wash hands

Review of the facility's policy titled, Hand hygiene/hand washing, dated August 2020, reflected, .Hand hygiene is the most important component for preventing the spread of infection .Wash hands . When hands are visibly soiled .before putting on gloves, when changing into a fresh pair of gloves, and immediately after removing gloves .before and after patient/resident contact . After contact with an object or source where there is a concentration of microorganisms, such as, mucous membranes, non-intact skin, body fluids or wounds .

gloves. Apply moisture barrier if needed. Reapply appropriate incontinent brief/undergarment .

Wash labia majora .Separate labia to expose urethra meatus and vaginal orifice. Apply cleanser as directed. Wash downward from pubic area toward rectum in one smooth stroke. Use separate section of cloth for each stroke. Retract labia from thigh, washing carefully in skin folds from perineum to rectum. Repeat on opposite side using separate section of washcloth .Lower legs and assist or have patient/resident assume side lying position .Clean anal area by first wiping off excessive fecal material with toilet paper or disposable wipes (for female, wash by wiping from vagina toward ansu with one stroke). Discard soiled wipes. Wash hands, don

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

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