STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676072	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corrigan Ltc Nursing & Rehabilitation	300 Hyde St Corrigan, TX 75939

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 2 out of 5 (Resident #1 and Resident #2) residents reviewed for enhanced barrier precautions (EBP) for infection control practices. 1. Hospice Aides A and B failed to put on EBP while providing ADL care for Resident #1 on 05/18/26.2. The facility did not implement EBP for Resident #2 after she returned to the facility with a surgical wound on 05/13/26. These failures could place residents at risk for cross contamination and the spread of infection.The findings included: 1.Record review of Resident #1's face sheet dated 05/19/26 indicated she was an [AGE] year old female, admitted on [DATE] and her diagnoses included chronic kidney disease (long term condition where kidneys gradually lose function), unspecified disorder of the skin, and Alzheimer's (brain disorder). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated was sometimes able to make herself understood, understood others, and had severely impaired cognitive skills. She had 2 stage 3 pressure ulcers. Treatment included application of nonsurgical dressing and ointments/medications. Record review of Resident #1's care plan dated 04/06/25 (revised 03/18/26) indicated Resident #1 had a stage 3 wound on her right shin and a stage 3 wound on the back of her right knee. Interventions included assess weekly and report declines to MD. There was no EBP care plan available for review. Record review of Resident #1's physician orders dated 05/18/26 indicated Enhanced Barrier Precautions: Staff to wear gown and gloves when doing any of the following for the resident: dressing, bathing/showering; transferring, providing hygiene; changing lines, changing briefs or assisting with toileting; device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and wound care (any skin opening requiring a dressing). Record review of Resident #1's physician orders dated 05/19/26 indicated:-admit to hospice (order date 12/18/24),-cleanse stage 3 wound to back of left knee with NS, apply skin prep and leave open to air, cleanse wound to right calf with wound cleaner, apply SilvaSorb gel, and cover with dry dressing daily (order date 04/02/26), and -cleanse wound to right ankle with wound cleaner, pat dry, apply collagen powder and cover with bordered foam dressing daily every shift (order date 04/18/26). During an observation on 05/18/26 at 12:10 p.m., Hospice Aide A went into Resident #1's room. She was wearing gloves. She did not have on a gown. There was EBP sign adjacent to Resident #1's door. The EBP sign specified Everyone Must: clean their hands before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities.Dressing Bathing/Showering Transferring Changing Linens Providing Hygiene Changing briefs or assisting with toileting Device Care or use: central line, urinary catheter, feeding tube, tracheostomy, Wound Care: any skin opening requiring a dressing.Do not wear the same gown and gloves for the care of more than one person. The DON knocked and opened the door (at the request of the surveyor) and confirmed Hospice Aide A and Hospice Aide B were providing ADL care for Resident #1. Neither Hospice Aide A nor Hospice Aide B were wearing gowns as specified on the EBP sign. There was no observed EBP supplies available for use for Resident #1 (no cart with EBP supplies next to the room (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or other EBP supply delivery system). During an interview on 05/18/26 at 12:15 p.m., the DON said all staff were trained to use EBP as necessary. She said she was not aware if there was hand sanitizer in Resident #1's room. She said Resident #1 had been receiving hospice services, and she was not able to say who trained the hospice staff for EBP. She confirmed she was the Infection Preventionist. She said the residents that were placed on enhanced barrier precautions either had a Foley catheter (drains urine), an IV (intravenous therapy), a colostomy (allows waste to exit the body), pressure wounds, ports (dialysis access), fistulas (dialysis access), or g-tubes. She stated if the enhanced barrier precautions were not followed, it could contaminate clothes and pass from resident to resident. She stated staff should know because there were signs posted outside the door. She stated when wound care was being done, a gown and gloves should be worn, and at times a face mask depending on what was being done. She stated anyone that provided hands-on care should wear enhanced barrier precautions. The DON said not following enhanced barrier precautions could cause spread of infection or contamination. She said the signage was used to make outside providers aware of the EBP, as well as verbally. During an interview on 05/18/26 at 12:30 p.m., Hospice Aide A said she had provided care to Resident #1 for over 1 year and had never used a gown when providing care. She said she had never seen or noticed the EBP sign prior to 05/18/26. She said she cleaned her hands with hand sanitizer that was available in Resident #1's room. She said there was no EBP supplies in Resident #1's room. She said if EBP were not used as required, there was a risk of spreading infection in the facility. During an interview on 05/18/26 at 12:45 p.m., Hospice Aide B said she was filling in for the usual hospice aide and did not notice the EBP sign adjacent to Resident #1's door. She said she provided Resident #1 with a bed bath and incontinent care. She said she wore gloves and used hand sanitizer, as necessary. She said if EBP were not used as required, there was a risk of spreading infection in the facility. During an interview on 05/18/26 at 1:35 p.m., LVN D said she was trained on infection control. She said she thought there was an EBP supply cart outside of Resident #1's room but she could not be 100% positive. She said she did not direct the hospice aides to use EBP. She said if EBP were not used as required, there was a risk of spreading infection in the facility. During an interview on 05/18/26 at 2:02 p.m., CNA E said she was trained on infection control and EBP. She said an EBP sign meant you had to wear a gown and gloves for all resident care and transfers. She said there was an EBP supply cart outside of Resident #1's door on 05/17/26 but could not say where the cart was on 05/18/26. She said if she needed any EBP supplies and there was no cart, she would get supplies from the storge closet. She said if EBP were not used as required there was a risk of spreading infection in the facility. 2. Record review of Resident #2's face sheet dated 05/19/26 indicated she was a [AGE] year-old female, re-admitted on [DATE] (initial admit 3/25/26), and her diagnoses included chronic COPD, displaced intertrochanteric fracture of the left femur, history of falling, dementia (decline in cognitive function), and Alzheimer's (brain disorder). Record review of Resident #2's admission assessment date 04/02/26) indicated she was usually able to make herself understood and usually understood others and had severe cognitive impairment (BIMS-3). Record review of Resident #2's re-admission assessment dated [DATE], completed by LVN C indicated a left femur surgical incision. Record review of Resident #2's admission MDS dated [DATE] indicated she was usually able to make herself understood and usually understood others and had severe cognitive impairment (BIMS-3). Record review of Resident #2's physician orders dated 05/13/26 indicated cleanse wound at left hip with NS/WC, pat dry, apply TOA and dry dressing q day and PRN everyday shift until healed. Record review of Resident #2' physician orders dated 05/18/26 indicated Enhanced Barrier Precautions: Staff to wear gown and gloves when doing any of the following for the resident: dressing, bathing/showering; transferring, providing hygiene; changing lines, changing briefs or assisting with toileting; device care or use (central line- long, flexible catheter inserted into a large vein near the heart to deliver medications, fluids, nutrition, or to draw blood for testing, urinary catheter (drains urine from bladder), feeding tube (provides nutrition), tracheostomy (opening in the neck to facilitate breathing)/ventilator (medical machine that helps a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	person breath, etc.); and wound care (any skin opening requiring a dressing). Record review of Resident #2's care plan dated 05/18/26 indicated enhanced barrier precautions would be used. Interventions included gloves and gowns when performing contact activity. There was no EBP care plan available for review prior to 05/18/26. During an observation on 05/18/26 at 1:15 p.m., Resident #2 was in bed. There was no EBP or sign observed near or adjacent to Resident #1's door or room. During an interview on 05/18/26 at 2:12 p.m., CNA F said she was trained on infection control and EBP. She said EBP included gloves and gowns during resident contact and care. She could not say what happened to the missing EBP supply carts. During an observation on 05/19/26 at 8:30 a.m., Resident #2 was in bed. There was an EBP sign on the room door and EBP supplies available on the door. During an interview on 05/19/26 at 8:28 a.m., LVN C said she re-admitted Resident #2 on 05/13/26 from hospital after she had surgery for fracture of her hip. She said she was not aware EBP was required for surgical wounds. She said she was trained on infection control. She said the training did not include EBP. She said she should have placed an EBP sign on or adjacent to Resident #2's door and had the EBP supplies in a cart in place outside of Resident #2's door. She said if EBP were not used as required, there was a risk of spreading infection in the facility. During an interview on 05/19/26 at 8:42 a.m., the DON said after an audit of resident clinical charts completed on 05/18/26, there was no EBP signage or supplies for Resident #2. She said it was an oversite by the admitting nurse. She said the EBP sign and supplies should have been in place when Resident #2 was re-admitted from hospital on [DATE]. During an interview on 05/19/26 at 1:14 p.m., the RDC confirmed staff training for infection control did not include EBP. Record review of a facility's Enhanced Barrier Precautions policy dated August 2022 indicated Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug- resistant organisms (MDROs) to residents. 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. 2 EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. A. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). b. Personal protective equipment (PPE) is changed before caring for another resident. c. Face protection may be used if there is also a risk of splash or spray. 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. transferring; d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and h. wound care (any skin opening requiring a dressing). 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. 6. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk. 8. Standard precautions apply to the care of all residents regardless of suspected or confirmed infection or colonization status. 9.Staff are trained prior to caring for residents on EBPs.