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, ZIP CODE
Corinth Rehabilitation Suites on the Parkway	3511 Corinth Parkway Corinth, TX 76208

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399 40316 Based on observation, interview, and record review, the facility failed to notify the resident's physician when there was a significant change in the physical status, and when a decision for transfer of the resident from the facility was made for one (Resident #5) of 24 residents reviewed for notification of changes and transfer of the resident from facility to hospital. 1. 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). 2. The facility failed to notify the physician of high blood sugar levels (greater than 300 mg/dL) on multiple occasions between 1/28/23-2/28/23 for Resident #5. 3. The facility failed to notify the physician when Resident #5 showed signs 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 policy of physician notification of elevated blood sugars greater than 300 mg/dL. 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 #5 showed signs and symptoms of hyperglycemia (profuse sweating, flushed face, and clammy skin). Resident #5 was transferred to the hospital for elevated blood sugar of 537 mg/dL 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). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 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. 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. 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 thru the next review date. Review of care plan revealed no statement as to the normal 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 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. Review of TAR for Resident #5 indicated that on 2/09/23 at 4:00 PM LVN E documented a blood sugar of 332 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/09/23 revealed no documentation that the physician was notified of the elevated blood sugar of 332 mg/dL. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. No medication was given for this high blood sugar. Review of the progress notes dated 2/10/23 revealed no documentation that the physician was notified of the elevated blood sugar of 335 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. No medication was given for this high blood sugar. Review of the progress notes dated 2/14/23 revealed no documentation that the physician was notified of the elevated blood sugar of 356 mg/dL. Review of TAR for Resident #5 indicated that on 2/17/23 at 4:00 PM LVN E documented a blood sugar of 397 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/17/23 revealed no documentation that the physician was notified of the elevated blood sugar of 397 mg/dL. Review of TAR for Resident #5 indicated that on 2/18/23 at 4:00 PM LVN E documented a blood sugar of 309 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/18/23 revealed no documentation that the physician was notified of the elevated blood sugar of 309 mg/dL. Review of TAR for Resident #5 indicated that on 2/20/23 at 4:00 PM LVN E documented a blood sugar of 377 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/20/23 revealed no documentation that the physician was notified of the elevated blood sugar of 377 mg/dL. Review of TAR for Resident #5 indicated that on 2/21/23 at 4:00 PM ADON documented a blood sugar of 400 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/21/23 revealed no documentation that the physician was notified of the elevated blood sugar of 400 mg/dL. Review of TAR for Resident #5 indicated that on 2/22/23 at 4:00 PM LVN E documented a blood sugar of 384 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/22/23 revealed no documentation that the physician was notified of the elevated blood sugar of 384 mg/dL. Review of TAR for Resident #5 indicated that on 2/23/23 at 4:00 PM LVN E documented a blood sugar of 400 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/23/23 revealed no documentation that the physician was notified of the elevated blood sugar of 400 mg/dL. Review of TAR for Resident #5 indicated that on 2/24/23 at 7:00 AM LVN R documented a blood sugar of 306 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/24/23 revealed no documentation that the physician was notified of the elevated blood sugar of 306 mg/dL. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of TAR for Resident #5 indicated that on 2/24/23 at 4:00 PM LVN E documented a blood sugar of 375 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/24/23 revealed no documentation that the physician was notified of the elevated blood sugar of 375 mg/dL. Review of TAR for Resident #5 indicated that on 2/25/23 at 7:00 AM RN Q documented a blood sugar of 304 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/25/23 revealed no documentation that the physician was notified of the elevated blood sugar of 304 mg/dL. Review of TAR for Resident #5 indicated that on 2/25/23 at 4:00 PM RN Q documented a blood sugar of 421 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/25/23 revealed no documentation that the physician was notified of the elevated blood sugar of 421 mg/dL. Review of TAR for Resident #5 indicated that on 2/26/23 at 4:00 PM LVN N documented a blood sugar of 406 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/26/23 revealed no documentation that the physician was notified of the elevated blood sugar of 406 mg/dL. Review of TAR for Resident #5 indicated that on 2/27/23 at 7:00 AM LVN R documented a blood sugar of 305 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/27/23 revealed no documentation that the physician was notified of the elevated blood sugar of 305mg/dL. Review of TAR for Resident #5 indicated that on 2/27/23 at 4:00 PM LVN E documented a blood sugar of 397 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/27/23 revealed no documentation that the physician was notified of the elevated blood sugar of 397 mg/dL. Review of TAR for Resident #5 indicated that on 2/28/23 at 7:00 AM LVN P documented a blood sugar of 477 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/28/23 revealed no documentation that the physician was notified of the elevated blood sugar of 477mg/dL. Review of nursing progress notes for the period of 1/27/23 through 2/27/23 revealed that none of the seven facility nurses who documented Resident #5's high blood sugar had reported these high blood sugars to MD T. Review of TAR for Resident #5 indicated that on 2/28/23 at 4:00 PM LVN E documented a blood sugar of 537 mg/dL. No medication was given for this high blood sugar. Review of progress notes dated 2/28/23 revealed the physician was not notified of the elevated blood sugar of 537 mg/dL. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of nursing progress note for Resident #5 dated 2/28/23 at 4:23 PM by LVN P read in part, blood sugar check this morning 477 . NP[AA] informed of blood sugar with new order for Lispro on [sliding scale] . At about 1pm this nurse noted individual having [signs and symptoms] of hyperglycemia . shaky . clammy . checked blood sugar which was 481 . Review of progress notes dated 2/28/23 revealed no documentation that the physician was notified of the elevated blood sugar of 477, nor any documentation that the physician was notified that Resident #5 was showing signs of hyperglycemia. Review of nursing progress note for Resident #5 dated 2/28/23 at 6:14 PM by LVN E read in part, Resident was sent to hospital as requested by both DON and [NP 5] . Review revealed the physician was not notified about the change in condition and transfer to the hospital. Interview with LVN R on 03/02/23 at 11:07 AM revealed Resident #5 was admitted to the hospital on 2/28/23 because she had a really high blood sugar. LVN R stated the resident was not receiving insulin. LVN R stated that she did not notify MD T of Resident #5's high blood sugars. Interview revealed the facility just ordered insulin for Resident #5 on the morning of 02/28/23. LVN R stated, I don't know why she [Resident #5] wasn't on insulin. When asked if she knew what the facility policy was during the interview, LVN R stated No. In an interview on 03/02/23 at 12:10 PM MD T was unaware of the decline that led to Resident #5's hospitalization . MD T said, I think her sugars are usually well-controlled? I think she was on metformin or something I think that was discontinued in the hospital . I remember that her metformin was discontinued in the hospital due to kidney failure. I know that I gave the order for Metformin and for Novolog Lispro sliding scale as well as accu-checks AC and HS on February 3, 2023. The progress notes that I write are received by medical records . I was under the impression that the orders I gave were put into the chart. When asked about the high blood sugars that led to Resident #5's hospitalization , MD T said that she knew that Resident #5 had been having high blood sugars and did not know that Resident #5 had been sent to the hospital. In an interview on 03/02/23 at 12:31 PM with NP AA (MD T's nurse practitioner), NP AA denied knowledge of Resident #5's high blood sugars, The first I heard of [the high blood sugars] was the day [Resident #5] was admitted to the hospital. NP AA said that MD T usually reviewed the laboratory results and denied knowledge that Resident #5 had no orders in her chart for diabetic medication from 1/27/23 to 2/28/23. In an interview on 03/02/23 at 12:41 PM, LVN P said she first discovered Resident #5's high blood sugar on 2/28/23. I found that [on 2/28/23] the blood sugar was 477, I notified the doctor who ordered 10 units of insulin per sliding scale. I gave [Resident #5] 10 units before lunch. She looked flushed so I checked her sugar again . I checked it, and it was 397 . When I re-checked it and the machine just said 'high' . To me, she didn't have a sliding scale. I called the doctor because she was trending high. I was shocked that nobody else intervened when the blood sugar was high. I didn't see no sliding scale, so I reached out to the physician. When she looked flushed, cool and clammy, I stayed in contact with the doctors . the doctor was saying she's hospice and the hospice nurse was saying to contact the doctor . her blood sugars were fine until recently. LVN P stated she did not know the facility policy for notifying the doctor for high blood sugars. (continued on next page)

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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 01:01 PM LVN E denied reporting Resident #5's high blood sugars to Resident #5's physician, MD 2. She stated, I didn't know I had to. I asked another nurse what I should do and she told me not to worry about it. Per nurse, she had graduated from nursing school 2 months ago. When asked if she learned how to monitor blood sugar in nursing school, nurse said yes. LVN E stated she did not know the facility policy for notifying the doctor for high blood sugars. In an interview on 03/02/23 at 01:05 PM ADON denied reporting Resident #5's high blood sugars to MD T, 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 did not know the facility policy for notifying the doctor for high blood sugars. In an interview on 03/02/23 at 01:11 PM LVN O (the nurse who admitted Resident #5 from the hospital on 1/27/23) said he did not frequently work at the facility. He stated, .I go once a month, once every 2 weeks. I haven't been there in three weeks. LVN O said he remembered admitting Resident #5, The DON asked me if I could do an admission and I said I would try . I tried to enter the order, but I was having trouble with the eMAR because I hadn't done an admission for a while. I passed on in report to [LVN BB] that I wasn't done with the admission yet and I needed help finishing the orders. I told [LVN BB] 'this is what I reviewed, and this is what I did. This is what needs to be done by the ADON and DON and can you please pass it on in the morning.' The patient came in at about 8pm. I stayed late to finish the admission to do as much as I could do. I passed it on in report assuming that the DON and ADON would finish the admission. They are supposed to review the chart to make sure everything is up to date and correct. In an interview on 03/02/23 at 01:22 PM the DON said, The nurses, the DON, and the ADON are responsible for ensuring orders on newly admitted residents are entered into the eMAR. The nurses, and ADON and the DON are supposed to review the discharge orders. Every morning, we review the charts to make sure everything is correct. The DON said that a blood sugar level of 200 would prompt her to contact the resident's physician but was unsure why she did not contact the physician, saying, I would have to check my notes. In an interview on 03/02/23 at 02:11 PM ADM said that the best practice when a resident is admitted is: Receiving nurse sees orders, clarifies orders with physician, and they go into effect. Best practice is during Interdisciplinary Team meeting and during care planning. The ADM said that the DON or ADON is responsible for making sure new orders are entered, and that nurses should contact the physician Upon recognizing that there has been a change of condition . When there is something that continues to be not normal, the nursing staff should report it to the physician . I recognize there are things that need to be addressed. In an interview on 03/04/23 at 02:14 PM with RN Q, the nurse said she had been working at the facility for 1 week. The nurse who was supposed to be training her (LVN N) just left me alone without any guidance. I'm supposed to be still on orientation training, and I don't know these people. RN Q was unable to recall what happened on 2/25/23, when she documented a blood sugar of 305 mg/dL. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 03/04/23 at 02:46 PM LVN N said she was not sure when to notify the physician of a resident's high blood sugar: I wasn't educated on that. I don't know if there's a policy. LVN N went on to say, I know that [a blood sugar of] 500 is dangerous . I know that 400 is of some concern, but we would monitor for signs and symptoms. LVN N denied contacting the physician on 2/26/23 when she documented a blood sugar level of 406 for Resident #5.I monitored for signs and symptoms. LVN N confirmed that there was no sliding scale in place for Resident #5, There was only an order for blood sugar checks BID. LVN N also said that she did not see any orders for diabetes medication on Resident #5's chart. LVN N said that if a diabetic resident didn't receive any orders for diabetes medication I 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, I would expect [the facility] to inform me if anyone has a high blood sugar. MD T said she wanted to be notified of any resident who had a blood sugar over 400, according to the sliding scale orders. MD T said she first became aware of Resident #5's high blood sugars and subsequent hospital admission, When the surveyor called me [on 3/02/23]. MD T said that she saw Resident #5 on approximately February 3 or 4,, 2023, I gave an order for Metformin around February 4th, when I saw her after she got back from the hospital. Her creatinine was normal, so I wrote the order for Metformin . I thought she was on sliding scale, because I think that she came back from the hospital on sliding scale. MD T denied checking the chart to see if Resident #5 had orders for diabetes medication. MD T said her next visit to Resident #5 was on February 10 or 11, I gave orders for Metformin then as well because I saw it wasn't entered in Resident #5's chart. MD T said she gave verbal orders for Metformin but could not remember which nurse she gave them to. The second time I specifically talked to the nurse and told her I didn't see the order for Metformin in the computer, so I was going to give another order. In an interview on 3/04/23 at 03:18 PM with Interim DON, she explained how she would know when to report high blood sugar to the resident's physician: I look at the parameters. I look at the Resident's orders. If they don't have an order, I would call the physician if the blood sugar was over 110 or below 70. When a resident gets admitted from the hospital, I look at the hospital orders and I call the doctor and make sure that they want to continue the orders. The Interim DON was unable to describe facility protocol for making sure physician orders are entered into the e-chart, Well that's in development. Sometimes the doctor enters the orders in the computer. Sometimes they give us written orders. Sometimes they give a verbal order. If a diabetic resident doesn't receive any medication for diabetes, Interim DON said, There's a possibility they could go into diabetic ketoacidosis [a life-threatening condition]. The Interim DON also said that a resident could develop pressure ulcers (bed sores) if the resident's blood sugar was not being medically managed. In an interview on 3/06/23 at 4:51 PM LVN BB explained what resident blood sugar levels would prompt her to call the resident's physician: It's between 400 and 450, whichever the sliding scale is. If the resident didn't have a sliding scale, I'd have to call the physician and get a sliding scale if one wasn't ordered. LVN BB stated that when the resident is admitted to the facility, the resident's nurse is responsible for making sure orders get entered into the computer. If a resident on her hall gets admitted right before her shift, LVN BB said, If it's my resident I make sure the orders are entered, because I want to make sure their medication is on the way before I leave . First, I gotta call the doctor to get everything reconciled, and then I gotta put the orders in. If the admission happens late at night, I have to call [the physician] and wake them up. LVN BB said that she had experienced difficulty contacting MD T: Well, she's a doctor but she hates being woken up. She will snap at you but if you gotta call you gotta call. If a resident with diabetes didn't get diabetes medication, Well, eventually they would die. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of personnel files for nurses who cared for Resident #5 revealed that most of the nurses who had documented high blood sugar for Resident #5 (LVN R, LVN O, LVN N, LVN P, LVN E, RN Q, DON, and ADON) had no documented training in either checking blood glucose or reporting change in condition. The personnel files of 2 nurses (Wound Care Nurse M and LVN BB) contained a skills check off form regarding checking blood glucose, but the form was not signed by either nurse. One nurse's personnel file (LVN CC) had skills check off forms for checking blood glucose and reporting a change in condition to the physician. Review of job descriptions for LVN, RN, DON, and ADON positions revealed that each required the nurse to report a resident's change in condition to the resident's physician. Review of facility policy (dated 10/16/17) titled Physician and Other Communication/Change in Condition read in part, Glucose . Follow specific physician orders if present; or > 300mg/dL in diabetic patient not using sliding scale insulin; or >450 mg/dL (or machine registers high) in diabetic patient using sliding scale insulin . Review revealed the physician was to be notified of blood sugars greater than 300 mg/dL in a diabetic resident not using insulin sliding scale and 450 mg/dL (or blood glucose monitoring registers high) in diabetic residents using an insulin sliding scale. Review of facility's policy Physician and Other Communication/Change in Condition revised 10/16/17 reflected to improve communication between physicians and nursing staff to promote optimal patient/resident care, provide nursing staff with guidelines for making decisions regarding appropriate and timely notification of medical staff regarding patient's/resident's condition, and provide guidance for the notification of patients/residents and their responsible party regarding changes in condition .3. Notify the physician of the change in medical condition (The physician notification grid may be used as a reference tool regarding acceptable notification timeframes.) The nurse will document all assessments and changes in the patient's/resident's condition in the medical record. 4. If the physician does not respond within an acceptable time frame, the Medical Director and Director of Nursing will be notified. The Medical Director will provide medical orders as necessary to treat the resident's/patient's condition .6. Patient's/residents family member/legal representative will be notified of any change in condition required an emergent transfer to the hospital. An Immediate Jeopardy (IJ) situation was identified on 03/02/23 at 4:15 PM. The ADM was notified, and a POR was requested. The POR was accepted on 03/04/23 at 4pm. The accepted POR reflected the following: Resident #5 is not currently in the facility. Residents who are admitted or readmitted to the facility or have a change of condition or Diabetic have the potential to be affected by this alleged deficient practice. Director of Nursing resigned and notice accepted on 3/3/23. Interim Director of Nursing in place and Mobile Director of Nursing will start 3/6/23. Agency checklist will be reviewed and revised to include the admission process, order entry, change in condition and monitoring of blood sugars and notification of physician when out of parameters or above 300. This will be completed by clinical consultants by 3/7/23 (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A house wide audit of admission or readmission orders on current residents admitted or readmitted [DATE] to 3/2/23 will be conducted by Director of Nursing / designee to validate that orders were transcribed /entered into matrix as ordered from the discharge summary or hospital discharge orders. 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. Any concern identified will be addressed at the time of discovery including notification of physician for further direction. This will be completed by 3/7/23. 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 following expectations: This will be completed on 3/3/23 The admission policy including the requirement that orders are to be entered into matrix completely and accurately Abuse and Neglect Admission and readmission orders are to be transcribed/entered into Matrix from the discharge summary or hospital admission orders and verified by the physician Matrix physician order entry training will be done for accurate and complete order entry. Admission and readmission orders are to be validated by members of nursing management as part of the clinical meeting process and by charge nurse on the weekends including validation of accurate and complete entry into matrix When admitting a resident without nursing management or supervisor in the facility a second nurse will validate that orders on discharge summary/hospital admission / readmission orders have been entered into matrix completely and accurately and verified by a physician. If any concern the Mobile Director of Nursing or Interim Director of Nursing is to be notified for further direction. Licensed nurses, including agency nurses and new hires should appropriately identify, assess and document acute change in condition and notify the physician for further direction. (continued on next page)

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, ZIP CODE
Corinth Rehabilitation Suites on the Parkway	3511 Corinth Parkway Corinth, TX 76208

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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 showing signs of a change of condition should be assessed to appropriately identify and document the acute change in condition and notify the physician 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 policy Any blood glucose monitoring when nursing management not in facility will be reviewed by 2nd nurse and signed as validated that it is within range or out of ordered parameters or above 300 and that physician is notified. Notification of responsible party for acute change in condition Abuse Neglect and Misappropriation training (continued on next page)

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	676319	A. Building B. Wing	03/07/2023

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399 40316 Based on observation , interview, and record review, the facility failed to ensure each resident was free from neglect when the facility failed to provide care and services for treatment of diabetes for one resident (Resident #5) of 24 residents reviewed for neglect. Resident # 5 did not receive oral medications and insulin for treatment of diabetes from 01/27/23 to 02/28/23. 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 elevated blood sugars equal to or greater than 300 mg/dL on multiple occasions for Resident #5. 3) Their policy of notifying the physician for elevated blood sugars equal to or greater than 300 mg/dL for Resident #5. 4) Treatment was provided when Resident #5 showed signs and symptoms 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 #5 showed signs and symptoms of hyperglycemia (profuse sweating, flushed face, and clammy skin). Resident #5 was transferred to the hospital for elevated blood sugar on 2/28/23 at 6:14 PM. This failure could place residents of the facility at risk for neglect and could lead to serious injury, serious impairment, pain, mental anguish and death. 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)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. 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. Review of the care plan dated 2/20/23 revealed the following goal statement, Diabetic status will remain stable as evidenced by residents [blood sugar] staying within the resident's normal limits thru the next review date. Review of care plan revealed no statement as to the normal 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 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)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of TAR for Resident #5 indicated that on 2/09/23 at 4:00 PM LVN E documented a blood sugar of 332 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/09/23 revealed no documentation that the physician was notified of the elevated blood sugar of 332 mg/dL. 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. No medication was given for this high blood sugar. Review of the progress notes dated 2/10/23 revealed no documentation that the physician was notified of the elevated blood sugar of 335 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. No medication was given for this high blood sugar. Review of the progress notes dated 2/14/23 revealed no documentation that the physician was notified of the elevated blood sugar of 356 mg/dL. Review of TAR for Resident #5 indicated that on 2/17/23 at 4:00 PM LVN E documented a blood sugar of 397 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/17/23 revealed no documentation that the physician was notified of the elevated blood sugar of 397 mg/dL. Review of TAR for Resident #5 indicated that on 2/18/23 at 4:00 PM LVN E documented a blood sugar of 309 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/18/23 revealed no documentation that the physician was notified of the elevated blood sugar of 309 mg/dL. Review of TAR for Resident #5 indicated that on 2/20/23 at 4:00 PM LVN E documented a blood sugar of 377 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/20/23 revealed no documentation that the physician was notified of the elevated blood sugar of 377 mg/dL. Review of TAR for Resident #5 indicated that on 2/21/23 at 4:00 PM ADON documented a blood sugar of 400 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/21/23 revealed no documentation that the physician was notified of the elevated blood sugar of 400 mg/dL. Review of TAR for Resident #5 indicated that on 2/22/23 at 4:00 PM LVN E documented a blood sugar of 384 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/22/23 revealed no documentation that the physician was notified of the elevated blood sugar of 384 mg/dL. Review of TAR for Resident #5 indicated that on 2/23/23 at 4:00 PM LVN E documented a blood sugar of 400 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/23/23 revealed no documentation that the physician was notified of the elevated blood sugar of 400 mg/dL. (continued on next page)

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	676319	A. Building B. Wing	03/07/2023

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of TAR for Resident #5 indicated that on 2/24/23 at 7:00 AM LVN R documented a blood sugar of 306 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/24/23 revealed no documentation that the physician was notified of the elevated blood sugar of 306 mg/dL. Review of TAR for Resident #5 indicated that on 2/24/23 at 4:00 PM LVN E documented a blood sugar of 375 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/24/23 revealed no documentation that the physician was notified of the elevated blood sugar of 375 mg/dL. Review of TAR for Resident #5 indicated that on 2/25/23 at 7:00 AM RN Q documented a blood sugar of 304 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/25/23 revealed no documentation that the physician was notified of the elevated blood sugar of 304 mg/dL. Review of TAR for Resident #5 indicated that on 2/25/23 at 4:00 PM RN Q documented a blood sugar of 421 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/25/23 revealed no documentation that the physician was notified of the elevated blood sugar of 421 mg/dL. Review of TAR for Resident #5 indicated that on 2/26/23 at 4:00 PM LVN N documented a blood sugar of 406 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/26/23 revealed no documentation that the physician was notified of the elevated blood sugar of 406 mg/dL. Review of TAR for Resident #5 indicated that on 2/27/23 at 7:00 AM LVN R documented a blood sugar of 305 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/27/23 revealed no documentation that the physician was notified of the elevated blood sugar of 305mg/dL. Review of TAR for Resident #5 indicated that on 2/27/23 at 4:00 PM LVN E documented a blood sugar of 397 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/27/23 revealed no documentation that the physician was notified of the elevated blood sugar of 397 mg/dL. Review of TAR for Resident #5 indicated that on 2/28/23 at 7:00 AM LVN P documented a blood sugar of 477 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/28/23 revealed no documentation that the physician was notified of the elevated blood sugar of 477mg/dL. Review of nursing progress notes for the period of 1/27/23 through 2/27/23 revealed that none of the seven facility nurses who documented Resident #5's high blood sugar had reported these high blood sugars to MD T. Review of TAR for Resident #5 indicated that on 2/28/23 at 4:00 PM LVN E documented a blood sugar of 537 mg/dL. No medication was given for this high blood sugar. Review of progress notes dated 2/28/23 revealed the physician was not notified of the elevated blood sugar of 537 mg/dL. (continued on next page)

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	676319	A. Building B. Wing	03/07/2023

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of nursing progress note for Resident #5 dated 2/28/23 at 4:23 PM by LVN P read in part, blood sugar check this morning 477 . NP[AA] informed of blood sugar with new order for Lispro on [sliding scale] . At about 1pm this nurse noted individual having [signs and symptoms] of hyperglycemia . shaky . clammy . checked blood sugar which was 481 . Review of progress notes dated 2/28/23 revealed no documentation that the physician was notified of the elevated blood sugar of 477, nor any documentation that the physician was notified that Resident #5 was showing signs of hyperglycemia. Review of nursing progress note for Resident #5 dated 2/28/23 at 6:14 PM by LVN E read in part, Resident was sent to hospital as requested by both DON and [NP 5] . Review revealed the physician was not notified about the change in condition and transfer to the hospital. Interview with LVN R on 03/02/23 at 11:07 AM revealed Resident #5 was admitted to the hospital because she had a really high blood sugar. LVN R stated the resident was not receiving insulin. Interview revealed the facility just ordered insulin for Resident #5 on the morning of 02/28/23. LVN R stated she did not know why the resident wasn't on insulin. In an interview on 03/02/23 at 12:10 PM with MD T , the doctor said, I remember that [Resident #5's] Metformin (a diabetes pill) was discontinued in the hospital due to kidney failure. I know that I gave the order for Metformin and for Novolog Lispro sliding scale as well as accu-checks AC and HS on February 3, 2023 . I was under the impression that the orders I gave were put into the chart. In an interview on 03/02/23 at 12:31 PM with NP AA (MD T's nurse practitioner), NP AA denied knowledge of Resident #5's high blood sugars, The first I heard of [the high blood sugars] was the day [Resident #5] was admitted to the hospital. NP AA said that MD T usually reviewed the laboratory results and denied knowledge that Resident #5 had no orders in her chart for diabetic medication from 1/27/23 to 2/28/23. In an interview on 03/02/23 at 12:41 PM, LVN P said she first discovered Resident #5's high blood sugar: I found that [on 2/28/23] the blood sugar was 477, I notified the doctor who ordered 10 units of insulin per sliding scale. I gave [Resident #5] 10 units before lunch. She looked flushed so I checked her sugar again . I checked it, 397 . When I re-checked it and the machine just said 'high' . To me, she didn't have a sliding scale. I called the doctor because she was trending high. I was shocked that nobody else intervened when the blood sugar was high. I didn't see no sliding scale, so I reached out to the physician. When she looked flushed, cool and clammy, I stayed in contact with the doctors . the doctor was saying she's hospice and the hospice nurse was saying to contact the doctor . her blood sugars were fine until recently. In an interview on 03/02/23 at 01:01 PM LVN E denied reporting Resident #5's high blood sugars to Resident #5's physician, MD T. I didn't know I had to. I asked another nurse what I should do and she told me not to worry about it. Per nurse, she had graduated from nursing school 2 months ago. When asked if she learned how to monitor blood sugar in nursing school, nurse said yes. 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 said that the staff had been trained on neglect but was unable to say when the last training was. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 03/02/23 at 01:11 PM LVN O (the nurse who admitted Resident #5 from the hospital on 1/27/23) said he did not frequently work at the facility.I go once a month, once every 2 weeks. I haven't been there in three weeks. LVN O said he remembered admitting Resident #5, The DON asked me if I could do an admission and I said I would try . I tried to enter the order, but I was having trouble with the eMAR because I hadn't done an admission for a while. I passed on in report to [LVN BB] that I wasn't done with the admission yet and I needed help finishing the orders. I told [LVN BB] 'this is what I reviewed, and this is what I did. This is what needs to be done by the ADON and DON and can you please pass it on in the morning.' The patient came in at about 8pm. I stayed late to finish the admission to do as much as I could do. I passed it on in report assuming that the DON and ADON would finish the admission. They are supposed to review the chart to make sure everything is up to date and correct. In an interview on 03/02/23 at 01:22 PM the DON said, The nurses, the DON, and the ADON are responsible for ensuring orders on newly admitted residents are entered into the eMAR. The nurses, and ADON and the DON are supposed to review the discharge orders. Every morning, we review the charts to make sure everything is correct. The DON said that a blood sugar level of 200 would prompt her to contact the resident's physician but was unsure why she did not contact the physician, saying, I would have to check my notes. The DON said that the staff had been trained on neglect but was unable to say when the last training was. In an interview on 03/02/23 at 02:11 PM ADM said that the best practice when a resident is admitted is: Receiving nurse sees orders, clarifies orders with physician, and they go into effect. Best practice is during Interdisciplinary Team meeting and during care planning. The ADM said that the DON or ADON is responsible for making sure new orders are entered, and that nurses should contact the physician Upon recognizing that there has been a change of condition . When there is something that continues to be not normal, the nursing staff should report it to the physician . I recognize there are things that need to be addressed. The administrator said he was not sure when the staff had last been trained on neglect. In an interview on 03/04/23 at 02:14 PM with RN Q, the nurse said she had been working at the facility for 1 week. The nurse who was supposed to be training her (LVN N) just left me alone without any guidance. I'm supposed to be still on orientation training, and I don't know these people. RN Q was unable to recall what happened on 2/25/23, when she documented a blood sugar of 305 mg/dL. In an interview on 03/04/23 at 02:46 PM LVN N said she wasn't sure when to notify the physician of a resident's high blood sugar: I wasn't educated on that. I don't know if there's a policy. LVN N went on to say, I know that [a blood sugar of] 500 is dangerous . I know that 400 is of some concern, but we would monitor for signs and symptoms. LVN N denied contacting the physician on 2/26/23 when she documented a blood sugar level of 406 for Resident #5.I monitored for signs and symptoms. LVN N confirmed that there was no sliding scale in place for Resident #5, There was only an order for blood sugar checks BID. LVN N also said that she did not see any orders for diabetes medication on Resident #5's chart. LVN N said that if a diabetic resident didn't receive any orders for diabetes medication I would think that it would be life-threatening. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 03/04/23 at 3:00 PM MD T said that if a resident had high blood sugar, I would expect [the facility] to inform me if anyone has a high blood sugar. MD T said she wanted to be notified of any resident who had a blood sugar over 400, according to the sliding scale orders. MD T said she first became aware of Resident #5's high blood sugars and subsequent hospital admission, When the surveyor called me [on 3/02/23]. MD T said that she saw Resident #5 on approximately February 3 or 4,, 2023, I gave an order for Metformin around February 4th, when I saw her after she got back from the hospital. Her creatinine was normal, so I wrote the order for Metformin . I thought she was on sliding scale, because I think that she came back from the hospital on sliding scale. MD T denied checking the chart to see if Resident #5 had orders for diabetes medication. MD T said her next visit to Resident #5 was on February 10 or 11, I gave orders for Metformin then as well because I saw it wasn't entered in Resident #5's chart. MD T said she gave verbal orders for Metformin but couldn't remember which nurse she gave them to. The second time I specifically talked to the nurse and told her I didn't see the order for Metformin in the computer, so I was going to give another order. In an interview on 3/04/23 at 03:18 PM with Interim DON , she explained how she would know when to report high blood sugar to the resident's physician: I look at the parameters. I look at the Resident's orders. If they don't have an order, I would call the physician if the blood sugar was over 110 or below 70. When a resident gets admitted from the hospital, I look at the hospital orders and I call the doctor and make sure that they want to continue the orders. The Interim DON was unable to describe facility protocol for making sure physician orders are entered into the e-chart, Well that's in development. Sometimes the doctor enters the orders in the computer. Sometimes they give us written orders. Sometimes they give a verbal order. If a diabetic resident doesn't receive any medication for diabetes, There's a possibility they could go into diabetic ketoacidosis, which is a life-threatening condition. The Interim DON also said that a resident could develop pressure ulcers (bed sores) if the resident's blood sugar was not being medically managed. The Interim DON was able to explain what neglect was but was unsure when the nursing staff had last been trained on neglect. In an interview on 3/06/23 at 4:51 PM LVN BB explained what resident blood sugar levels would prompt her to call the resident's physician: It's between 400 and 450, whichever the sliding scale is. If the resident didn't have a sliding scale, I'd have to call the physician and get a sliding scale if one wasn't ordered. LVN BB stated that when the resident is admitted to the facility, the resident's nurse is responsible for making sure orders get entered into the computer. If a resident on her hall gets admitted right before her shift, LVN BB said, If it's my resident I make sure the orders are entered, because I want to make sure their medication is on the way before I leave . First, I gotta call the doctor to get everything reconciled, and then I gotta put the orders in. If the admission happens late at night, I have to call [the physician] and wake them up. LVN BB said that she had experienced difficulty contacting MD T: Well, she's a doctor but she hates being woken up. She will snap at you but if you gotta call you gotta call. If a resident with diabetes didn't get diabetes medication, Well, eventually they would die. Review of job descriptions for LVN, RN, DON, and ADON positions revealed that each required the nurse to report neglect to the appropriate authorities. Review of facility policy (dated 10/16/17) titled Physician and Other Communication/Change in Condition read in part, Glucose . Follow specific physician orders if present; or > 300mg/dL in diabetic patient not using sliding scale insulin; or >450 mg/dL (or machine registers high) in diabetic patient using sliding scale insulin . (continued on next page)

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, ZIP CODE
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility policy titled Abuse, Neglect, Exploitation or Mistreatment (dated 10/01/2020) revealed the following statement, Neglect is the failure to provide goods and services or treatment and care necessary to avoid physical harm, mental anguish, or mental illness. Review of facility's In-service Abuse and Neglect/Falls dated 01/31/23 by DON reflected staff were in-serviced on abuse and neglect. It reflected that LVN E, LVN I, LVN O, LVN P, LVN S, ADON, Wound Care Nurse M and RN U were all in-serviced on abuse/neglect policy. Review of facility policy (dated 10/16/17) titled Physician and Other Communication/Change in Condition read in part, Glucose . Follow specific physician orders if present; or > 300mg/dL in diabetic patient not using sliding scale insulin; or >450 mg/dL (or machine registers high) in diabetic patient using sliding scale insulin . Review revealed the physician was to be notified of blood sugars greater than 300 mg/dL in a diabetic resident not using insulin sliding scale and 450 mg/dL (or blood glucose monitoring registers high) in diabetic residents using an insulin sliding scale. An Immediate Jeopardy (IJ) situation was identified on 03/02/23 at 4:15 PM. The ADM was notified, and a POR was requested. The POR was accepted on 03/04/23 at 4pm. The accepted POR reflected the following : Resident #5 is not currently in the facility. The allegation of neglect has been reported to the state agency and is being thoroughly investigated. Appropriate actions will be taken as the investigation is conducted. The results of the investigation will be submitted to the state agency in 5 days. The administrator will be re-educated by the Regional [NAME] President of Operations or the Clinical Consultant on timely reporting and investigation of allegations of abuse and neglect. This will be completed on 3/4/23. Residents who are admitted or readmitted to the facility or have a change of condition or Diabetic have the potential to be affected by this alleged deficient practice. Director of Nursing resigned and notice accepted on 3/3/23. Interim Director of Nursing in place and Mobile Director of Nursing will start 3/6/23. Agency checklist will be reviewed and revised to include the admission process, order entry, change in condition and monitoring of blood sugars and notification of physician when out of parameters or above 300. This will be completed by clinical consultants by 3/7/23 A house wide audit of admission or readmission orders on current residents admitted or readmitted [DATE], to 3/2/23 will be conducted by Director of Nursing / designee to validate that orders were transcribed /entered into matrix as ordered from the discharge summary or hospital discharge orders. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. Any concern identified will be addressed at the time of discovery including notification of physician for further direction. This will be completed by 3/7/23. 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 following expectations: This will be completed on 3/3/23 The admission policy including the requirement that orders are to be entered into matrix completely and accurately Abuse and Neglect Admission and readmission orders are to be transcribed/entered into Matrix from the discharge summary or hospital admission orders and verified by the physician Matrix physician order entry training will be done for accurate and complete order entry. Admission and readmission orders are to be validated by members of nursing management as part of the clinical meeting process and by charge nurse on the weekends including validation of accurate and complete entry into matrix When admitting a resident without nursing management or supervisor in the facility a second nurse will validate that orders on discharge summary/hospital admission / readmission orders have been entered into matrix completely and accurately and verified by a physician. If any concern the Mobile Director of Nursing or Interim Director of Nursing is to be notified for further direction. Licensed nurses, including agency nurses and new hires should appropriately identify, assess and document acute change in condition and notify the physician for further direction. 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 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 showing signs of a change of condition should be assessed to appropriately identify and document the acute change in condition and notify the physician 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 policy. Any blood glucose monitoring when nursing management not in facility will be reviewed by 2nd nurse and signed as validated that it is within range or out of ordered parameters or above 300 and that physician is notified. Notification of responsible party for acute change in condition Abuse Neglect and Misappropriation training. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 working scheduled shift. This will also be presented in new hire orientation. Licensed Nurses including agency Nurses will not work until training completed. Agency nurse training will be tracked by the Mobile Director of Nursing or Interim Director of Nursing to validate that the agency nurse scheduled to work has had the training and education and if not, training and education will be arranged or completed by the Mobile Director of Nursing or Interim Director of Nursing. The next 6 shift changes a member of nursing management (Nurse Assessment Coordinator, RN Supervisor, Interim Director of Nursing, Mobile Director of Nursing, Assistant Director of Nurs [TRUNCATED]

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F 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399 40316 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. 1. The facility failed to reconcile hospital discharge orders for diabetes medication (insulin sliding scale) upon Resident #5's readmission to the facility from the hospital on 1/27/23. 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). 3. The facility failed to have physician orders for treatment of high blood sugar levels (greater than 300 mg/dL) on multiple occasions between 1/28/23-2/28/23 for Resident #5. 4. The facility failed to physician orders when Resident #5 showed signs and symptoms of hyperglycemia. This failure resulted in Resident #5 having no orders for diabetes medication, and no orders for the physician 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 (profuse sweating, 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 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 that is not immediate jeopardy because the facility was still monitoring the effectiveness of their Plan of Removal (POR). 5. The facility failed to ensure Resident #173 had admitting physician orders for wound care for her pressure ulcer when she was admitted on [DATE] from the hospital. These failures could place all 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: (continued on next page)

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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 normal 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 Lisper 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 physician orders 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. (Normal range is 70-110 mg/dL) Review of TAR for Resident #5 indicated that on 2/09/23 at 4:00 PM LVN E documented a blood sugar of 332 mg/dL. (Normal range is 70-110 mg/dL). 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 indicated that on 2/17/23 at 4:00 PM documented a blood sugar of 397 mg/dL. (Normal range is 70-110 mg/dL). Review of TAR for Resident #5 indicated that on 2/18/23 at 4:00 PM LVN E documented a blood sugar of 309 mg/dL. (Normal range is 70-110 mg/dL). (continued on next page)

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F 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of TAR for Resident #5 indicated that on 2/20/23 at 4:00 PM LVN E documented a blood sugar of 377 mg/dL. (Normal range is 70-110 mg/dL). Review of TAR for Resident #5 indicated that on 2/21/23 at 4:00 PM ADON documented a blood sugar of 400 mg/dL. (Normal range is 70-110 mg/dL). Review of TAR for Resident #5 indicated that on 2/22/23 at 4:00 PM LVN E documented a blood sugar of 384 mg/dL. (Normal range is 70-110 mg/dL). Review of TAR for Resident #5 indicated that on 2/23/23 at 4:00 PM LVN E documented a blood sugar of 400 mg/dL. (Normal range is 70-110 mg/dL). Review of TAR for Resident #5 indicated that on 2/24/23 at 7:00 AM LVN R documented a blood sugar of 306 mg/dL. (Normal range is 70-110 mg/dL). Review of TAR for Resident #5 indicated that on 2/24/23 at 4:00 PM LVN E documented a blood sugar of 375 mg/dL. (Normal range is 70-110 mg/dL). Review of TAR for Resident #5 indicated that on 2/25/23 at 7:00 AM RN Q documented a blood sugar of 304 mg/dL. (Normal range is 70-110 mg/dL). Review of TAR for Resident #5 indicated that on 2/25/23 at 4:00 PM RN Q documented a blood sugar of 421 mg/dL. (Normal range is 70-110 mg/dL). Review of TAR for Resident #5 indicated that on 2/26/23 at 4:00 PM LVN N documented a blood sugar of 406 mg/dL. (Normal range is 70-110 mg/dL). Review of TAR for Resident #5 indicated that on 2/27/23 at 7:00 AM LVN R documented a blood sugar of 305 mg/dL. (Normal range is 70-110 mg/dL). Review of TAR for Resident #5 indicated that on 2/27/23 at 4:00 PM LVN E documented a blood sugar of 397 mg/dL. (Normal range is 70-110 mg/dL). Review of TAR for Resident #5 indicated that on 2/28/23 at 7:00 AM LVN P documented a blood sugar of 477 mg/dL. (Normal range is 70-110 mg/dL). Review of TAR for Resident #5 indicated that on 2/28/23 at 4:00 PM LVN E documented a blood sugar of 537 mg/dL. (Normal range is 70-110 mg/dL). Review of nursing progress notes for the period of 1/27/23 through 2/27/23 revealed that none of the seven facility nurses, who documented Resident #5's high blood sugar, reported these high blood sugars to MD T. Review of nursing progress note for Resident #5 dated 2/28/23 at 4:23 PM by LVN P read in part, blood sugar check this morning 477 . [NP AA] informed of blood sugar with new order for Lispro on [sliding scale] . At about 1pm this nurse noted individual having [signs and symptoms] of hyperglycemia . shaky . clammy . checked blood sugar which was 481 . Review revealed the physician was not notified of the elevated blood sugar of 477. (continued on next page)

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F 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of nursing progress note for Resident #5 dated 2/28/23 at 6:14 PM by LVN E read in part, Resident was sent to hospital as requested by both DON and [NP 5] . Review revealed the physician was not notified about the change in condition. Interview with LVN R on 03/02/23 at 11:07 AM revealed Resident #5 was admitted to the hospital because she had a really high blood sugar. LVN R stated the resident was not receiving insulin. Interview revealed the facility just ordered insulin for Resident #5 on the morning of 02/28/23. LVN R stated she did not know why the resident was not on insulin. LVN R was unsure of the facility policy for admission orders and was not sure if she had been trained by administration on physician order entry. In an interview on 03/02/23 at 01:11 PM LVN O (the nurse who admitted Resident #5 from the hospital on 1/27/23) said he did not frequently work at the facility.I go once a month, once every 2 weeks. I haven't been there in three weeks. LVN O said he remembered admitting Resident #5, The DON asked me if I could do an admission and I said I would try . I tried to enter the order, but I was having trouble with the eMAR because I hadn't done an admission for a while. I passed on in report to [LVN BB] that I wasn't done with the admission yet and I needed help finishing the orders. I told [LVN BB] 'this is what I reviewed, and this is what I did. This is what needs to be done by the ADON and DON and can you please pass it on in the morning.' The patient came in at about 8pm. I stayed late to finish the admission to do as much as I could do. I passed it on in report assuming that the DON and ADON would finish the admission. They are supposed to review the chart to make sure everything is up to date and correct. LVN O said he hadn't received training from administration on physician order entry. In an interview on 03/02/23 at 12:10 PM with MD T, the doctor said, I remember that [Resident #5's] Metformin (a diabetes pill) was discontinued in the hospital due to kidney failure. I know that I gave the order for Metformin and for Novolog Lispro sliding scale as well as accu-checks AC and HS on February 3, 2023 . I was under the impression that the orders I gave were put into the chart. In an interview on 03/02/23 at 12:31 PM with NP AA (MD T's nurse practitioner), NP AA denied knowledge of Resident #5's high blood sugars, The first I heard of [the high blood sugars] was the day [Resident #5] was admitted to the hospital. NP AA said that MD 2 usually reviewed the laboratory results and denied knowledge that Resident #5 had no orders in her chart for diabetic medication from 1/27/23 to 2/28/23. In an interview on 03/02/23 at 12:41 PM, LVN P said she first discovered Resident #5's high blood sugar: I found that [on 2/28/23] the blood sugar was 477, I notified the doctor who ordered 10 units of insulin per sliding scale. I gave [Resident #5] 10 units before lunch. She looked flushed so I checked her sugar again . I checked it, 397 . When I re-checked it and the machine just said 'high' . To me, she didn't have a sliding scale. I called the doctor because she was trending high. I was shocked that nobody else intervened when the blood sugar was high. I didn't see no sliding scale, so I reached out to the physician. When she looked flushed, cool and clammy, I stayed in contact with the doctors . the doctor was saying she's hospice and the hospice nurse was saying to contact the doctor . her blood sugars were fine until recently. LVN P said she had not received training from administration on physician order entry. (continued on next page)

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F 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 03/02/23 at 01:01 PM, LVN E denied reporting Resident #5's high blood sugars to Resident #5's physician, MD 2. I didn't know I had to. I asked another nurse [LVN R] what I should do and she told me not to worry about it. Per nurse, she had graduated from nursing school 2 months ago. When asked if she learned how to monitor blood sugar in nursing school, nurse said yes. LVN E said she had not received training from administration on physician order entry. In an interview on 03/02/23 at 01:05 PM, the ADON denied reporting Resident #5's high blood sugars to MD T, saying, .depends on who the doctor is, what the parameters are . Each doctor has parameters that they follow . The ADON said she was not sure if staff had received training from administration on physician order entry. The ADON was unable to state what MD T's parameters were. The ADON chose not to answer the question, What would you consider a high blood sugar level? In an interview on 03/02/23 at 01:22 PM the DON said, The nurses, the DON, and the ADON are responsible for ensuring orders on newly admitted residents are entered into the eMAR. The nurses, and ADON and the DON are supposed to review the discharge orders. Every morning, we review the charts to make sure everything is correct. The DON said that a blood sugar level of 200 would prompt her to contact the resident's physician but was unsure why she did not contact the physician, saying, I would have to check my notes. The DON said she was not sure if staff had received training from administration on physician order entry. In an interview on 03/02/23 at 02:11 PM, the ADM said, Best practice? Receiving nurse sees orders, clarifies orders with physician, and they go into effect. Best practice is during Interdisciplinary Team meeting and during care planning. The ADM said that the DON or ADON is responsible for making sure new orders are entered, and that nurses should contact the physician upon recognizing that there has been a change of condition . When there is something that continues to be not normal, the nursing staff should report it to the physician . I recognize there are things that need to be addressed. ADM said he was not sure if staff had received training from administration on physician order entry. In an interview on 03/04/23 at 02:14 PM with RN Q, the nurse said she had been working at the facility for 1 week. The nurse who was supposed to be training her (LVN N) just left me alone without any guidance. I'm supposed to be still on orientation training, and I don't know these people. RN Q was unable to recall what happened on 2/25/23, when she documented a blood sugar of 305 mg/dL. RN Q said she had not received training from administration on physician order entry. In an interview on 03/04/23 at 02:46 PM, LVN N said she was not sure when to notify the physician of a resident's high blood sugar: I wasn't educated on that. I don't know if there's a policy. LVN N went on to say, I know that [a blood sugar of] 500 is dangerous . I know that 400 is of some concern, but we would monitor for signs and symptoms. LVN N denied contacting the physician on 2/26/23 when she documented a blood sugar level of 406 for Resident #5.I monitored for signs and symptoms. LVN N confirmed that there was no sliding scale in place for Resident #5, There was only an order for blood sugar checks BID. LVN N also said that she did not see any orders for diabetes medication on Resident #5's chart. LVN N said that if a diabetic resident did not receive any orders for diabetes medication I would think that it would be life-threatening. LVN N said she had not received training from administration on physician order entry. (continued on next page)

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, ZIP CODE
Corinth Rehabilitation Suites on the Parkway	3511 Corinth Parkway Corinth, TX 76208

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F 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 03/04/23 at 3:00 PM, MD T said that if a resident had high blood sugar, I would expect [the facility] to inform me if anyone has a high blood sugar. MD T said she wanted to be notified of any resident who had a blood sugar over 400, according to the sliding scale orders. MD T said she first became aware of Resident #5's high blood sugars and subsequent hospital admission, When the surveyor called me [on 3/02/23]. MD T said that she saw Resident #5 on approximately February 3 or 4,, 2023, I gave an order for Metformin around February 4th, when I saw her after she got back from the hospital. Her creatinine was normal, so I wrote the order for Metformin . I thought she was on sliding scale, because I think that she came back from the hospital on sliding scale. MD T denied checking the chart to see if Resident #5 had orders for diabetes medication. MD T said her next visit to Resident #5 was on February 10 or 11, I gave orders for Metformin then as well because I saw it wasn't entered in Resident #5's chart. MD T said she gave verbal orders for Metformin but couldn't remember which nurse she gave them to. The second time I specifically talked to the nurse and told her I didn't see the order for Metformin in the computer, so I was going to give another order. In an interview on 3/04/23 at 03:18 PM with the Interim DON, she explained how she would know when to report high blood sugar to the resident's physician: I look at the parameters. I look at the Resident's orders. If they don't have an order, I would call the physician if the blood sugar was over 110 or below 70. When a resident gets admitted from the hospital, I look at the hospital orders and I call the doctor and make sure that they want to continue the orders. The Interim DON was unable to describe facility protocol for making sure physician orders are entered into the e-chart, Well that's in development. Sometimes the doctor enters the orders in the computer. Sometimes they give us written orders. Sometimes they give a verbal order. If a diabetic resident does not receive any medication for diabetes, There's a possibility they could go into diabetic ketoacidosis, which is a life-threatening condition. The Interim DON also said that a resident could develop pressure ulcers (bed sores) if the resident's blood sugar was not being medically managed. Interim DON said she was not sure if staff had received training from administration on physician order entry. In an interview on 3/06/23 at 4:51 PM, LVN BB explained what resident blood sugar levels would prompt her to call the resident's physician: It's between 400 and 450, whichever the sliding scale is. If the resident didn't have a sliding scale, I'd have to call the physician and get a sliding scale if one wasn't ordered. LVN BB stated that when a resident is admitted to the facility, the resident's nurse is responsible for making sure orders get entered into the computer. If a resident on her hall got admitted right before her shift, LVN BB said, If it's my resident I make sure the orders are entered, because I want to make sure their medication is on the way before I leave . First, I gotta call the doctor to get everything reconciled, and then I gotta put the orders in. If the admission happened late at night, I have to call [the physician] and wake them up. LVN BB said that she had experienced difficulty contacting MD T: Well, she's a doctor but she hates being woken up. She will snap at you but if you gotta call you gotta call. If a resident with diabetes did not get diabetes medication, Well, eventually they would die. LVN BB said she hadn't received training from administration on physician order entry. Review of personnel files for nurses who cared for Resident #5 revealed that most of the nurses who had documented high blood sugar for Resident #5 (LVN R, LVN O, LVN N, LVN P, LVN E, RN Q, DON, and ADON) had no documented training in order reconciliation or entry of physician orders. Review of job descriptions for LVN, RN, DON, and ADON positions revealed that each required the nurse to enter physician orders. (continued on next page)

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F 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of facility In-service Admission Compliance dated 12/09/22 reflected LVN I, LVN P, LVN S, Wound Care Nurse M were in-serviced with a total of seven nurses that received this facility in-service. The in-service reflected under Admissions Instructions about a new resident to Alert the DON and physician that a pt [patient] is here and send med list to the physician. Physician may have changes to the med orders, or additional labs they want ordered, so be ready to make notes. 2. Input the med orders - if not done by 8 pm that day, meds will not arrive at midnight, and will be delayed until the next day . [patients] generally aren't too pleased about missed meds either Under medication orders it reflected about readmitted patients that prior physician orders have to be discontinued and would have medication list in admittance/hospital pack that needed to be confirmed with the attending physician. It reflected all medications must be entered into electronic record and included instructions on how to input orders into the electronic record. Review of facility in-service Train the trainer dated 12/12/22 by Regional Nurse reflected 2. All nurses must complete training prior to next scheduled shift including agency. 3. Instructed on Audit tools and Admission process and follow up. 4. ADONs will audit new admits within 24 hours Monday through Friday. Weekend Supervisor/Designees will audit Sat/Sunday. Management and Weekend will address concerns and provide education redirection of clinical if necessary. 5. ADON will validate using clinical meeting from M - F. Weekend Supervisor or Designee will validate using clinical meeting form assigned by DON. It reflected Staffing Coordinator (Previous ADON) and DON were in-serviced on 12/13/22. Review of facility In-service Admissions dated 12/12/22 by DON reflected Please follow the attached guidelines when new admission arrives. Assessment completed immediately All medication should be put in system before end of shift. Licensed Nurse will be re-educated on the admission process including the expectation that orders are to be transcribed and implemented as ordered. Licensed Nurse will utilize admission check list for guidance on completion and will have admission orders verified and validated by another nurse on the shift. This in-service reflected a sign-in sheet which included ADON, Wound Care Nurse M, LVN I, LVN P and LVN S. Review of facility's policy Physician Orders last revised 10/27/17 reflected The qualified licensed nurse will obtain and transcribe orders according to Facility Practice Guidelines .Admission: 1. The qualified licensed nurse reviews orders from the transfer record from an acute care hospital or other entity. 2. A call is placed to the physician to confirm the orders and request any additional orders as needed .3. Upon admission, the Facility has physician orders for the resident's immediate care to include but not limited to: A. Dietary orders B. Medications, if necessary C. Routine care orders to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an appropriate care plan. Under Telephone and Verbal section it reflected 2. Record the actual order received from the physician. Review of facility policy (dated 10/16/17) titled Physician and Other Communication/Change in Condition read in part, Glucose . Follow specific physician orders if present; or > 300mg/dL in diabetic patient not using sliding scale insulin; or >450 mg/dL (or machine registers high) in diabetic patient using sliding scale insulin . Review revealed the physician was to be notified of blood sugars greater than 300 mg/dL in a diabetic resident not using insulin sliding scale and 450 mg/dL (or blood glucose monitoring registers high) in diabetic residents using an insulin sliding scale. An Immediate Jeopardy (IJ) situation was identified on 03/02/23 at 4:15 PM. The ADM was notified, and a POR was requested . The POR was accepted on 03/04/23 at 4pm. (continued on next page)

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F 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The accepted POR for admission physician orders reflected the following: Resident #5 is not currently in the facility. Residents who are admitted or readmitted to the facility or have a change of condition or Diabetic have the potential to be affected by this alleged deficient practice. Director of Nursing resigned and notice accepted on 3/3/23. Interim Director of Nursing in place and Mobile Director of Nursing will start 3/6/23. Agency checklist will be reviewed and revised to include the admission process, order entry, change in condition and monitoring of blood sugars and notification of physician when out of parameters or above 300. This will be completed by clinical consultants by 3/7/23 A house wide audit of admission or readmission orders on current residents admitted or readmitted [DATE] to 3/2/23 will be conducted by Director of Nursing / designee to validate that orders were transcribed /entered into matrix as ordered from the discharge summary or hospital discharge orders. 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. Any concern identified will be addressed at the time of discovery including notification of physician for further direction. This will be completed by 3/7/23. 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 following expectations: This will be completed on 3/3/23 The admission policy including the requirement that orders are to be entered into matrix completely and accurately Abuse and Neglect Admission and readmission orders are to be transcribed/entered into Matrix from the discharge summary or hospital admission orders and verified by the physician (continued on next page)

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F 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Matrix physician order entry training will be done for accurate and complete order entry. Admission and readmission orders are to be validated by members of nursing management as part of the clinical meeting process and by charge nurse on the weekends including validation of accurate and complete entry into matrix When admitting a resident without nursing management or supervisor in the facility a second nurse will validate that orders on discharge summary/hospital admission / readmission orders have been entered into matrix completely and accurately and verified by a physician. If any concern the Mobile Director of Nursing or Interim Director of Nursing is to be notified for further direction. Licensed nurses, including agency nurses and new hires should appropriately identify, assess and document acute change in condition and notify the physician for further direction. 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 showing signs of a change of condition should be assessed to appropriately identify and document the acute change in condition and notify the physician for further direction (continued on next page)

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F 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 policy Any blood glucose monitoring when nursing management not in facility will be reviewed by 2nd nurse and signed as validated that it is within range or out of ordered parameters or above 300 and that physician is notified. Notification of responsible party for acute change in condition Abuse Neglect and Misappropriation training 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 working scheduled shift. This will also be presented in new hire orientation. Licensed Nurses including agency Nurses will not work until training completed. Agency nurse training will be tracked by the Mobile Director of Nursing or Interim Director of Nursing to validate that the agency nurse scheduled to work has had the training and education and if not, training and education will be arranged or completed by the Mobile Director of Nursing or Interim Director of Nursing The next 6 shift changes a member of nursing management (Nurse Assessment Coordinator, RN Supervisor, Interim Director of Nursing, Mobile Director of Nursing, Assistant Director of Nursing) will attend shift to shift report to validate that any resident that has had a change of condition has been assessed appropriately, physician notified and orders implemented promptly. Blood sugars ordered and monitored during the shift will be reviewed to validate that 2nd nurse validated that results were within parameters or below 300 or physician notified if out of parameters or above 300. This will begin on 3/3/23 at 11PM and end on Sunday 3/5/23 3pm shift. After this will be done as monitoring in clinical morning meeting and on weekends by charge nurse. The Director of Nursing/Designee and/or Manager on Duty will review the 24-hour report and the facility activity report to identify any documentation regarding a change of condition and validate that the resident has been assessed appropriately, physician notified, RP/Family notified and orders implemented promptly. This includes signs and symptoms of hyper and hypoglycemia. This will be completed Monday -Friday in the Clinical Meeting and Charge Nurse on weekends. When a change of condition is identified the medical record will be reviewed by the clinical management team for any [NAME] [TRUNCATED]

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	676319	A. Building B. Wing	03/07/2023

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for two (Residents #31 and Resident # 52) of eighteen residents reviewed for comprehensive care plans. 1. The facility failed to care plan Resident #31's contractures to her right and left shoulders with interventions required to prevent further decline. 2. The facility failed to care plan Resident #52's contractures to his right hand with interventions required to prevent further decline. These failures could place residents at risk for possible adverse side effects, adverse consequences, and decreased quality of life and care and worsening of contractures. Findings include: 1. Record review of Resident #31's Quarterly MDS assessment dated [DATE], reflected a [AGE] year-old female with an admitted [DATE]. Resident #31 was severely cognitively impaired and unable to complete the interview for mental status. Resident #31 had functional limitation in Range of Motion on both sides in her upper and lower extremities. She was totally dependent of one-to-two-person assistance with all ADLs and was always 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). Record review of Resident #31's care plan revised on 02/28/23 did not address the residents' contractures or any interventions to help prevent further decline. Record review of Occupational Therapy Evaluation and Plan of treatment dated 02/27/23 reflected, .Reason for Skilled Services: Patient required skilled OT services to facilitate tone in upper extremity in order to enhance patients' quality of life .Upper extremity muscle tone- Rigid .Fine Motor Coordination -impaired . Gross Motor Coordination- Impaired . Start of care 02/27/23. An observation on 03/01/23 at 10:00 a.m. revealed CNA B and NA C providing incontinence care to Resident #31. Resident was observed with a pillow under her left arm, and her right hand was observed to be drawn up in a fist. During care, the staff were unable to raise the resident's right arm and she had limited ROM on her left side. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Resident #31's responsible party on 02/28/23 at 11:25 a.m. she stated they had a care conference last week and had requested therapy due to the residents declining range of motion. She stated she had requested they keep a pillow under her left arm so she can maintain some mobility in that shoulder. She stated Resident #31 kept her right hand clutched but could still open it. She stated the Resident had never had a splint for her right hand but thought that was a good idea. She stated she had to post signs above the Resident's bed to make sure they kept a pillow under her arm but stated that still did not always help. In an interview with CNA B on 03/01/23 at 10:05 a.m. she stated Resident #31's responsible party requested they always kept a pillow under her left arm. She stated the resident was very stiff and unable to move her right shoulder. She stated she was not aware of any thing they were supposed to be doing for her right hand. In an interview on 03/01/23 at 1:35 p.m. with OT K, she stated she picked up Resident #31 on services 02/27/23. She stated the resident did not have a contracture to her right shoulder and very limited ROM to her left shoulder. She stated the Responsible party requested they keep a pillow under her left arm. She stated the resident was able to extend her right hand, but stated they needed to educate the staff to lay her hand flat on her stomach to keep her from drawing it up in a fist. She stated she would evaluate her for a resting splint but stated she would be concerned with skin breakdown. In an interview with the DOR on 03/01/23 at 1:40 p.m., she stated they met with nursing and updated them on any residents they placed on therapy. She stated interventions for the staff to follow to prevent further contractures or improve mobility, should have been placed on the care plan to be able to maintain what progress is made with therapy. She stated they needed to do a better job in communicating those interventions with the staff. 2. Record review of Resident #52's Quarterly MDS assessment dated [DATE], reflected a [AGE] year-old male with an admitted [DATE]. Resident #52 was severely cognitively impaired and unable to complete the interview for mental status. Resident #52 had functional limitation in Range of Motion on both sides in his upper and lower extremities. He was totally dependent of one-to-two-person assistance with all ADLs and was always incontinent of bowel and bladder. His diagnoses included aphasia (disorder that affects communication), cerebral vascular accident (stroke) hemiparesis (paralysis of one side), seizure disorder and schizoaffective disorders (mood disorder). Resident had not received any Range of motion, passive or active, or splint or brace in the last 7 days of the look back period. Record review of Resident #52's care plan revised on 01/13/23 did not address the residents' contractures to his right hand or any interventions that had been put into place to help prevent further decline. Record review of the OT Discharge Summary dated 06/21/21 reflected, Patient will safely wear a resting hand splint on right hand for up to > 8 hours with minimal s/s of redness, swelling, discomfort or pain (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 03/01/23 at 9:15 a.m. revealed Hospice Aide L providing ADL care and dressing Resident #52 for the day. Resident's Responsible Party was present in the room. Observed Resident #52's right hand was contracted. Resident's Responsible Party stated he used to wear a hand splint but stated he had not been able to wear if for some time due to his decline and increased behaviors. She stated his hand often smells and stated she wished they would try and keep in clean. Hospice aide L attempted to place a washcloth in his hand, but resident resisted. In an interview with LVN I on 03/01/23 at 1:15 p.m., she stated they attempted to do exercise on Resident #52's hand but stated his behaviors limited their ability to do very much. She stated the staff should be trying to place a washcloth in his hand to help keep it dry and prevent skin breakdown. She stated they were not doing any type of exercises with Resident #31 that she was aware of. She stated contractures were supposed to be care planned and any interventions the staff were to provide. She stated she was not aware of interventions, other than placing a pillow under Resident #31'a left arm. In an interview with MDS D on 03/01/23 at 1:15 p.m., she stated she was responsible for updating the comprehensive care plan. She stated she and the Director of Rehab did quality of life rounds every quarter. She stated the contracture on Resident #31 and Resident #52 should have been care planned and they should document what prevention had been put into place. She stated the care plan should reflect when a resident's intervention were no longer effective or if they had refused. She stated the care plan was supposed to be a comprehensive approach to what the needs of the resident were or what their wished were. An interview with the DON on 03/01/23 at 2:00 p.m. revealed the MDS Coordinator was responsible for updating the care plan. She stated all contractures should have been care planned with interventions in place. She stated if a resident had splinting ordered, it should be placed on the physician's orders. The DON stated if a resident refused the required splint, then it should be documented on the care plan. She stated failing to have interventions in place, put residents at risk of further decline and decreased range of motion and by not updating the care plan, they had no evidence of what attempts had been made to prevent a resident's decline. Review of the facility's policy titled Person Centered Care Plan Process, dated October 2017, reflected, The facility will develop and implement a baseline and comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care .develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's [NAME], nursing, and mental and psychosocial needs that are identified in the comprehensive assessment .The Interdisciplinary Team will review for effectiveness and revise the care plan after each assessment .Thru ongoing assessment, the facility will initiate care plans when the resident's clinical status or change of condition dictates the need .The person centered care plan will include .Problem .Interventions, discipline specific services, and frequency . Refusal of services and/pr treatments .Attempts to find alternative means to address the identified risk/need .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 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 to 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 intact. His active diagnoses included quadriplegia (paralysis of all four limbs). He was totally dependent for bathing 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, odor 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 Point of Care history report for February 2023 reflected he had not received 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, 02/23/23, 02/25/23, and 02/27/23. Review of Resident #64's CNA Shower Review sheet reflected Resident #65 was provided a shower on 02/07/22, a bed bath on 02/12/23, shower on 02/16/23 and 02/20/23, 02/22/23. There were no shower 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. (continued on next page)

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	676319	A. Building B. Wing	03/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corinth Rehabilitation Suites on the Parkway	3511 Corinth Parkway Corinth, TX 76208

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a follow up interview with Resident #64 on 03/02/23 at 8:30 a.m., he stated it had been an ongoing issue with him getting his showers. He stated he would occasionally get a bed bath, but stated he wanted to go to the shower. He stated they used to have a shower aide, but since the first of the year they had done away with the shower aide. He stated they usually have a lot of agency staff on the weekend. He stated he was not even aware he was supposed to be getting a shower on Saturdays. 2. Record review of Resident #65's Quarterly MDS assessment, dated 01/17/23, reflected an [AGE] year-old male admitted to the facility on [DATE]. He had a BIMSs of 8 which indicated he was moderately cognitively impaired. His active diagnoses included cerebrovascular accident (stroke) hemiplegia right side (paralysis on one side) and dementia. He was totally dependent for bathing and required extensive one person assistance of personal hygiene, dressing, toilet use and transfers. He was frequently incontinent of bladder and always incontinent of bowel. Resident #65 did not have a history of refusal of care. Record review of Resident #65's care plan, with a revision date of 01/18/23 , reflected, . [Resident #65] is at risk for pressure ulcers R/T decreased mobility, wakens, incontinence .Goal .Resident's skin will remain intact .Approach .Keep clean and dry as possible. Minimize skin exposure to moisture .Keep linens clean, dry and wrinkle free . Record review of the undated shower schedule for hall 200 reflected Resident #65 was scheduled for a shower on Mondays, Wednesday's, and Fridays on the 2 p.m. to 10 p.m. shift. Record review of Resident #65's Point of Care history report for February 2023 reflected no showers on scheduled days for 02/01/23, 02/08/23, and 02/15/23. Review of Resident #65's CNA Shower Review sheet reflected Resident #65 was provided a shower on 02/03/22, 02/10/23, 02/13/23, 02/17/23, 02/20/23, 02/22/23 and 02/24/23. There were no shower sheets for 02/01/23, 02/08/23, 02/15/23, and 02/27/23 which indicated why the shower was not provided. An observation of Resident #65 on 03/01/23 at 11:25 a.m. resident appeared clean shaven with no apparent body odor. In an interview with Resident #65 on 03/01/23 at 11:30 a.m., he stated he was only getting a shower once a week. In a follow up interview with Resident #65 on 03/02/23 at 08:35 a.m., he stated he had been shaved yesterday (03/01/23) but had not received a shower at all this week. Resident #65 stated he wanted his showers and to be shaved on his shower days. In an interview with CNA G on 03/02/23 at 8:45 a.m., she stated she had been working at the facility for about a month. She stated the showers were divided between the 6:00 a.m. to 2:00 p.m. shift and the 2:00 p. m. to 10:00 p.m. shift. She stated there is a scheduled posted in front of the shower book. She stated they were supposed to complete a shower sheet on all their scheduled showers and turn it into the charge nurse. She stated if they missed giving a shower, they were supposed to report it to the charge nurse. She stated there had been a problem with the 2:00 p.m. to 10:00 p.m. shift giving their showers and stated the DON was aware of the problem. (continued on next page)

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	676319	A. Building B. Wing	03/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corinth Rehabilitation Suites on the Parkway	3511 Corinth Parkway Corinth, TX 76208

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 Agency 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. In an interview with the ADON on 03/02/23 at 9:40 a.m., she stated she had only been in this position for a short time. She stated she was aware there had been issues with resident's getting their showers on the 2:00 to 10:00 p.m. shift. She stated they had in serviced the staff on the use of the shower sheets and the expectation of the Charge Nurses to review those shower sheets. She stated the biggest challenge they had were getting the Charge Nurses to act like Charge Nurses. She stated the Charge Nurse for the 200 hall on 2:00 to 10:00 p.m. was a brand new nurse and stated she was not sure if she was holding the CNAs accountable. She stated she had not been able to follow up with the residents to see if things had improved, because she was working as a floor nurse frequently. In an interview with the DON on 03/02/23 at 10:00 a.m., she stated there had been an issue with residents not getting their showers, so they implemented the shower sheets. She stated the Charge Nurses were supposed to check the shower sheets and make sure all the residents had received their showers if they wanted one. She stated the nurses were supposed to text her at the end of their shifts that all showers had been completed. She stated she was not aware Resident #65 and Resident #64 were still not receiving their showers as scheduled. She stated it was her expectation that all residents received their showers as scheduled or when they preferred them. She stated it was not acceptable for residents to go without their showers and this could cause a loss of dignity and overall cleanliness. (continued on next page)

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Corinth Rehabilitation Suites on the Parkway	3511 Corinth Parkway Corinth, TX 76208

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with LVN E on 03/02/23 at 10:13 p.m., she stated she worked at the facility since January 2023. She stated she was the Charge Nurse for the 200 hall on the 2:00 to 10:00 p.m. shift Monday through Friday. She stated the CNAs brought her their shower sheets at the end of the shift. When asked how she ensured all the scheduled showers were provided, she stated she trusted her CNAs to give their scheduled showers. She stated she had not asked the residents if they had gotten their showers or not. She stated she was surprised Resident #64 had not told her he was not getting his shower. She stated she had no idea he was not being showered. She stated she had been texting the DON at the end of shift that all the showers had been completed. In an interview with Agency CNA J on 03/06/23 at 12:27 p.m. she stated she had worked at the facility on the weekend of 02/25/23 and 02/26/23. She stated she did not provide any showers on either of those days. She stated she had not seen a shower schedule. She stated she did not ask the Charge nurse about a shower schedule and stated she did not complete any shower sheets. She stated she did provide a few bed baths to some of the residents but stated she could not recall who they were. Record review of the Inservice titled Shower schedules, dated 01/04/23, reflected, .Shower sheets need to be turned in. No shower sheet means no shower and will result in disciplinary action .NO bed baths unless the nurse say resident is an unsafe transfer : Review of the facility's policy titled, Activities of Daily Living , Optimal Function, dated August 2017, reflected, .The Facility provides necessary care to all residents that are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition, grooming and hygiene .Facility staff develop and implement interventions in accordance with the resident's assess needs, goals for care, preferences and recognized standards of practice that address the identified limitations in ability to perform ADLs .Facility staff monitors and evaluates the resident's response to care plan interventions and treatments .

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	676319	A. Building B. Wing	03/07/2023

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40316 Based on observations, interviews and record review, the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice and the resident's comprehensive person-centered care plan for one (Resident #5) of 24 residents reviewed for quality of care. 1. 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). 2. The facility failed to notify the physician of high blood sugar levels (greater than 300 mg/dL) on multiple occasions between 1/28/23-2/28/23 for Resident #5. 3. The facility failed to notify the physician when Resident #5 showed signs 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 policy of physician notification of elevated blood sugars great than 300 mg/dL. 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 #5 showed signs and symptoms of hyperglycemia (profuse sweating, 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. 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). This failure could place all 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 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. (continued on next page)

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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 normal 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] 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)

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	676319	A. Building B. Wing	03/07/2023

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of TAR for Resident #5 indicated that on 2/09/23 at 4:00 PM LVN E documented a blood sugar of 332 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/09/23 revealed no documentation that the physician was notified of the elevated blood sugar of 332 mg/dL. 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. No medication was given for this high blood sugar. Review of the progress notes dated 2/10/23 revealed no documentation that the physician was notified of the elevated blood sugar of 335 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. No medication was given for this high blood sugar. Review of the progress notes dated 2/14/23 revealed no documentation that the physician was notified of the elevated blood sugar of 356 mg/dL. Review of TAR for Resident #5 indicated that on 2/17/23 at 4:00 PM LVN E documented a blood sugar of 397 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/17/23 revealed no documentation that the physician was notified of the elevated blood sugar of 397 mg/dL. Review of TAR for Resident #5 indicated that on 2/18/23 at 4:00 PM LVN E documented a blood sugar of 309 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/18/23 revealed no documentation that the physician was notified of the elevated blood sugar of 309 mg/dL. Review of TAR for Resident #5 indicated that on 2/20/23 at 4:00 PM LVN E documented a blood sugar of 377 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/20/23 revealed no documentation that the physician was notified of the elevated blood sugar of 377 mg/dL. Review of TAR for Resident #5 indicated that on 2/21/23 at 4:00 PM ADON documented a blood sugar of 400 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/21/23 revealed no documentation that the physician was notified of the elevated blood sugar of 400 mg/dL. Review of TAR for Resident #5 indicated that on 2/22/23 at 4:00 PM LVN E documented a blood sugar of 384 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/22/23 revealed no documentation that the physician was notified of the elevated blood sugar of 384 mg/dL. Review of TAR for Resident #5 indicated that on 2/23/23 at 4:00 PM LVN E documented a blood sugar of 400 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/23/23 revealed no documentation that the physician was notified of the elevated blood sugar of 400 mg/dL. (continued on next page)

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	676319	A. Building B. Wing	03/07/2023

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Corinth Rehabilitation Suites on the Parkway	3511 Corinth Parkway Corinth, TX 76208

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of TAR for Resident #5 indicated that on 2/24/23 at 7:00 AM LVN R documented a blood sugar of 306 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/24/23 revealed no documentation that the physician was notified of the elevated blood sugar of 306 mg/dL. Review of TAR for Resident #5 indicated that on 2/24/23 at 4:00 PM LVN E documented a blood sugar of 375 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/24/23 revealed no documentation that the physician was notified of the elevated blood sugar of 375 mg/dL. Review of TAR for Resident #5 indicated that on 2/25/23 at 7:00 AM RN Q documented a blood sugar of 304 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/25/23 revealed no documentation that the physician was notified of the elevated blood sugar of 304 mg/dL. Review of TAR for Resident #5 indicated that on 2/25/23 at 4:00 PM RN Q documented a blood sugar of 421 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/25/23 revealed no documentation that the physician was notified of the elevated blood sugar of 421 mg/dL. Review of TAR for Resident #5 indicated that on 2/26/23 at 4:00 PM LVN N documented a blood sugar of 406 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/26/23 revealed no documentation that the physician was notified of the elevated blood sugar of 406 mg/dL. Review of TAR for Resident #5 indicated that on 2/27/23 at 7:00 AM LVN R documented a blood sugar of 305 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/27/23 revealed no documentation that the physician was notified of the elevated blood sugar of 305 mg/dL. Review of TAR for Resident #5 indicated that on 2/27/23 at 4:00 PM LVN E documented a blood sugar of 397 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/27/23 revealed no documentation that the physician was notified of the elevated blood sugar of 397 mg/dL. Review of TAR for Resident #5 indicated that on 2/28/23 at 7:00 AM LVN P documented a blood sugar of 477 mg/dL. No medication was given for this high blood sugar. Review of the progress notes dated 2/28/23 revealed no documentation that the physician was notified of the elevated blood sugar of 477 mg/dL. Review of nursing progress notes for the period of 1/27/23 through 2/27/23 revealed that none of the seven facility nurses who documented Resident #5's high blood sugar had reported these high blood sugars to MD T. Review of TAR for Resident #5 indicated that on 2/28/23 at 4:00 PM LVN E documented a blood sugar of 537 mg/dL. No medication was given for this high blood sugar. Review of progress notes dated 2/28/23 revealed the physician was not notified of the elevated blood sugar of 537 mg/dL. (continued on next page)

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	676319	A. Building B. Wing	03/07/2023

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of nursing progress note for Resident #5 dated 2/28/23 at 4:23 PM by LVN P read in part, blood sugar check this morning 477 . NP[AA] informed of blood sugar with new order for Lispro on [sliding scale] . At about 1pm this nurse noted individual having [signs and symptoms] of hyperglycemia . shaky . clammy . checked blood sugar which was 481 . Review of progress notes dated 2/28/23 revealed no documentation that the physician was notified of the elevated blood sugar of 477, nor any documentation that the physician was notified that Resident #5 was showing signs of hyperglycemia. Review of nursing progress note for Resident #5 dated 2/28/23 at 6:14 PM by LVN E read in part, Resident was sent to hospital as requested by both DON and [NP AA] . Review revealed the physician was not notified about the change in condition and transfer to the hospital. Interview with LVN R on 03/02/23 at 11:07 AM revealed Resident #5 was admitted to the hospital because she had a really high blood sugar. LVN R stated the resident was not receiving insulin. Interview revealed the facility just ordered insulin for Resident #5 on the morning of 02/28/23. LVN R stated she did not know why the resident wasn't on insulin. LVN R stated she didn't know the facility policy on notifying the MD for elevated blood sugars. In an interview on 03/02/23 at 12:10 PM with MD T, the doctor said, I remember that [Resident #5's] Metformin (a diabetes pill) was discontinued in the hospital due to kidney failure. I know that I gave the order for Metformin and for Novolog Lispro sliding scale as well as accu-checks AC and HS on February 3, 2023 . I was under the impression that the orders I gave were put into the chart. In an interview on 03/02/23 at 12:31 PM with NP AA (MD T's nurse practitioner), NP AA denied knowledge of Resident #5's high blood sugars, The first I heard of [the high blood sugars] was the day [Resident #5] was admitted to the hospital. NP AA said that MD T usually reviewed the laboratory results and denied knowledge that Resident #5 had no orders in her chart for diabetic medication from 1/27/23 to 2/28/23. In an interview on 03/02/23 at 12:41 PM, LVN P said she first discovered Resident #5's high blood sugar: I found that [on 2/28/23] the blood sugar was 477, I notified the doctor who ordered 10 units of insulin per sliding scale. I gave [Resident #5] 10 units before lunch. She looked flushed so I checked her sugar again . I checked it, 397 . When I re-checked it and the machine just said 'high' . To me, she didn't have a sliding scale. I called the doctor because she was trending high. I was shocked that nobody else intervened when the blood sugar was high. I didn't see no sliding scale, so I reached out to the physician. When she looked flushed, cool and clammy, I stayed in contact with the doctors . the doctor was saying she's hospice and the hospice nurse was saying to contact the doctor . her blood sugars were fine until recently. LVN P stated she didn't know the facility policy on notifying the MD for elevated blood sugars. In an interview on 03/02/23 at 01:01 PM LVN E denied reporting Resident #5's high blood sugars to Resident #5's physician, MD T. I didn't know I had to. I asked another nurse what I should do and she told me not to worry about it. Per nurse, she had graduated from nursing school 2 months ago. When asked if she learned how to monitor blood sugar in nursing school, nurse said yes. LVN E stated she didn't know the facility policy on notifying the MD for elevated blood sugars. (continued on next page)

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, ZIP CODE
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. In an interview on 03/02/23 at 01:11 PM LVN O (the nurse who admitted Resident #5 from the hospital on 1/27/23) said he did not frequently work at the facility.I go once a month, once every 2 weeks. I haven't been there in three weeks. LVN O said he remembered admitting Resident #5, The DON asked me if I could do an admission and I said I would try . I tried to enter the order, but I was having trouble with the eMAR because I hadn't done an admission for a while. I passed on in report to [LVN 7] that I wasn't done with the admission yet and I needed help finishing the orders. I told [LVN 7] 'this is what I reviewed, and this is what I did. This is what needs to be done by the ADON and DON and can you please pass it on in the morning.' The patient came in at about 8pm. I stayed late to finish the admission to do as much as I could do. I passed it on in report assuming that the DON and ADON would finish the admission. They are supposed to review the chart to make sure everything is up to date and correct. LVN O stated he didn't know the facility policy on notifying the MD for elevated blood sugars. In an interview on 03/02/23 at 01:22 PM the DON said, The nurses, the DON, and the ADON are responsible for ensuring orders on newly admitted residents are entered into the eMAR. The nurses, and ADON and the DON are supposed to review the discharge orders. Every morning, we review the charts to make sure everything is correct. The DON said that a blood sugar level of 200 would prompt her to contact the resident's physician but was unsure why she did not contact the physician, saying, I would have to check my notes. DON stated she didn't know the facility policy on notifying the MD for elevated blood sugars. In an interview on 03/02/23 at 02:11 PM ADM said that the best practice when a resident is admitted is: Receiving nurse sees orders, clarifies orders with physician, and they go into effect. Best practice is during Interdisciplinary Team meeting and during care planning. The ADM said that the DON or ADON is responsible for making sure new orders are entered, and that nurses should contact the physician Upon recognizing that there has been a change of condition . When there is something that continues to be not normal, the nursing staff should report it to the physician . I recognize there are things that need to be addressed. ADM stated he didn't know the facility policy on notifying the MD for elevated blood sugars. In an interview on 03/04/23 at 02:14 PM with RN Q, the nurse said she had been working at the facility for 1 week. The nurse who was supposed to be training her (LVN N) just left me alone without any guidance. I'm supposed to be still on orientation training, and I don't know these people. RN Q was unable to recall what happened on 2/25/23, when she documented a blood sugar of 305 mg/dL. RN Q stated she didn't know the facility policy on notifying the MD for elevated blood sugars. (continued on next page)

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	676319	A. Building B. Wing	03/07/2023

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 03/04/23 at 02:46 PM LVN N said she wasn't sure when to notify the physician of a resident's high blood sugar: I wasn't educated on that. I don't know if there's a policy. LVN N went on to say, I know that [a blood sugar of] 500 is dangerous . I know that 400 is of some concern, but we would monitor for signs and symptoms. LVN N denied contacting the physician on 2/26/23 when she documented a blood sugar level of 406 for Resident #5.I monitored for signs and symptoms. LVN N confirmed that there was no sliding scale in place for Resident #5, There was only an order for blood sugar checks BID. LVN N also said that she did not see any orders for diabetes medication on Resident #5's chart. LVN N said that if a diabetic resident didn't receive any orders for diabetes medication I would think that it would be life-threatening. LVN N stated she didn't know the facility policy on notifying the MD for elevated blood sugars. In an interview on 03/04/23 at 3:00 PM MD T said that if a resident had high blood sugar, I would expect [the facility] to inform me if anyone has a high blood sugar. MD T said she wanted to be notified of any resident who had a blood sugar over 400, according to the sliding scale orders. MD T said she first became aware of Resident #5's high blood sugars and subsequent hospital admission, When the surveyor called me [on 3/02/23]. MD T said that she saw Resident #5 on approximately February 3 or 4,, 2023, I gave an order for Metformin around February 4th, when I saw her after she got back from the hospital. Her creatinine was normal, so I wrote the order for Metformin . I thought she was on sliding scale, because I think that she came back from the hospital on sliding scale. MD T denied checking the chart to see if Resident #5 had orders for diabetes medication. MD T said her next visit to Resident #5 was on February 10 or 11, I gave orders for Metformin then as well because I saw it wasn't entered in Resident #5's chart. MD T said she gave verbal orders for Metformin but couldn't remember which nurse she gave them to. The second time I specifically talked to the nurse and told her I didn't see the order for Metformin in the computer, so I was going to give another order. In an interview on 3/04/23 at 03:18 PM with Interim DON, she explained how she would know when to report high blood sugar to the resident's physician: I look at the parameters. I look at the Resident's orders. If they don't have an order, I would call the physician if the blood sugar was over 110 or below 70. When a resident gets admitted from the hospital, I look at the hospital orders and I call the doctor and make sure that they want to continue the orders. The Interim DON was unable to describe facility protocol for making sure physician orders are entered into the e-chart, Well that's in development. Sometimes the doctor enters the orders in the computer. Sometimes they give us written orders. Sometimes they give a verbal order. If a diabetic resident doesn't receive any medication for diabetes, There's a possibility they could go into diabetic ketoacidosis, which is a life-threatening condition. The Interim DON also said that a resident could develop pressure ulcers (bed sores) if the resident's blood sugar was not being medically managed. Interim DON stated she didn't know the facility policy on notifying the MD for elevated blood sugars. (continued on next page)

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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 PM LVN BB explained what resident blood sugar levels would prompt her to call the resident's physician: It's between 400 and 450, whichever the sliding scale is. If the resident didn't have a sliding scale, I'd have to call the physician and get a sliding scale if one wasn't ordered. LVN BB stated that when the resident is admitted to the facility, the resident's nurse is responsible for making sure orders get entered into the computer. If a resident on her hall gets admitted right before her shift, LVN BB said, If it's my resident I make sure the orders are entered, because I want to make sure their medication is on the way before I leave . First, I gotta call the doctor to get everything reconciled, and then I gotta put the orders in. If the admission happens late at night, I have to call [the physician] and wake them up. LVN BB said that she had experienced difficulty contacting MD T: Well, she's a doctor but she hates being woken up. She will snap at you but if you gotta call you gotta call. If a resident with diabetes didn't get diabetes medication, Well, eventually they would die. LVN BB stated she didn't know the facility policy on notifying the MD for elevated blood sugars. Review of personnel files for nurses who cared for Resident #5 revealed that most of the nurses who had documented high blood sugar for Resident #5 (LVN R, LVN O, LVN N, LVN P, LVN E, RN Q, DON, and ADON) had no documented training in either checking blood glucose or reporting change in condition to the physician. The personnel files of 2 nurses (Wound Care Nurse M and LVN BB) contained a skills check off form regarding checking blood glucose, but the form was not signed by either nurse. One nurse's personnel file (LVN CC) had skills check off forms for checking blood glucose and reporting a change in condition to the physician. Review of job descriptions for LVN, RN, DON, and ADON positions revealed that each required the nurse to report a resident's change in condition to the resident's physician. Review of facility In-service Admission Compliance dated 12/09/22 reflected LVN I, LVN P, LVN S, Wound Care Nurse M were in-serviced with a total of seven nurses that received this facility in-service. The in-service reflected under Admissions Instructions about a new resident to Alert the DON and physician that a pt [patient] is here and send med list to the physician. Physician may have changes to the med orders, or additional labs they want ordered, so be ready to make notes. 2. Input the med orders - if not done by 8 pm that day, meds will not arrive at midnight, and will be delayed until the next day . [patients] generally aren't too pleased about missed meds either Under medication orders it reflected about readmitted patients that prior physician orders have to be discontinued and would have medication list in admittance/hospital pack that needed to be confirmed with the attending physician. It reflected all medications must be entered into electronic record and included instructions on how to input orders into the electronic record. Review of facility in-service Train the trainer dated 12/12/22 by Regional Nurse reflected 2. All nurses must complete training prior to next scheduled shift including agency. 3. Instructed on Audit tools and Admission process and follow up. 4. ADONs will audit new admits within 24 hours Monday through Friday. Weekend Supervisor/Designees will audit Sat/Sunday. Management and Weekend will address concerns and provide education redirection of clinical if necessary. 5. ADON will validate using clinical meeting from M - F. Weekend Supervisor or Designee will validate using clinical meeting form assigned by DON. It reflected Staffing Coordinator (Previous ADON) and DON were in-serviced on 12/13/22. (continued on next page)

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	676319	A. Building B. Wing	03/07/2023

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of facility In-service Admissions dated 12/12/22 by DON reflected Please follow the attached guidelines when new admission arrives. Assessment completed immediately All medication should be put in system before end of shift. Licensed Nurse will be re-educated on the admission process including the expectation that orders are to be transcribed and implemented as ordered. Licensed Nurse will utilize admission check list for guidance on completion and will have admission orders verified and validated by another nurse on the shift. This in-service reflected a sign-in sheet which included ADON, Wound Care Nurse M, LVN I, LVN P and LVN S. Review of facility policy (dated 10/16/17) titled Physician and Other Communication/Change in Condition read in part, Glucose . Follow specific physician orders if present; or > 300mg/dL in diabetic patient not using sliding scale insulin; or >450 mg/dL (or machine registers high) in diabetic patient using sliding scale insulin . Review revealed the physician was to be notified of blood sugars greater than 300 mg/dL in a diabetic resident not using insulin sliding scale and 450 mg/dL (or blood glucose monitoring registers high) in diabetic residents using an insulin sliding scale. Review of facility's policy Physician and Other Communication/Change in Condition revised 10/16/17 reflected to improve communication between physicians and nursing staff to promote optimal patient/resident care, provide nursing staff with guidelines for making decisions regarding appropriate and timely notification of medical staff regarding patient's/resident's condition, and provide guidance for the notification of patients/residents and their responsible party regarding changes in condition .3. Notify the physician of the change in medical condition (The physician notification grid may be used as a reference tool regarding acceptable notification timeframes.) The nurse will document all assessments and changes in the patient's/resident's condition in the medical record. 4. If the physician does not respond within an acceptable time frame, the Medical Director and Director of Nursing will be notified. The Medical Director will provide medical orders as necessary to treat the resident's/patient's condition .6. Patient's/residents family member/legal representative will be notified of any change in condition required an emergent transfer to the hospital. Review of facility's policy Physician Orders last revised 10/27/17 reflected The qualified licensed nurse will obtain and transcribe orders according to Facility Practice Guidelines .Admission: 1. The qualified licensed nurse reviews orders from the transfer record from an acute care hospital or other entity. 2. A call is placed to the physician to confirm the orders and request any additional orders as needed .3. Upon admission, the Facility has physician orders for the resident's immediate care to include but not limited to: A. Dietary orders B. Medications, if necessary C. Routine care orders to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an appropriate care plan. Under Telephone and Verbal section it reflected 2. Record the actual order received from the physician. An Immediate Jeopardy (IJ) situation was identified on 03/02/23 at 4:15 PM. The ADM was notified, and a POR was requested. The POR was accepted on 03/04/23 at 4pm. The accepted POR for quality of care reflected the following: Resident #5 is not currently in the facility. Residents who are admitted or readmitted to the facility or have a change of condition or Diabetic have the potential to be affected by this alleged deficient practice. (continued on next page)

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	676319	A. Building B. Wing	03/07/2023

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Director of Nursing resigned and notice accepted on 3/3/23. Interim Director of Nursing in place and Mobile Director of Nursing will start 3/6/23. Agency checklist will be reviewed and revised to include the admission process, order entry, change in condition and monitoring of blood sugars and notification of physician when out of parameters or above 300. This will be completed by clinical consultants by 3/7/23 A house wide audit of admission or readmission orders on current residents admitted or readmitted [DATE] to 3/2/23 will be conducted by Director of Nursing / designee to validate that orders were transcribed /entered into matrix as ordered from the discharge summary or hospital discharge orders. 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. Any concern identified will be addressed at the time of discovery including notification of physician for further direction. This will be completed by 3/7/23. 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 following expectations: This will be completed on 3/3/23 The admission policy including the requirement that orders are to be entered into matrix completely

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. 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 for the development and/or worsening of urinary tract infections and skin breakdown. Findings include: Review of Resident #31's Quarterly MDS assessment dated [DATE], reflected a [AGE] year-old female with an admitted [DATE]. Resident #31 was severely cognitively impaired and unable to complete the interview for mental status. She was totally dependent of one-to-two-person assistance with all ADLs and was always 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). Review of Resident #31's care plan revised on 02/28/23 reflected, . [Resident #31] experiences bladder incontinence r/t cognition resident is unaware of the need to void .Goal .Resident will not develop skin breakdown related to incontinence .Approach .check for incontinent episodes at least every 2 hours .Apply moisture barrier to skin .Ensure adequate bowel elimination .Provide incontinence care after each incontinent episode . An observation on 03/01/23 at 10:00 a.m. revealed CNA B and NA C entered Resident #31's room to provide incontinence care. Both staff washed their hands and put on gloves. NA C unfastened Resident #31's brief to reveal the resident had been incontinent of urine and bowel. Fecal matter was observed in the Resident's perineal area and the groin area. NA C pushed the soiled brief down between the Resident's legs, which were held tightly together, toward her buttocks and cleaned her peri area from front to back but did not separate the labia and clean down the middle. With the assistance of CNA B, they rolled the resident onto her side and continued to provide incontinence care, wiping from front to back and reapplied a clean brief. An interview with NA C on 03/01/23 at 10:15 a.m. revealed she failed to separate the resident's labia and by missing this step could lead to an infection. She stated she was going to go back and re-clean the resident. She stated she had been in training and knew the importance of hand hygiene and properly cleaning a resident. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with DON A on 03/01/23 at 02:00 p.m., she stated staff were to separate the labia on female residents during incontinence care and wipe downward. She stated by not following proper peri care it placed residents at risk of urinary tract infections, especially if they did not remove the fecal matter. In an interview with the ADON on 03/02/23 at 09:45 a.m. stated she had not completed skills check off on NA C because she was still in training and had not taken her CNA certification yet. She stated she completed the training on incontinence care and hand hygiene and could perform these tasks if she were with a CNA with the assumption the CNA would ensure the proper steps were followed. She stated they should had placed her with a more tenured CNA, since CNA B was also a recent graduate. Review of CNA B's competency check completed on 08/17//22 reflected she met criteria for hand hygiene and on 08/08/22 she had met criteria for Peri-care. Review of the facility's policy titled, Perineal care/incontinent care, revised July 2016, reflected, .Wash hands .Don glove .Position patient/resident with legs flexed at knees and spread apart .For female patient/resident . 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 anus with one stroke). Discard soiled wipes. Wash hands, don gloves. Apply moisture barrier if needed. Reapply appropriate incontinent brief/undergarment .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34399 Based on observations, interview and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards in one of one kitchen reviewed for kitchen sanitation. 1. Facility failed to ensure fryer was cleaned after use and grease was changed. 2. Dietary Cook Z failed to wash hands during lunch meal preparation on 02/28/23. These failures could place residents at risk for food contamination and food-borne illness. Findings included: 1. Observation in facility's kitchen on 02/28/23 at 9:43 AM revealed grease in fryer was dark brown with couple fries floating on top of grease with food particles and crumbs on fryer. Interview on 02/28/23 at 9:45 AM revealed Dietary Manager stated the fryer was last used for dinner yesterday evening. She stated she expected the fryer should have been cleaned off after use. Dietary Manager stated the grease in the fryer had not been changed due to grease container was full. She stated the company had not come out to dispose of the used grease in 4 months. She stated she had called them several times. She stated the grease was last changed last week. Observations on 02/28/23 at 9:50 AM and 03/01/23 at 12:54 PM revealed grease disposal trash container to the side of the facility's dumpster revealed it was closed but full to the top with pieces of fries on top. Observation on 03/01/23 at 12:54 PM revealed barrel from company was empty and Regional Director of Operations stated they could put the grease in this barrel. Interview on 03/01/23 at 12:58 PM with Regional Director of Plant Operations revealed he had not been notified of any issues with company not picking up grease disposal for facility. He stated the used grease container being full and not being disposed of could attract flies. He would follow-up with Dietary Manager to see about her contact with the company and let Dietary Manager know they can use the barrel to put used grease in for disposal. 2. Observation on 02/28/23 at 12:24 PM Dietary Cook Z took her surgical mask off and drank water. She did not wash her hands. She scooped food on plates for resident meals and touched her hands on top of the inner part of the plates. At 12:28 PM Dietary Cook Z went to sink and ran hot water on cloth. Dietary Cook Z did not wash her hands. She went back to plating food on lunch plates. She wiped her hands with wash cloth. Dietary Cook Z went back to plating food on lunch plates. Interview on 02/28/23 at 12:35 PM with Dietary Cook Z revealed she washed her hands one time but should have washed her hands more. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/28/23 at 12:40 PM and 1:30 PM with Dietary Manager revealed Dietary Cook Z was usually the relief cook and this was the first time she was observed by the state. She should have washed her hands when she took her mask off and drank water. She stated Dietary Cook Z was nervous and usually did wash her hands appropriately. She stated she should not have used a wash cloth to wash her hands and should have stopped to wash her hands before going back to plating food. Review of facility's policy Hand hygiene/Hand Washing revised 08/01/2020 reflected Hand hygiene is the most important component for preventing the spread of infection .Employees will keep their hands and exposed portions of arms clean .1. Clean hands in a hand washing sink. Hands may not be cleaned in a sink used for food preparation or ware washing or in a service sink used for disposal of mop water. 2. Wash hands: A. When hands are visibly soiled .D. Before handling or eating food .J After contact with soiled or contaminated articles .

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	676319	A. Building B. Wing	03/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corinth Rehabilitation Suites on the Parkway	3511 Corinth Parkway Corinth, TX 76208

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 34399 Based on observation, interview and record review, the facility failed to dispose of garbage and refuse properly for facility's one dumpster and used grease disposal container for garbage disposal, in that: 1. Facility failed to ensure used grease disposal container was disposed 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 residents at risk for exposure to germs and diseases carried by vermin and rodents. Findings included: Observations on 02/28/23 at 9:50 AM and 03/01/23 at 12:54 PM revealed grease disposal trash container to the side of the facility's dumpster revealed it was closed but full to the top with pieces of fries on top. Observation on 02/28/23 at 9:50 AM of behind exterior dumpster revealed a recliner, four wheelchairs and mattress behind it with used gloves and trash debris on ground. There was a sticky substance on ground behind dumpster. Dumpster was open. Observation on 03/01/23 at 12:57 PM of behind exterior dumpster revealed a mattress and three wheelchairs with trash debris. There was a sticky substance on ground behind the dumpster. Observation on 03/01/23 at 12:54 PM revealed barrel from Company was empty. Interview with Regional Director of Operations revealed dietary staff could put the used grease in this barrel for disposal. Interview on 03/01/23 at 12:58 PM with Regional Director of Plant Operations revealed he had not been notified of any issues with company not picking up grease disposal for facility. He stated the used grease container being full and not being disposed of could attract flies and other bugs. He stated to be careful not to step in the substance behind the dumpster. He stated he was covering for the facility's Maintenance Director today. He stated there should not be items behind the dumpster and he would have to clean up the substance on the ground. He stated the items should go in the dumpster so they can be disposed of. Follow-up interview on 03/02/23 at 11:03 AM with Regional Director of Plant Operations revealed he followed up with Dietary Manager and found out she had contacted the disposal company 4 times since January 2023 to get them to dispose of the used grease. He stated last time the disposal company had come out was in October 2022. (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 Based on interview and record review the facility failed to obtain from hospice the hospice plan of care, hospice election form and the physician certification of the terminal illness for two (Resident #21 and #4) of two residents reviewed for hospice 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 hospice a physician certification of terminal illness for Resident #4. These failures could place residents at risk for services and treatments not being coordinated. Findings included: 1. Record review of Resident #21's electronic face sheet revealed an [AGE] year-old female admitted to the facility on [DATE]. Resident #21 had diagnoses which included Rhabdomyolysis, pain, psychosis, cirrhosis of liver. Record review of Resident #21's March 2023 electronic physician's orders reflected on 10/25/22 she was admitted to hospice. Record review of Resident #21's electronic clinical record and hospice documentation reflected no hospice election form or physician certification of terminal illness from Hospice A. 2. Record review of Resident #4's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #4 had diagnoses which included heart failure, dementia, and insomnia. Record review of Resident #4's March 2023 electronic physician's orders reflected on 01/23/23 she was admitted to hospice. Record review of Resident #4's electronic clinical record and hospice documentation reflected no physician certification of terminal illness from Hospice A. Interview on 03/01/23 at 10:15 AM the DON stated it was the Social Worker's responsibility to ensure that the appropriate hospice documentation was in the resident's record. The DON stated the importance of the paperwork was to ensure accurate care was provided to the resident. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/01/23 at 10:27 AM the Social Worker stated she did not see the hospice election form and physician certification of terminal illness form from Hospice A in Resident #21's hospice binder or electronic clinical record. The Social Worker stated she did not see the physician certification of terminal illness form from Hospice A in Resident #4's hospice binder or electronic clinical record. The Social Worker stated she would call Hospice A to obtain the missing information for Resident #21 and #4. Interview on 03/01/23 at 11:42 AM the Social Worker stated she had been working at the facility for approximately four months and to the best of her knowledge she was not aware she was responsible to ensure the appropriate hospice documentation was in the resident's record. The Social Worker provided the hospice election form and physician certification of terminal illness form for Resident #21 and the physician certification of terminal illness form for Resident #4 from Hospice A which was send over electronically since it was not available on site. Interview on 03/01/23 at 1:09 PM with the ADM revealed he was aware of the regulation for the hospice plan of care, hospice election form, physician certification of terminal illness and hospice medication information form to be onsite, he continued by stating he was new to the facility. He stated it would confirm that it was the responsibility of the Social Worker to ensure the appropriate hospice documentation was on site and moving forward the ADM would ensure there is an appropriate process in place. The ADM stated the importance of the paperwork was to ensure accurate care was provided to the resident. Interview on 03/01/23 at 1:22 PM with the ADON revealed she was not familiar with the appropriate hospice documentation that was required in a resident's clinical record. Record review of the facility policy titled, Hospice Care, dated 2017, reflected .Policy:1.The facility has established procedures for ongoing assessment, communication, and care collaboration between hospice care providers, physicians, and facility staff to clarify goals and preferences regarding treatment including pain management and symptom control, treatment of acute illness, and choices regarding hospitalization s .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (Resident #31) of five residents observed for infection control. CNA B and NA C failed to perform hand hygiene during incontinent care for Resident #31 and CNA B failed to perform hand hygiene before leaving Resident #31's room. Theses failure could place residents at risk for infection and cross contamination. Findings included: Review of Resident #31's Quarterly MDS assessment dated [DATE], reflected a [AGE] year-old female with an admitted [DATE]. Resident #31 was severely cognitively impaired and unable to complete the interview for mental status. She was totally dependent of one-to-two-person assistance with all ADLs and was always 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). Review of Resident #31's care plan revised on 02/28/23 reflected, . [Resident #31] experiences bladder incontinence r/t cognition resident is unaware of the need to void .Goal .Resident will not develop skin breakdown related to incontinence .Approach .check for incontinent episodes at least every 2 hours .Apply moisture barrier to skin .Ensure adequate bowel elimination .Provide incontinence care after each incontinent episode . An observation on 03/01/23 at 10:00 a.m. revealed CNA B and NA C entered Resident #31's room to provide incontinence care. Both staff washed their hands and put on gloves. NA C unfastened Resident #31's brief to reveal the resident had been incontinent of urine and bowel. Fecal matter was observed in the perineal area and the groin area. NA C pushed the soiled brief down between the resident's legs toward her buttocks and cleaned her peri area from front to back but did not separate the labia and clean down the middle. With the assistance of CNA B, they rolled the resident onto her side and removed the soiled brief revealing the draw sheet was also soiled with fecal matter. CNA B continued to provide incontinence care, wiping from front to back, and then applied barrier cream while wearing soiled gloves. CNA B, without changing her gloves pushed the soiled draw sheet under the resident and placed the clean draw sheet and brief under the resident and rolled her onto her back and then on her opposite side, while NA C, wearing the same soiled gloves, pulled out the soiled draw sheet and pulled the clean draw sheet and brief under the resident. Both staff then rolled the resident onto her back, straightened her bed linens, and placed a pillow under her left arm. CNA B removed her gloves and without performing hand hygiene, sacked up the dirty linen and trash and left the room, walked across the hall, and entered the soiled linen room to deposit the linen and trash. NA C removed gloves and washed hands before leaving the resident's room (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with NA C on 03/01/23 at 10:15 a.m. revealed they were supposed to perform hand hygiene when they enter a resident's room, any time they change their gloves and before they leave a resident's room. NA B stated she knew she missed a step and forgot to perform hand hygiene when she went from dirty to clean. She stated she also failed to separate the resident's labia and by missing this step could lead to an infection. She stated she was going to go back and re-clean the resident. She stated she had been in training and knew the importance of hand hygiene and properly cleaning a resident. In an interview with CNA B on 03/01/23 at 10:25 a.m. revealed they were supposed to perform hand hygiene when they enter a resident's room, any time they change their gloves and before they leave a resident's room. CNA B stated she was a new CNA. She stated she should have changed her gloves perform hand hygiene after she cleaned up the resident, and before putting the barrier cream on the resident. She stated by not doing this, it could cause an infection. CNA B stated she should have performed hand hygiene after she took off her gloves and before leaving the room to dispose of the dirty linen. She stated by not doing this she could spread infection. Review of CNA B's competency check completed on 08/17//22 reflected she met criteria for hand hygiene and on 08/08/22 she had met criteria for Peri-care. In an interview with DON A on 03/01/23 at 02:00 p.m. she stated staff were to perform hand hygiene when they entered a resident's room, after contact with any bodily fluid, and they were to change their gloves and perform hand hygiene during incontinent care when they went from dirty to clean and before leaving a resident's room. She stated by not following standard precautions with hand hygiene it placed residents at risk of infections and cross contamination. In an interview with the ADON on 03/02/23 at 09:45 a.m. stated she had not completed skills check off on NA C because she was still in training and had not taken her CNA certification yet. She stated she had completed the training on incontinence care and hand hygiene and could perform these tasks if she were with a CNA with the assumption the CNA would ensure the proper steps were followed. She stated they should had placed her with a more tenured CNA, since CNA B was also a recent graduate. Review of the facility's policy titled, Perineal care/incontinent care, revised July 2016, reflected, .Wash hands .Don glove .Position patient/resident with legs flexed at knees and spread apart .For female patient/resident . 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 gloves. Apply moisture barrier if needed. Reapply appropriate incontinent brief/undergarment . 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 .