

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 09/18/2024
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</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 the resident had a right to a safe, clean, comfortable, and home-like environment for 1 of 5 residents (Resident #1) reviewed for environment.</p> <p>The facility failed to ensure Resident #1's bed was made in a timely manner after being sanitized, which prevent the resident from being able to lie in bed.</p> <p>These failures could place residents at risk of an unsafe or uncomfortable environment.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 09/18/24 reflected the resident was an [AGE] year-old female admitted on [DATE] with diagnoses including dementia (general decline in cognitive ability), history of falling, muscle weakness, lack of coordination, hypertension (high blood pressure).</p> <p>Record review of Resident #1's Quarterly MDS assessment dated [DATE] reflected the resident was usually understood and understood others. The MDS indicated a BIMS score of 05 indicating Resident #1 was severely cognitively impaired. The MDS reflected Resident #1 utilized a wheelchair and required partial assistance from staff for activities of daily living.</p> <p>Record review of Resident #1's care plan reflected Resident #1 was a fall risk with goals that included maintaining the resident's safety and having the resident verbalizing understanding of the need for assistance. The care plan interventions included checking on the resident frequently, anticipating her needs, and assessing for contributing factors related to her fall history.</p> <p>During an observation on 09/17/24 at 1:13 PM, Resident #1's bed was observed without any sheets, and the bed was not made. Resident #1's mattress had small puddles of liquid on top of the mattress. The mattress appeared to have been sprayed some time ago, leaving the mattress with wet areas that had not dried or been wiped. Some areas appeared as though it had rings of liquid that had dried on the mattress and had not been wiped. On Resident #1's dresser, there were three pillows, one without a pillowcase, and 2 with pillowcases and a blanket.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and observation on 09/17/24 at 1:19 PM revealed Resident #1 leaving the dining room after having lunch. Resident #1 asked if she could transfer herself to bed, as she wanted to lay down. After entering Resident #1's room, observation of Resident #1's bed revealed the bed was not made and had small puddles of liquid on the mattress. Resident #1 revealed staff removed her linen to clean the bed and had not returned to make the bed.</p> <p>Interview on 09/17/24 at 1:30 PM with CNA A revealed she was working with Resident #1 today. CNA A stated Resident #1's bed was not made because she stripped the bed when Resident #1 got up because today (09/17/24) was Resident #1's shower day. CNA A stated Resident #1 showered on the 2:00 PM-10:00 PM shift. According to CNA A, she asked housekeeping to spray Resident #1's mattress, and they had not returned to wipe it down. CNA A stated Resident #1 had a visitor that came often and would smell the mattress reporting it smelled like urine, so she wanted to ensure the bed was sanitized. CNA A stated she was responsible for ensuring Resident #1's bed was sanitized, cleaned, and made daily. CNA A stated she did not think it was a problem that Resident #1's bed was not made because Resident #1 usually was in her wheelchair until after dinner time. CNA A stated she was working a double-shift and would ensure the bed was made. She did not see any risk to the resident. CNA A stated she was not aware Resident #1 wanted to get into bed.</p> <p>Observation on 09/17/24 at 2:35 PM revealed Resident #1's bed still had dried rings of liquid and small wet puddles on the mattress. Resident #1's bed had not been wiped down, cleaned, and the bed was not made.</p> <p>Interview on 09/18/24 at 11:11 AM with LVN B revealed Resident #1 was able to transfer herself and could place herself in bed whenever she wanted. LVN B stated he did not work yesterday (09/17/24) and was not aware of any visitor complaints regarding Resident #1's bed. LVN B stated he expected CNAs to clean and make resident beds on shower days and as needed. LVN B stated housekeeping did have a different sanitizing agent which may have a wait time before wiping; however, it was not acceptable to let the bed sit all day without cleaning it. LVN B stated the CNA should have returned to the room, cleaned, and made the bed immediately. LVN B stated there was a shortage of linen and that could have been the issue; however, letting the bed sit for eight hours was not acceptable. LVN B stated letting the liquid sit on the bed so long placed Resident #1 at risk of infection and caused detriment to the resident.</p> <p>During an interview on 09/18/24 at 2:17 PM with the DON, she said it was the responsibility of CNAs to ensure resident bed linens were properly replaced each day in a timely manner. The DON said if there was a concern doing so; CNAs should report to their nurses. She stated she was not aware of Resident #1 wanted to lie in bed after lunch and was not aware her bed was not made throughout the 6:00 AM-2:00 PM shift. She stated the resident's bed should not have been that way all day long. She stated the facility had ordered new linen due to a shortage. She stated when CNA did not make the bed in a timely manner it placed Resident #1 at risk of not being able to lie down when tired, possibly gaining skin issues, and not feeling comfortable in her home.</p> <p>Review of the facility's Resident Rights policy revised 08/14/22 reflected: The staff will abide by and protect resident rights in accordance with state and federal guidelines .In the event a resident rights issue is observed or alleged, staff will report the issue to the Administrator. The Administrator will pursue appropriate action regarding the alleged issues regarding resident rights</p>		