STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675274	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willis Nursing and Rehabilitation LP	3000 N Danville St Willis, TX 77378

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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, 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 1 (Resident #1) of 5 residents viewed for infection control. - LVN B did not wear appropriate PPE when performing wound care on Resident #1, when he was on Enhanced Barrier Precautions. This failure could place residents and staff at risk for cross-contamination, spread of infection and could potentially affect all others in the building. Findings include: Record review of Resident #1's undated face sheet, revealed he was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses of sepsis (infection throughout the body), urinary tract infection, neuromuscular dysfunction of bladder (bladder does not empty), atrial fibrillation (heart beat is not regular), and acute embolism and thrombosis of deep veins of lower extremity (blood clot in the vein of lower leg). Resident #1's admission MDS Assessment had not been completed yet. Record review of Resident #1's Baseline Care Plan only had a Focus of Sepsis with a goal to not exhibiting signs of infection. The interventions included administering antibiotics (Ceftriaxone). There was also a Focus regarding tasks to be documented in the POC about his bowel movements, bath/showers, food intake, etc. Those were the only two areas on the Baseline Care Plan. Record review of Resident #1's Physician Orders revealed the following orders from MD G:- Zosyn in dextrose (piperacillin-tazobactam-dextrs) [antibiotic] 3.375 g/50ml IV Q8hr, 10pm, 6am, 2pm. Ordered on 12/3/25.- Colostomy [hole through abdomen so stool can drain into a pouch on outside] Care Every Shift. Ordered on 11/21/25.- Enhanced Barrier Precautions-I have a PICC line [IV line that is inserted deeper into vein], foley [tube into bladder to drain urine], colostomy, and wounds. Ordered on 11/25/25.- Foley catheter: Diagnosis: Neurogenic bladder dysfunction. Ordered on 11/21/25.- Wound Treatment Order: Bottom of R great toe/foot: Clean with NS/WC, apply betadine, LOTA, QD. Ordered on 11/26/25.- Wound Treatment Order: R Dorsal [top]: Clean with NS/WC, apply calcium alginate [wound treatment], cover with silicone bordered dressing, QD. Ordered 11/21/25.- Wound Treatment Order: Sacrum [tailbone]/bilateral buttocks: Clean with NS/WC, pack center wound with calcium alginate w/ silver rope, place large calcium alginate sheets on top of wound, cover with silicone bordered dressing, QD. Ordered on 11/26/25.- Midline IV for intravenous therapy to LUA. Ordered on 11/20/25. Record review of Resident #1's Progress Notes revealed a note from 11/20/25 at 10:11pm from RN A that said, .Initial Nursing Services Provided: Intravenous Therapy, Ostomy Care [colostomy], Urinary Catheter Care [tube into bladder to drain urine].Wound Care.Resident is paraplegic [paralyzed in legs] with foley, midline [IV that is deeper in vein] LUA, Colostomy, intact. Extensive wound to coccyx [tailbone], buttocks, left hip, left calf and Right great toe. Skin dry scaly and peeling. Resident to start ceftriaxone 2G Q day x2 days on 11/21. In an observation on 12/3/25 at 10:01am, Resident #1 had an EBP sign on his door with a cart outside his room with PPE in it. Resident #1 was observed lying on his right side in bed while LVN B was performing wound care. LVN B did not have a gown on and only had gloves on. Resident #1 was observed to have a colostomy to his abdomen, a foley catheter hanging on the side of the bed, and a PICC line to his LUA. In an interview on 12/3/25 at 10:10am, LVN B said EBP was to protect everyone from infections, the staff and the residents. He said when a resident was on EBP, staff were supposed to wear a gown and gloves during treatment. LVN B said he was supposed to have worn a gown when he was performing wound care, but he forgot to put it on. LVN B said if he did not wear the appropriate PPE the resident and himself were at risk for getting infections. In an interview on 12/3/25 at 3:49pm, the DON said EBP was for any residents with invasive lines. She said the staff had to wear a gown and gloves, and they were worn during any treatment that was given to the resident. She said EBP was to prevent any contamination from the resident or the staff. The DON said she provided training on EBP at the monthly staff meetings and the last one was in November 2025. Record review of the facility's policy and procedures on Enhanced Barrier Precautions (June 2025) read in part: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.An order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g.