STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676190	A. Building B. Wing	06/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stillhouse Rehabilitation and Healthcare Center	2900 Stillhouse Road Paris, TX 75462

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 observation, interview and record review the facility failed to establish and 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 1 of 4 residents (Resident #1) reviewed for infection control. The facility failed to ensure CNA B followed enhanced barrier precautions when providing incontinent care to Resident #1 on 06/06/2026. This failure could place residents at risk for cross contamination and the spread of infection due to lack of implementation of orders. Finding include: Record review of Resident #1's face sheet, dated 06/06/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included pneumonitis (swelling and irritation of the lungs) due to inhalation of food and vomit and need for assistance with personal care. Record review of Resident #1's admission Comprehensive MDS assessment, dated 05/21/2026 revealed Resident #1 was able to make himself understood and had the ability to understand others. Resident #1 had a BIMS score of 15, which indicated no cognitive impairment. Resident #1 had urinary incontinence and an indwelling catheter, feeding tube, and pressure ulcer. Record review of Resident #1's care plan, dated 06/06/2026, revealed Resident #1 was care planned for feeding tube, pressure ulcer, and bowel and bladder incontinence with the intervention of enhanced barrier precautions with care. Record review of Resident #1's order summary report revealed Resident #1 had an order to cleanse gastronomy tube stoma with normal saline, dry with gauze and apply sponge gauze every day shift started on 06/05/2026. Order summary report indicated an order for sacrum clean with normal saline, dry with gauze, apply calcium alginate with silver, and cover with island bordered dressing every day shift started on 06/05/2026. Order summary report indicated the resident had an order for enteral feeding every shift started on 05/19/2026. During observation on 06/06/2026 at 11:30 a.m., revealed CNA A performed incontinent care on Resident #1 without donning a gown. The CNA cleaned the resident's bowel movement with open sacral wound with cleansing wipe, applied new clean brief, with one pair of gloves without changing her gloves. Observation of EBP sign on door and supplies in cart inside door of Resident #1 room. During interview on 06/06/2026 at 11:35 a.m., Resident #1 revealed he had a feeding tube, wound on his stoma, and sacral wound. Resident #1 stated staff normally wore a gown and gloves when proving care to him but sometimes they forget. During interview on 06/06/2026 at 11:40 p.m., CNA A revealed she had forgotten to wear a gown when providing care to Resident #1. CNA A stated Resident #1 had a gastronomy tube, wound on his sacrum, and wound on his tube side. CNA A stated Resident #1 was at risk of cross contamination and infection. CNA A stated she only worked as needed on the floor and she had forgotten to wear EBP. During interview on 06/06/2026 at 12:00 p.m., revealed RN B expected all nursing staff to wear EBP when providing direct contact care to Resident #1. RN B stated Resident #1 was on enhanced barrier precautions for his feeding tube and wounds to his sacrum and stoma. During interview on 06/07/2026 at 10:15 a.m., the DON stated she was told by the CNA A that she had forgotten to wear EBP when providing care to Resident #1. The DON stated she expected all staff who came in direct contact with Resident #1 to wear a gown and gloves when providing care to Resident #1. The DON stated there were signs posted on Resident #1 (continued on next page)

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	door and a box of supplies needed in his room. The DON stated she educated CNA A on EBP and to wear her gown and gloves. The DON stated Resident #1 was at risk for the spread of infection. During interview on 06/07/2026 at 10:30 a.m., the Administrator stated he expected all staff to follow policy and procedures regarding infection control. The Administrator stated he expected CNA A to wear a gown and gloves with providing incontinent care to Resident #1 due to his tube and wounds. The Administrator stated EBP was used to prevent the spread of infection and cross contamination. Record review of the facility's Policy and Procedure Infection Prevention Control Program Standard and Transmission-Based precautions, revised 03/2024, indicated Enhanced Barrier Protection (EBP): used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. (e.g., residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs). a. PPE: The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with: i. Wounds and/or indwelling medical devices regardless of known MDRO infection or colonization.