

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675756	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/23/2024
NAME OF PROVIDER OR SUPPLIER Williamsburg Village Healthcare Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 941 Scotland Dr Desoto, TX 75115	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140</p> <p>Based on interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 2 of 6 residents (Residents #1 and #2) reviewed for ADLs.</p> <p>The facility failed to ensure Resident #1 and Resident #2 received showers as scheduled for the month of December 2023, January 2024, and February 2024.</p> <p>These failures could place residents at risk of not receiving services or care, decreased quality of life, and decreased self-esteem.</p> <p>Findings included:</p> <p>1. Review of Resident #1's face sheet, dated 02/23/24, revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis of partial or total body function on one side of the body), muscle wasting and atrophy, Type 2 diabetes mellitus, muscle weakness, other lack of coordination.</p> <p>Review of Resident #1's MDS Quarterly Assessment, dated 01/01/24, reflected a BIMS score of 05, which indicated severe cognitive impairment. Further review reflected Resident #1 needed substantial/maximal assistance from staff in regard to bathing.</p> <p>Review of Resident #1's care plan, dated 02/23/24, reflected Non-Compliance [09/11/2023: Updated], refusing scheduled showers [09/11/23]. Goal: Resident will verbalize understanding of consequences of non-compliance. Interventions: Accept resident's right to refuse and show respect for resident's decisions.</p> <p>Review of Resident #1's ADL Flow Record for December 2023 reflected the following under Bathing five entries dated: 12/08/23, 12/15/23, 12/18/23, 12/20/23, and 12/29/23 bath/shower were provided - No indications of refusals.</p> <p>ADL Flow Record for January 2024 reflected the following under Bathing six entries dated: 01/03/24, 01/17/24, 01/24/24, 01/26/24, 01/29/24, and 01/31/24 bath/shower were provided and three days bath/shower were refused 01/05/24, 01/8/24, and 01/12/24.</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>ADL Flow Record for February 2024 reflected the following under Bathing four entries dated: 02/07/24, 02/09/24, 02/12/24, and 02/19/24 bath/shower were provided - No indications of refusals.</p> <p>2. Review of Resident #2's face sheet, dated 02/23/24, revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included fluid overload, chronic kidney disease, pulmonary hypertension (a condition that affects the blood vessels in the lungs), muscle weakness, unsteadiness on feet.</p> <p>Review of Resident #2's MDS Quarterly Assessment, dated 01/15/24, reflected a BIMS score of 15, which indicated no cognitive impairment. Further review reflected Resident #2 needed Partial/moderate assistance from staff in regard to bathing.</p> <p>Review of Resident #2's care plan, dated 02/23/24, reflected Self-Care Deficit [10/20/2023], generalized weakness; Goal: Resident will maintain or improve self-care area of dressing, grooming hygiene and bathing over the next 90 days. Bathing: Resident will assist with bathing and hygiene on a daily basis over the next 90 days. Interventions: Prefers Bath in AM. Provide assistance with self-care as needed. The care plan did not indicate bath/shower refusals.</p> <p>Review of Resident #2's ADL Flow Record for December 2023 reflected the following under Bathing two entries dated: 12/13/23 and 12/27/23 bath/shower were provided - No indications of refusals.</p> <p>ADL Flow Record for January 2024 reflected the following under Bathing seven entries dated: 01/03/24, 01/05/24, 01/08/24, 01/15/24, 01/17/24, 01/24/24, and 01/26/24 bath/shower were provided and one refusal 01/19/24.</p> <p>ADL Flow Record for February 2024 reflected the following under Bathing four entries dated: 02/02/24, 02/07/24, 02/16/24, and 02/21/24 bath/shower were provided - No indications of refusals.</p> <p>Observation and interview on 02/21/24 at 10:48 AM of Resident #1 sitting in her wheelchair outside her room. Resident #1 appeared clean and well-groomed. Resident #1 revealed her shower days were Monday, Wednesday, and Fridays. She stated she recently received a shower on Monday 02/19/24; however, she had gone without a shower for weeks. She stated she had only refused showers about 2-3 times. She stated it upsets her when she does not receive her showers. Resident #1 denied any skin breakdowns.</p> <p>Observation and interview on 02/21/24 at 11:07 AM of Resident #2 sitting on her bed, observed Resident #2 had a hospital gown on. Resident #2 stated her shower days were Monday, Wednesdays, and Fridays. She stated today (02/21/24) was her shower day. She stated she did not receive a shower on Monday (2/19/24). Resident #2 stated she would go days without showering. She stated staff are not consistent with their shower days, and when she asked to get a shower, the staff provided different explanations like they have no linen or staff to provide showers or they would leave and not come back. Resident #2 denied any skin breakdowns.</p> <p>Interview on 02/22/24 at 11:34 AM with CNA B revealed CNAs were responsible for providing showers to residents on their shower days. She stated shower days are Monday, Wednesday, and Fridays for even rooms and Tuesday, Thursday, and Saturdays for odd rooms. She stated they document all showers provided or refusals on the kiosk under the ADL tab. She stated even if a resident refused a shower, they must document the refusal and notify the charge nurse.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 02/22/24 at 11:46 AM with CNA C revealed CNAs were responsible for providing showers to residents on their shower days. She stated shower days are Monday, Wednesday, and Fridays for even rooms and Tuesday, Thursday, and Saturdays for odd rooms. She stated residents in bed A get showers during the 6:00 AM-2:00 PM shift and residents in bed B get showers during the 2:00 PM-10:00 PM shift. She stated they document all showers provided or refusals on the kiosk under the ADL tab. She stated even if a resident refused a shower, they must document the refusal and notify the charge nurse. She stated even if the resident is known to refuse, they must still offer the shower. She stated Resident #2 was not known to refuse showers. She stated she was unaware of any residents not receiving their showers, she stated she made sure her residents on her hall get their showers. CNA C stated if residents did not receive their showers or baths like they were supposed to, it could lead to them developing skin breakdowns.</p> <p>Interview on 02/22/24 at 12:05 PM with LVN A revealed it was the responsibility of the CNAs to provide showers and it was the nurses' responsibility to ensure showers were being completed. She stated shower days are Monday, Wednesday, and Fridays for even rooms and Tuesday, Thursday, and Saturdays for odd rooms. She stated residents in bed A get showers during the 6:00 AM-2:00 PM shift and residents in bed B get showers during the 2:00 PM-10:00 PM shift. She stated CNAs document showers on the kiosk and if a resident refused CNAs would notify the nurses and they would follow up with the residents. LVN A reviewed Resident #1's ADLs and stated she was missing documentation whether if she received a shower or refused. She stated if it was not documented it did not happen. LVN A stated residents who did not receive their showers or baths like they were supposed to, it could lead to them developing skin breakdowns.</p> <p>Interview on 02/22/24 at 1:05 PM with LVN E revealed it was the responsibility of the CNAs to provide showers and it was the nurses' responsibility to ensure showers were being completed. He stated he has had residents who have complained about showers; however, they address the concern immediately. He stated CNAs should document on the kiosk under ADLs if showers were given or refused. LVN E reviewed Resident #1's ADLs and stated Resident #1 had missing shower dates, he stated he was not sure if Resident #1 received or refused her showers. He stated residents who did not receive their showers or baths like they were supposed to, it could lead to them developing infections and skin breakdowns.</p> <p>Interview on 02/23/24 at 11:06 AM with the ADON revealed her expectations are for staff to provide residents with showers on their shower days. She stated it was the charge nurse's responsibility to ensure showers were being completed. She stated CNAs should be documenting in the POC whether a shower/bed bath was provided and if refused. The ADON stated residents who did not receive their showers or baths like they were supposed to, it could lead to them developing infections.</p> <p>Interview on 02/23/24 at 12:09 PM with the DON revealed her expectations are for staff to provide residents with showers on their shower days and to document if showers were provided or refused in the resident's charts under ADLs. She stated if residents are known to refuse, they should still offer showers and documents any refusals. She stated if it was not documented it did not happen. She stated it was the nurse's responsibility to ensure showers were being provided and from there it goes up the chain. She stated the potential risk of showers not being provided would be cleanliness and infections.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's Bathing (Not partial or completed bed bath) policy, revised 01/20/23, reflected the following: .Staff will provide bathing services for resident within standard guidelines 37. Document bath in EHR. If the resident refuses to independently or allow staff to assist with bathing, document the refusal in the record</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937</p> <p>Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care was provided such care, consistent with professional standards of practice for one of three residents (Resident #3) reviewed for oxygen.</p> <p>The facility failed to ensure Resident #3's oxygen concentrator and nasal cannula was dated, labeled, and changed on a weekly basis. The facility failed to ensure Resident #3's oxygen delivered as ordered by physician at 2 liters per minute.</p> <p>This failure placed residents who received oxygen therapy at risk for inadequate or inappropriate amounts of oxygen delivery and possible infection.</p> <p>Findings included:</p> <p>Review of Resident #3's Admission Record dated 02/23/24 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included low back pain, Hypoxemia (an abnormally low level of oxygen in the blood), chronic pain due to trauma, elevated blood-pressure reading with diagnosis of high blood pressure, anemia (reduced ability to carry oxygen), shortness of breath, dehydration, hypokalemia (low blood potassium levels), difficulty walking.</p> <p>Review of Resident #3's quarterly MDS assessment, dated 02/12/24, revealed a BIMS score of 8, indicating moderate cognitive impairment. Her MDS indicated she received oxygen therapy while a resident.</p> <p>Review of Resident #3's baseline care plan dated with onset of 08/02/23 revealed Resident #3 had issues with breathing patterns. Goal: Resident #3 will demonstrate an effective respiratory rate, depth, and pattern. Intervention: Adjust head of bed and body positioning to assist ease of respirations, Administer medications, respiratory treatments, and oxygen as ordered, administer nebulizer treatments as ordered, monitor lung sounds, pallor, cough, and character of sputum, monitor respiratory rate, depth, and effort, notify medical doctor and family of any change of condition.</p> <p>Record review of Resident #3's orders dated 08/02/23 revealed:</p> <p>Oxygen at 2 liters per minutes delivered by nasal cannula, every shift, Oxygen saturation check, if Oxygen saturation less than 90 percent notify medical doctor.</p> <p>Oxygen, every Sunday on every night shift (10:00 PM-6:00 AM) Change and label oxygen tubing and humidifier bottle and clean concentrator filter weekly.</p> <p>Record review of Resident #3's electronic medication and treatment record revealed:</p> <p>Orders to change and label oxygen tubing and humidifier bottle and clean concentrator filter was completed on 02/04/24, 02/11/24, 02/18/24.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Orders to check oxygen saturation every shift was completed daily starting from 02/01/24 - 02/23/24 morning shift, all readings above 90 percent.</p> <p>Observation and interview on 02/21/24 at 10:47 AM with Resident #3 revealed she had constant use of oxygen. Resident #3 stated she had issues with breathing, pain, anxiety and required oxygen to help her breath and calm down. Resident #3 stated staff was not changing out her oxygen bottle or tube, and she could not recall the last time staff had come in to check the oxygen level or the humidifier on the oxygen machine before today. Observation of Resident #3 revealed she was not wearing the tubing., She stated staff had just came in to check the machine. Observation of Resident's nasal cannula revealed it was not labeled or dated and water bottle concentrator was empty, not labeled or dated, delivered 2.5 liters per minute. Observation revealed staff entered the room to change out the tubing and humidifier and left the room when she observed surveyor in the room.</p> <p>Interview on 02/21/24 at 11:28 AM with LVN A revealed she entered the room to change out Resident #3's nasal cannula and water bottle because she did a round to check and noticed it had not been changed. LVN A stated the tubing and water bottle should be changed out on the overnight shift every Sunday. LVN A stated the nursing staff was responsible for changing both the tubing and water bottle. LVN A stated both the tubing and water bottle should be labeled and dated. According to LVN A, Resident #3's machine should be running at 2 liters. LVN A stated she was not sure of any risk to Resident #3 not having her tubing changed weekly or her water bottle checked often because Resident #3 hardly wore the tubing and frequently took it off.</p> <p>Interview on 02/21/24 at 11:40 AM with CNA B revealed she was working today with Resident #3; CAN B stated she had entered the room a couple times during the morning. CNA B stated she often saw Resident #3 with her tubing in her nose but has not seen her having a hard time breathing. CNA B stated when she completed care she did not notice that the water bottle on the oxygen machine was empty, but if she did, she would have notified the nurse.</p> <p>Interview on 02/23/24 at 11:10 AM with ADON revealed nursing staff on the overnight shift were responsible to change out humidifiers and tubing every Sunday on the 10:00 PM-6:00 AM shift. ADON stated nursing staff should be monitoring oxygen every shift, therefore if the water bottle was empty, it should have been changed out at that time it was found empty. ADON stated Resident #3 had orders to have 2 liters per minute, and she was not aware Resident #3 was using the machine at 2.5 liters. ADON stated it was expectation to have tubing and humidifiers dated and labeled, and nurses should be following physician orders to change, label, date and monitor according to the orders. According to ADON, Resident #3 should be only on 2 liters. ADON stated using oxygen at 2 liters per minute does not require water, only when you use at 3 liters but there could be a risk of respiratory problems. ADON stated ADON's were responsible for checking to ensure nursing staff were changing out the tubing and oxygen weekly.</p> <p>Interview on 02/23/24 at 12:21 PM with DON revealed nursing staff was responsible for ensuring to follow physician orders when it came to Resident #3's oxygen use. DON stated she expected the tubing and humidifier to be changed, labeled, and dated weekly. DON stated the humidifier was just for comfort, there was no risk to Resident #3 if there was not water present. DON stated Resident #3 did not wear her tubing all the time; however, nursing staff needed to always follow orders.</p> <p>Record review of facility's Applying an Oxygen Delivery Device policy, revised 01/12/20, reflected:</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Standard of Practice: Staff will apply oxygen delivery devices in accordance with standard practice guidelines.</p> <p>Procedure:</p> <p>Identify the resident.</p> <p>Validate physician orders.</p> <p>Validate peripheral capillary oxygen saturation.</p> <p>Attach oxygen delivery device as required.</p> <p>Attach humidified oxygen source if required, nasal cannula.</p> <p>Verify setting on the flowmeter and oxygen source and the prescribed flow rate .</p>