STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675756	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsburg Village Healthcare Campus	941 Scotland Dr Desoto, TX 75115

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for one of six residents (Resident #6) reviewed for abuse. The facility failed to ensure Resident #6 had the right to be free from abuse when Resident #7 punched and then pushed her on 02/05/25 located on a secure unit, causing Resident #6 to fall which resulted in a right hip fracture that required a hospital stay and surgery to repair the injury. The noncompliance was identified as PNC. The IJ began on 02/05/25 and ended on 02/05/25. The facility had corrected the noncompliance before the survey began. This failure placed residents at risk for abuse. Findings included: Record review of Resident #6's face sheet, dated 02/26/25, reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE]. Record review of Resident #6's Quarterly MDS Assessment, dated 02/12/25, reflected she had a BIMS score of 01, indicating severe cognitive impairment. Her diagnoses included hip fracture, anxiety disorder, and other orthopedic condition. The MDS indicated she had no behaviors of any kind and that she utilized a wheelchair. Record review of Resident #6's care plan, updated 01/13/25, reflected she was a fall risk. Record review of Resident #6's Nurses Notes reflected the following: - Resident noted standing up off from couch when another resident pushed her, and she went down landing on her sacral area resident removed from area made safe during assessment resident screaming and protecting right leg and hip area prn apap given dr [Physician Z] called 911 called DON preset and aware family called and message left resident transferred to [Hospital Y] for evaluation. Written on 02/05/25 by LVN X. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- 1830; Met with [Resident #6's RP] in person to discuss fall and injury. She was made aware, per investigation, fell ow resident pushed her as she was standing from sofa, she lost her balance and fell landing on her buttocks. [Resident #6] complained of pain to her right hip and thigh area, could not recall event or how she landed on floor. [Resident #6's RP] informed resident was sent to ER at [Hospital Y] due to c/o pain and inability to bear weight on right leg . written on 02/05/25 by the DON. - Resident returned from [Hospital Y] via stretcher and EMT with oxygen therapy at 2L/min via nasal cannula at 1810. Resident diagnosed with subcapital fracture of the right femoral neck. Resident surgical wound is clean and dry, with no signs of infection . Written by RN W on 02/08/25. Record review of Resident #6's hospital records reflected the following: Hospital Course: patient got into physical altercation with another resident, they pushed to this patient [sic] to the ground when she landed on her bottom, she developed severe pain in the right hip, presented to the ER where she was found to have right neck femur fracture, s/p surgery 02/06 .Active Problems: Closed fracture of neck of right femur . Observation and interview on 02/26/25 at 1:40 PM with Resident #6 revealed she was sitting on the couch in the common area. Resident #6 had her wheelchair next to her and said she was doing okay. Resident #6 said she was not in any pain and felt safe in the facility. Resident #6 said she never had a fall or had anyone push her in the facility before. Attempted phone interview on 02/26/25 at 1:57 PM with Resident #6's RP was unsuccessful as they did not answer or call back. Record review of Resident #7's face sheet, dated 02/26/25, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Record review of Resident #7's Quarterly MDS Assessment, dated 02/12/25, reflected she had a BIMS score of 07, indicating severe cognitive impairment. Her diagnoses included other neurological conditions, Alzheimer's disease, and anxiety disorder. Her MDS indicated she did not have any behaviors towards anyone. Record review of Resident #7's care plan, updated 04/08/25, did not reflect or include anything about her behaviors. Record review of Resident #7's Nurses Notes reflected the following: - Resident very disruptive and verbally aggressive with other residents, walked over to sofa and pushed another resident unprovoked and then went directly to her room. Dose not recall incident but is paranoid that fell ow residents are taking her belongings. DON notified and gave directive to contact PCP for order to send resident to [Hospital S] for eval and treatment, message left with [Resident #7's RP] NO ANSWER WHEN CALLED, [NP N] contacted, order received to send out for eval. Resident placed on 1:1 monitoring until transferred to [Hospital S]. written on 02/05/25 by the DON. - Resident return from [Hospital S] via EMT at 10:19. Resident is alert, appears calm and cooperative at this time. DON and family member notified. Plan of care continues. Written on 02/05/25 by the DON. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #7's Psychiatric Periodic Evaluation, dated 02/07/25, reflected the following: . [Resident #7] is seen today per staff request due to reports of increased anxiety, compulsivity, restlessness, and for psychotropics management. Resident is sitting up in the common area, she is calm at the moment and denying any pain or discomfort. Aspiration of reports of recent mood swing, agitation, and restlessness reported by nursing staff, patient started crying, and reports that people are 'getting to her face'. She reports mood swing, and spontaneous anxiety and agitation. Chart reviewed, medication profile reviewed, she is on the following psychotropics with no noticeable adverse effects: Aricept 10mg po daily for dementia, Levothyroxine 100 mcg for hypothyroidism, Cymbalta 20 mg p.o. twice daily for depression/anxiety lamotrigine 25 mg p.o. twice for mood regulation, and Atarax 25 mg po daily for anxiety. Due to reports of mood swing, and spontaneous combativeness, will increase lamotrigine and monitor closely. Nursing staff notified. Observation and interview on 02/26/25 at 1:42 PM with Resident #7 revealed she was sitting on a different couch in the common area. Resident #7 said she was doing okay and sometimes argued with others, but she never got into a fight with anyone or pushed anyone down. Resident #7 said she felt safe in the facility. Attempted phone interview on 02/26/25 at 1:55 PM with Resident #7's RP was unsuccessful as they did not answer or call back. Interview on the phone on 02/26/25 at 12:15 PM with CNA V revealed Resident #7 had a tendency to go off and always think someone was in her room. CNA V said she was down the hall making up a resident's bed when Resident #7 was upset at another resident saying things like she's going to jail and I'm going to kill her. CNA V said Resident #7 was not referring to Resident #6 at this time, but she de-escalated the situation and sat Resident #7 down on the couch. CNA V said she turned around and started to walk to the nurse's station when Resident #6 asked to go to the bathroom and stood up to get off the couch. CNA V said Resident #7 went over to Resident #6, punched her, then pushed her to the ground. CNA V said she ran over to the residents and asked Resident #7 why she did that and noticed Resident #7 was still trying to go after Resident #6 who was on the ground. CNA V said everything happened so fast but she was trying to get Resident #7 away from the situation and have her go to her room. CNA V said Resident #6 went to the hospital that night and did not come back for a few days and had a hip fracture. CNA V said Resident #7 was more alert than other residents on the secured unit because one of her triggers was when residents went down the hall who did not have rooms down there. CNA V said she was in-serviced after the incident happened on abuse and resident-to-resident altercations and knew to immediately separate residents and de-escalate any situation between residents. Interview on the phone on 02/26/25 at 12:43 PM with CNA U revealed it was after a meal one day (02/05/25), Resident #7 said that Resident #6 went to her room and stole something and then there was a lot of commotion. CNA U said she went towards Residents #6 and #7 to divide them up because Resident #7 had punched Resident #6 and then pushed her down to the ground. CNA U said she told Resident #7 not to do that and to let staff handle the situation but Resident #6 was already on the ground. CNA U said she was not working on the secured unit at the time but had just stopped by to drop something off. CNA U said she thought Resident #6 was injured when she said her head was hurting and she could not walk. CNA U said she was in-serviced after the incident happened on abuse and resident-to-resident altercations and knew to immediately separate residents and de-escalate any situation between residents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 02/26/25 at 1:34 PM with LVN X revealed Resident #6 was a sweet lady and Resident #7 was very nasty with her mouth and bossy. LVN X said on 02/05/25, Resident #7 was amped up for whatever reason and staff were not sure why. LVN X said Resident #6 was getting off the couch while talking to Resident #7 when Resident #7 pushed Resident #6. LVN X said she did not witness what happened but heard about it from another aide. LVN X said when Resident #6 was on the ground she called 911 and sent her to the hospital. LVN X said during her assessment while checking Resident #6's range of motion, she yelled when assessing her right side. LVN X said after the incident happened, the NP came to see Resident #7 and adjusted her medications which seems to have worked because she's been extremely pleasant and calm ever since. LVN X said she's never seen Resident #7 be physically aggressive towards others, only verbally aggressive. LVN X said she was in-serviced after the incident happened on abuse and resident-to-resident altercations and knew to immediately separate residents and de-escalate any situation between residents. Interview on 02/26/25 at 1:43 PM with CNA T revealed she was leaving the shower room and heard Resident #7 talking loudly and arguing about something when she hauled off and hit Resident #6 who fell down. CNA T said Resident #7 did not have any injuries from this situation but Resident #6 did because she was grabbing her leg and crying and saying her leg was hurting. CNA T said Resident #6 was sent to the hospital afterwards. CNA T said Resident #7 yells at others when she thought someone was stealing her clothes, but no one was. CNA T said she had never seen Resident #7 be physically aggressive towards anyone before this. CNA T said she was in-serviced after the incident happened on abuse and resident-to-resident altercations and knew to immediately separate residents and de-escalate any situation between residents. Interview on the phone on 02/26/25 at 2:14 PM with NP O revealed Resident #7 she had episodes of psychosis based on her thinking people were taking her things from her room. NP O said Resident #7 was very paranoid and had mood swings with agitation, so she was eventually moved to the all-female secured unit. NP O said he was informed Resident #7 was involved in a resident-to-resident altercation, so he went to assess her and review her medications. NP O said based on the assessment, he thought she needed mood stabilizers, so he added those to her orders. NP O said since then, Resident #7 was more stable and engaged in activities that she's participating more in. NP O said he was not aware of any other physical altercation Resident #7 was involved in. NP O said Resident #7 was now more redirectable. Interview on 02/26/25 at 3:19 PM with the DON revealed the day the incident occurred, LVN X was here and came to get the DON because she was concerned about Resident #6's leg. The DON said she was told that Resident #6 was trying to stand and Resident #7 pushed her, causing Resident #6 to lose her balance and fall in a squatting position since she's so tall. The DON said Resident #6 fell on her bottom and complained of her leg hurting. The DON said she was worried Resident #6 had a fracture from the incident. The DON said Resident #7 had walked away from the situation and went to her room but was clueless about what had just happened. The DON said Resident #7 was put on one-to-one care until she was sent to [Hospital S] where she was evaluated and sent back to the facility the same day. The DON said Resident #7 was also seen by the NP who adjusted her meds and she had been quiet ever since. The DON said Resident #7 had a behavior of thinking someone was stealing her clothes and would get upset but never became violent with anyone. The DON said she was not told that Resident #7 had first punched Resident #6 before pushing her down. The DON said after the situation happened, staff were in-serviced regarding abuse, resident-to-resident altercations, and frequent visual checks of residents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 02/26/25 at 4:01 PM with the Administrator revealed he was the abuse coordinator for the whole campus, but he had an Administrator's Assistant who was also the abuse coordinator for the South building where Residents #6 and #7 were. The Administrator said he understood that Resident #6 stood up from the sofa and Resident #7 pushed her causing her to fall to the ground when she started to complain of pain. The Administrator said Resident #6 was sent out to have x-rays done which showed she had a fracture. The Administrator said all staff were responsible for monitoring resident's and their behaviors to ensure they were not getting into an altercation with each other. The Administrator said several things could happen to residents if they were to get into an altercation with each other such as harm. The Administrator said because of the resident's diagnoses a lot of times they did not remember what they did or who they did something to. Interview on 02/26/25 at 4:17 PM with the Administrator's Assistant revealed based on what she heard and through her investigation, Resident #7 was the aggressor towards Resident #6. The Administrator's Assistant said Resident #6 was on the couch and as she was getting up, Resident #7 pushed her causing her to fall to the ground. The Administrator's Assistant said the charge nurse did an assessment on Resident #6 and found that she was complaining of pain, so she was sent to the hospital. The Administrator's Assistant said at the hospital, x-rays were done where it was found she had a fracture which required surgery to repair it. The Administrator's Assistant said there had not been any other instances of physical aggression from Resident #7 before this. The Administrator's Assistant said she was also the abuse coordinator for the facility and staff were to report any instance or allegation of abuse to her. The Administrator's Assistant said all residents have the right to be free from abuse in the facility. The Administrator's Assistant said she was not told that Resident #7 punched Resident #6 in the face. The Administrator's Assistant said staff were in-serviced regarding abuse, resident-to-resident altercations, and frequent visual checks of residents. Record review of a provider investigation report reflected the following information: Investigation Summary: On 2/5/25, a resident-to-resident altercation occurred between [Resident #6] and [Resident #7], both residing in the South Memory Community. The incident occurred when [Resident #7], who was loudly fussing, accused [Resident #6] of entering her room. As [Resident #6] attempted to rise from the couch in the dining room, [Resident #7] pushed [Resident #6], causing [Resident #6] to fall to the floor and land on her sacral area. Nursing staff were present and immediately intervened, separating the residents. A head-to-toe assessment was conducted for both residents by the charge nurse, [LVN X]. [Resident #6] complained of right hip pain, held her right leg, and was unable to bear weight on it. Although no visible injuries were noted and vital signs stable. Pain medication was administered and [Resident #6] was sent to the ER for further evaluation and treatment. [Resident #7], [sic] no adverse effect and injuries noted, vital signs stable. Placed on 1:1 supervision pending a transfer to [Hospital S]. Notifications made to Family, [Resident #6's RP and Resident #7's RP] notified. [Physician R and Physician Q] notified. Interview and statements collected from witnesses present attached. Social worker conducted safety survey, noting no concerns. Staff in-service [sic] resident to resident altercation, resident behaviors, resident 1:1, abuse and neglect. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[Resident #6] was admitted to the hospital and underwent surgery for a right hip repair. She returned to the facility on [DATE] with new order for Tylenol 3 and a follow-up appointment scheduled with [Physician P] on 2/20/25 at 11:30 AM. She is currently alert and resting in bed. [Resident #7] was placed on 1:1 supervision pending a transfer to [Hospital S]. On 2/5/25, [Resident #7] was evaluated by [Hospital S] and cleared to return to the facility the same day. Q15-minute checks were conducted for 72 hours per facility. [Resident #7] is currently cooperative and participating in normal activities without further incidents. Record review of resident safe surveys revealed 5 were completed with residents on 02/05/25 with no additional findings of any other abuse in the facility. Record review of an in-service, dated 02/05/25, reflected staff were in-serviced regarding abuse, falls, resident monitoring, injury of unknown origin, and resident-to-resident altercation. Record review of the facility's Abuse, Neglect and Exploitation and Misappropriation of Resident Property policy, dated 02/12/20, reflected: Policy 1. Resident Rights. Each resident has the right to be free from abuse, neglect, exploitation, misappropriation of resident's property, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse, neglect, exploitation, misappropriation of resident's property by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, resident representative, friends, or other individuals. 2. Facility Duty to Protect Resident Rights. The facility must prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident's property. The Administrator was notified on 03/12/25 at 10:00 AM that a past non-compliance IJ situation had been identified due to the above failures. It was determined this failure placed Resident #6 in an IJ situation on 02/05/25.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on interview and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for one of five residents (Resident #1) reviewed for misappropriation of property. The facility failed to prevent the ADON from taking two morphine pills prescribed for Resident #1 on 02/24/25. This failure could place residents at risk of pain and failure to achieve therapeutic effects intended by the physician. The noncompliance was identified as past noncompliance that began on 02/24/25 and ended on 02/24/25. The facility had corrected the noncompliance before the surveyor entered. No Plan of Correction required. Findings included: Record review of Resident #1's undated Face Sheet reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included lung cancer, brain cancer, and high blood pressure. Record review of Resident #1's admission MDS, dated [DATE], reflected a BIMS score of 8 indicating he was moderately cognitively impaired. His Function Status indicated he needed limited assistance with his ADLs. Record review of Resident #1's care plan, dated 02/19/25, reflected he had anxiety and depression, he had pain that was treated with morphine in pill and liquid forms, and he was a fall risk. Record review of Resident #1's physician orders reflected an order dated 02/18/25 Morphine 15 mg ER, one tablet twice a day for pain Interview on 02/26/25 at 12:04 PM with the DON revealed Resident #1 had been admitted from hospice at home with a bottle of Morphine 15 mg extended release tablets, as well as liquid morphine. The morphine pills were counted and a count sheet was created indicating he started with 9 pills. The DON stated the physician's order was 1 pill twice a day. The DON stated on 02/24/25 on the 6:00 AM-2:00 PM shift the ADON notified LVN A there was a change in Resident #1's medications, the morphine pills were discontinued and the resident was to only receive the liquid morphine. The ADON took the pills and the corresponding count sheet to her office. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated on the 2:00 PM-10:00 PM shift on 02/24/25 Resident #1's MAR indicated he was due for a morphine pill and there were none on the cart. The ADON was contacted about the order, and she brought the pills back out with a new count sheet that started with three pills. The resident was medicated, but staff thought there were pills missing. The DON was contacted the morning of 02/25/25 about their concern. The DON reviewed the order and determined Resident #1 should have had 5 pills the previous night, not 3. The count sheet should not have been a new one, it should have been the original sheet with all the previous doses documented. The DON contacted the ADON who brought in the original count sheet. The original count sheet had the numbers altered to indicate the resident had admitted with 7 pills instead of 9 pills. The ADON was currently suspended pending an investigation. The DON stated the resident did not miss any doses of his morphine pills, and his hospice nurse brought a refill of pills in a pill pack form instead of loose pills in a bottle. Interview on 02/26/25 at 1:15 PM with LVN A revealed the ADON came to her on 02/24/25 and stated there were no orders from hospice for any of Resident #1's medications. The ADON removed the morphine pills as well as the liquid morphine from her cart. LVN A stated the ADON brought the liquid morphine back to her within about an hour, but not the pills. LVN A stated the count at 2:00 PM was not off because the pills and the count sheet were not on the cart. Attempts were made on 02/26/25 at 1:30 PM and 2:00 PM to interview the the ADON by phone, but the attempts were unsuccessful. Record review of the facility's Abuse, Neglect, and Exploitation, and Misappropriation of Resident Property, dated 02/12/20, reflected the following: The facility must prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. Misappropriation: The deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on interviews and record reviews the facility failed to ensure residents were free of any significant medication errors for one of six residents (Resident #2) reviewed for pharmacy services. The facility failed to administer Resident #2's cancer medication, Ibrance, as prescribed, which resulted in the resident missing four doses between 08/26/24 and 08/29/24. This failure could place residents at risk of not achieving the therapeutic effects intended by the physician. Findings included: Record review of Resident #2's undated Face Sheet reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included heart failure, swelling of the legs, and breast cancer in 2019. Record review of resident #2's quarterly MDS, dated ,d+[DATE]//25, reflected a BIMS score of 8 indicating she mildly cognitively impaired. Her Functional Status indicated she required staff assistance with her ADLs. Record review of Resident #2's care plan, dated 02/18/25, reflected she had anxiety and seizures, breast cancer to the left breast. Record review of physician orders for Resident #2 reflected an order dated 08/08/24: Ibrance 125 mg capsule (PALBOCICLIB) 1 capsule by mouth 1 time per day 21 Days. Ibrance 125 mg 1 tablet by mouth daily x 21 days, then off for 1 week, then resume for another 3 weeks Dx: Malignant neoplasm of central portion of left female breast Record review of Resident #2's MARs from August 2024 to December 2024 reflected the resident did not receive her Ibrance as ordered from 08/26/24-08/29/24. Interview on 02/26/24 at 3:30 PM with the DON revealed there were some problems getting Resident #2's Ibrance delivered initially as it came from a specialty pharmacy, not their normal pharmacy. The DON stated there should be no reason the resident did not receive her Ibrance from August 26th through the 29th. The MAR indicated on the 27th (08/27/24) the resident was at a doctor's appointment, but the resident should have received her dose before she left or after she returned. The DON stated cancer medications like that were important to ensure all doses were given to maintain therapeutic blood levels. Record review of the facility's Medication Administration policy, dated January 2024, reflected: .Medications are administered as prescribed, in accordance with manufacturer's specifications, good nursing principles and practices . (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.19. For residents not in their rooms or otherwise unavailable to receive medications on the pass, the nurse returns to the missed residents to administer the medication .