

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 08/27/2024
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>44786</p> <p>Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access for one (Medication Cart #1) of three medication carts reviewed.</p> <p>MA B failed to ensure Medication Cart #1 was locked when unattended on 08/27/24.</p> <p>This failure could place residents at risk of having access to unauthorized medications and/or lead to possible harm or drug diversion.</p> <p>Findings included:</p> <p>In an observation on 08/27/24 at 10:23 AM, Medication Cart #1 was observed unlocked and unattended near the one of the main entrances of the facility. There were two staff members at the nurses' station but walked away after a couple of minutes. There were four residents in wheelchairs in the immediate area. Another resident wheeled himself into the building from outside while the cart was unlocked and unattended. LVN A was observed coming from an office area behind the nurses' station. The office did not have any windows. LVN A stated Medication Cart #1 belonged to MA B. He stated she was down the hall, and he would go get her. MA B was observed as she walked toward Medication Cart #1 at 10:31 AM.</p> <p>In an interview on 08/27/24 at 10:31 AM, MA B stated she could not say why she left the cart unlocked and unattended. She stated she last used Medication Cart #1 right before 10:00 AM. She stated the cart was used for the 100 hall and the hall across from the 100 hall. MA B stated she would usually take the cart with her down the halls when she used it and would return the medication cart to the entrance area once she was done using it. MA B stated the risk of leaving the medication cart unlocked when unattended was anyone could get medication from the cart.</p> <p>In an interview on 08/27/24 at 2:20 PM, the DON stated all staff who worked with medications had been trained on keeping the medication carts locked when unattended. The DON stated the risk of an unlocked and unattended medication cart was residents could get the medications. In the same interview, the Administrator stated the medications carts should always be locked when staff step away from it. The Administrator stated the risk was anyone could get to the medications.</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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's policy titled, Medication Administration General Guidelines, dated January 2024, reflected the following:</p> <p>.17. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications when unlocked.</p>