

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  03/08/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received services in the facility with reasonable accommodation of resident needs for one (Resident #1) five reviewed for resident call system, in that:</p> <p>Resident #1's call lights was on the floor and not within reach on 03/24/2025.</p> <p>This failure could place the residents at risk of not receiving the care and services to maintain their highest level of well-being.</p> <p>Findings included:</p> <p>Record review of Resident #1's electronic face sheet printed on 03/08/2025 reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included but not limited to Alzheimer's (a brain disorder that slowly destroys memory and thinking skills) and esophagitis (inflammation or irritation of esophagus, the pipe that carries food from mouth to stomach. This can cause pain, difficulty in swallowing or chest pain.)</p> <p>Record review of the annual MDS dated [DATE] did not indicate a BIMS score. Section GG Functional Abilities reflected Resident #1 required substantial/maximum assistance with transfers and sit to stand.</p> <p>Record review of Resident#1's service plan last reviewed 12/11/2024 reflected Resident #1 was a fall risk with interventions to include call light within reach.</p> <p>Observation and attempted interview on 03/08/2025 at 11:05 AM revealed the call button was on the floor and out of Resident #1's reach. Resident #1 was only able to answer yes or no questions.</p> <p>Interview and observation on 03/08/2025 at 11:15 AM with LVN A revealed the call light should have been within reach. LVN A stated all staff should ensure call lights were within reach each time they entered a room. LVN A stated Resident #1 never used her call light however it should have been within reach.</p> <p>Interview on 03/08/2025 at 11:53 AM with CNA B revealed he was last in Resident #1's room around 9:00 AM, and he thought the call light was within reach. CNA B stated he was not sure what the risk would be if the call light was not in reach.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/08/2025 at 12:22 PM with the Assistant Executive Director revealed when she was made aware of the call light not being in place, she stated, Those questions would be more suitable for the Director of Nursing. The interview was ended.</p> <p>Interview on 03/08/2025 at 1:30 PM with the Director of Nursing revealed staff should have ensured call lights were within reach each time they entered a resident room. The Director of Nursing revealed the risk of not ensuring the call light was in place would be residents would not be able to reach staff if needed.</p> <p>Record review of the facility's Resident Rights policy, dated 08/22/2020, reflected it did not address resident rights to reasonable accommodations.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident has a person-centered comprehensive care plan developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental and psychosocial needs for one of five residents (Resident #1) reviewed for care plans.</p> <p>The facility failed to follow Resident #1's care plan intervention of lowering the bed and the use of half bedrails due to fall risk.</p> <p>This failure could place residents at risk for receiving delayed treatment and not obtaining/maintaining their highest practicable wellbeing.</p> <p>Findings included:</p> <p>Record review of Resident #1's electronic face sheet printed on 03/08/2025 reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis that included but not limited to Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills) and esophagitis (inflammation or irritation of esophagus, the pipe that carries food from mouth to stomach. This can cause pain, difficulty in swallowing or chest pain.)</p> <p>Record review of the annual MDS dated [DATE] did not indicate a BIMS score. Section GG Functional Abilities reflected Resident #1 required substantial/maximum assistance with transfers and sit to stand. Resident #1 was not coded for falls on the MDS.</p> <p>Record review of Resident#1's service plan last reviewed 12/11/2024 revealed Resident #1 was a fall risk with interventions to include call light within reach and 1/2 bed rail use.</p> <p>Observation on 03/08/2025 at 11:05 AM of Resident #1's bed revealed it was not in the lowest position, the fall mat was leaning against the wall and the bed rails were down.</p> <p>Observation on 03/08/2025 at 3:09 PM of Resident #1 revealed she was in bed sleeping. The bed was not in the lowest position, the bed rails were not raised, and a fall mat was not on the floor.</p> <p>Interview on 03/08/2025 at 11:15 AM with LVN A revealed Resident #1's fall mat should have been down and the bed rail should have been up on one side. LVN A stated she was not sure why the fall mat was not down, bed not in lowest position and rail not up. LVN A stated anyone who entered the room should have ensured fall interventions were in place.</p> <p>Interview on 03/08/2025 at 11:53 AM with CNA B revealed he had not been in Resident #1's room since around 9:00 AM when he attempted to feed her. He stated he forgot to lower the bed and put the fall mat down when he left the room. CNA B stated he was not aware of what the risk would be if interventions were not followed.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/08/2025 at 1:30 PM with the Director of Nursing revealed Resident #1 was a fall risk and should have had the bed in the lowest position and the fall mat on the floor on one side of the bed and the bed rail up on the other side of the bed. The Director of Nursing stated all staff should ensure fall interventions were in place each time they enter the room. The Director of Nursing stated the risk of not ensuring interventions were in place would be the resident could fall and get hurt.</p> <p>Record review of the facility's Comprehensive Care plan policy, revised 02/12/2020, reflected: Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who were unable to carry out activities of daily living received the necessary services to maintain good nutrition for one of three residents (Resident #1) reviewed for ADLs in that:</p> <p>The facility failed to ensure Resident #1 was provided with feeding assistance.</p> <p>This failure could place residents at risk of not receiving care and services to meet their needs which could result in nutritional needs not being met and a diminished quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #1's electronic face sheet printed 03/08/2025 reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included but not limited to Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills) and esophagitis (inflammation or irritation of esophagus, the pipe that carries food from mouth to stomach. This can cause pain, difficulty in swallowing or chest pain.)</p> <p>Record review of Resident #1's service plan revised 12/11/2024 reflected Resident #1 was on puree diet with liquid nectar/mildly thick liquids. The care plan did not address the need for assistance with feeding.</p> <p>Record review of Resident #1's annual MDS dated [DATE] did not indicate a BIMS score. Section GG Functional Abilities reflected Resident #1 required partial/moderate assistance with eating.</p> <p>Record review of Resident #1's nutrition progress notes, dated 12/11/2024, and completed by the Physician reflected Resident #1 had unplanned weight loss/at risk for malnutrition. Interventions included diet as prescribed, encourage fluid intake, meals/ snacks as necessary and provide necessary assistance with fluid and meals.</p> <p>Record review of the electronic ADL sheet dated 03/08/2025 reflected there was no documentation of Resident #1 eating breakfast.</p> <p>During observation and attempted interview on 03/08/2025 at 11.05 AM, Resident #1's puree breakfast on the bedside table was completely intact. An interview was attempted with Resident #1, and the resident was able to answer yes/no questions. Resident #1 responded no when asked if someone had assisted her with feeding. Resident #1 responded yes when asked she wanted to eat.</p> <p>Interview and observation on 03/08/2025 at 11:15 AM with LVN A revealed she was the nurse for Resident #1, and she stated she was not aware Resident #1 had not eaten breakfast. LVN A stated Resident #1 did require assistance with feeding, and CNA B would have been responsible for ensuring Resident #1 was assisted with eating. LVN A stated CNA B did not inform her that Resident #1 had not eaten. LVN A entered Resident #1's room and asked Resident #1 if she wanted to eat, and Resident #1 responded yes. LVN A proceeded to feed Resident #1 applesauce and provided apple juice. She acknowledged that Resident #1 required total assistance from staff for eating.</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 - Few</p>	<p>Interview on 03/08/2025 at 11:53 AM with CNA B revealed he delivered the breakfast tray to Resident #1 at 8:15 AM and attempted to assist the resident with feeding; however, Resident #1 would not open her mouth. CNA B stated he went back around 9:00 AM to attempt to feed Resident #1 again, but he forgot to report to LVN A that Resident #1 did not eat breakfast. CNA B stated he was not sure what the risk would be if Resident #1 was not eating her meals. CNA B confirmed that Resident #1 required total assistance for eating.</p> <p>Interview on 03/08/2025 at 12:22 PM with the Assistant Executive Director revealed CNAs were responsible for ensuring residents who required assistance with eating received the assistance. The Assistant Executive Director revealed CNAs were responsible for ensuring they informed nursing staff if a resident did not eat. The Assistant Executive Director revealed there could be a risk to residents depending on the specifics for each resident however did not give any specific information stating the question would be more suitable for the Director of Nursing and the interview was ended.</p> <p>Interview on 03/08/2025 at 1:30 PM with the Director of Nursing revealed CNAs should make several attempts to assist residents with meals when required. The Director of Nursing stated Resident #1 did require full assistance during meals however would refuse occasionally. The Director of Nursing stated CNA B was responsible for ensuring LVN A was made aware of Resident #1 not eating. The Director of Nursing revealed the risk of not ensuring meals were eaten could be unwanted weight loss.</p> <p>Record review of the facility's Assisting Residents with Eating policy, revised 02/12/2020, reflected: Report to the licensed nurse if food consumption is 25% or less. Amount will be recorded by percentage in the HER or POCS device.</p>		