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	03/28/2025

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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on interview and record review, the facility failed to ensure residents were seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter or alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist for four (Residents #1, #2, #3 and #4) of four residents reviewed for physician services. The facility failed to ensure Residents #1, #2, #3 and #4 were seen by their attending physician at least once every 60 days. The attending physician's extender was completing all visits for the residents, not alternating visits with the physician. The failure could place residents at an increased risk of not receiving appropriate and adequate medical care and a lack of oversight by the physician, which could place the residents at risk of harm and health decline. Findings included: 1. Record review of Resident #1's face sheet dated 03/26/25 reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE] with active diagnoses of hypertensive chronic kidney disease (occurs when high blood pressure damages the kidneys, leading to impaired kidney function and potentially end-stage renal disease), intervertebral disc degeneration (a condition where the discs between vertebrae in the spine break down or wear down, potentially causing pain, numbness, and weakness), osteoarthritis in right knee (degenerative joint disease), mixed hyperlipidemia (a condition where multiple types of lipids (fats) in the blood are elevated above normal levels), morbid (severe) obesity, overactive bladder, constipation, and allergic rhinitis. Resident #1's face sheet reflected MD A was listed as her attending physician. Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 03, which indicated severe cognitive impairment. Resident #1 had no signs/symptoms of delirium (inattention, disorganized thinking and altered level of consciousness), her mood score was a 00 which indicated no negative mood issues. Resident #1 had no potential indicators of psychosis, physical or verbal behaviors, rejection of care or wandering. She required partial/moderate assistance from staff for her ADL's and was incontinent of bowel and bladder. Resident #1 had no indicators of pain and had no falls since the last MDS assessment. Resident #1 was administered three at-risk drugs-an antipsychotic, an antidepressant and a diuretic (medication that helps reduce fluid build-up). (continued on next page)

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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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's care plan initiated on 10/02/23 and last updated 01/14/25 reflected the following problem/issues: 1) Psychotropic drug use related to schizophrenia, 2) Impaired physical mobility due to stroke and 3) Dementia, dysphagia (difficulty swallowing) and inability to communicate. Record review of Resident #1's March 2025 Physician Orders reflected she was prescribed the current labs and medications while under MD A's medical care: TSH, CBC, CMP and lipid profile every 12 months in October (start date 10/04/23), montelukast 10 mg once every evening (start date 10/02/23), omeprazole 40 mg once a day (start date 08/15/24), oxybutynin 40 mg once a day (start date 10/03/23), simvastatin 20 mg once at bedtime (start date 10/02/23), duloxetine 20 mg at bedtime (start fate 10/02/23), risperidone 2 mg two tablets at bedtime (start date 10/17/24), loratadine 10 mg once a day (start day 11/25/23), Lisinopril 40 mg once a day-hole if SPB less than 110 and DBP less than 60 (start date 10/02/23), Mucinex 600 mg ER twice a day every 12 hours (start date 08/15/24), Ingrezza 40 mg once at bedtime (start date 03/05/25), furosemide 40 mg once a day (start date 11/05/23), fluticasone propionate 50 mcg/actuation nasal spray one in each nostril once a day (start date 10/03/23), fenofibrate nano crystallized 145 mg once at bedtime (start date 10/02/23) and donepezil 10 mg two tablets at bedtime (start date 11/08/24). Record review of Resident #1's clinical chart reflected no evidence of any visit by a physician in the past 12 months from 03/01/24 through 03/26/25. Review of Resident #1's clinical chart revealed the following physician extender visits by NP B since 03/01/2024: 03/08/24, 04/07/24, 05/07/24, 06/04/24, 07/04/24, 08/09/24, 09/04/24, 10/08/24 (NH annual History and Physical Exam), 11/03/24, 12/03/24, 01/02/25 and 02/05/25. 2. Record review of Resident #2's face sheet dated 03/26/25 reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE] with active diagnoses of paraplegia (the inability to voluntarily move the lower parts of the body), vitamin D deficiency, constipation, essential (primary) hypertension (a condition where the force of blood against the artery walls is consistently too high, potentially damaging the heart, brain, and other organs), neuromuscular dysfunction of bladder (lack of bladder control due to brain, spinal or nerve problems) , gastro-esophageal reflux disease (a common condition in which the stomach contents move up into the esophagus) and chronic pain due to trauma. Resident #2's face sheet reflected MD A was listed as her attending physician. Record review of Resident #2's quarterly MDS assessment dated [DATE] reflected a BIMS score of 08, which indicated moderate cognitive impairment. Resident #2 had fluctuating behaviors of inattention and disorganized thinking and sometimes experienced social isolation. She had no potential indicators of psychosis, physical or verbal behaviors, rejection of care or wandering. Resident #2 required physical assistance of staff for her ADL's, had an indwelling catheter and was frequently incontinent of bowel. She used a wheelchair for mobility and had no range of motion issues. Resident #2 had no indicators of pain and had no falls since the last MDS assessment. Resident #2 was administered three at-risk drugs: an antipsychotic, an antidepressant, an opioid and an anticonvulsant. Record review of Resident #2's care plan initiated 01/21/21 and last revised 03/07/25 reflected the following problems/issues: 1) Use of Xanax due to anxiety, restlessness and fidgeting; 2) History of depression and use of multiple antidepressants, 3) Acute pain from trauma due to paraplegia and spinal cord injury, 4) Use of antihypertensive medications due to elevated blood pressure, 5) Impaired physical mobility and self-care deficits and use of a F oley catheter. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's March 2025 Physician Orders reflected she was prescribed the current labs and medications while under MD A's medical care: TSH, CMP, CBC and lipid profile every 12 months (start date 12/16/24), duloxetine 20 mg twice a day (start 03/07/25), escitalopram 10 mg 1 1/2 tablet at bedtime to equal 15 mg (start date 03/07/25), lamotrigine 100 mg twice a day (start date 01/17/25), Uzedy 200 mg/0.56 ml subcutaneously once a month on the 27th (start date 10/25/24) and sennosides 8.6 mg-docusate sodium 50 mg twice a day (start date 03/11/21). Record review of Resident #2's clinical chart reflected no evidence of any visit by a physician in the past 12 months from 03/01/24 through 03/26/25. Review of Resident #2's clinical chart revealed the following physician extender visits by NP B since 03/01/2024: 03/04/24, 04/03/24, 05/07/24, 05/24/24, 06/06/24, 07/06/24, 08/11/24, 09/06/24, 10/06/24, 11/05/24, 12/23/24, 01/14/25 and 02/05/25. 3. Record review of Resident #3's face sheet dated 03/26/25 reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE] with active diagnoses of senile degeneration of brain (also known as dementia, is a group of conditions that cause a decline in cognitive function and memory and is a progressive and irreversible process that typically occurs in older adults), sequelae of cerebral infarction (also known as an ischemic stroke, is the death of brain tissue (cerebral infarct) due to a lack of blood flow (ischemia) caused by a blockage or narrowing of blood vessels in the brain), chronic kidney disease-stage 3 (a gradual progressive loss of kidney function leading to a buildup of waste and fluid in the body), major depressive disorder (persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities, impacting daily functioning), hyperlipidemia (a condition characterized by elevated levels of lipids (fats) in the blood which can increase the risk of heart disease and stroke), Alzheimer's disease (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior), neuromuscular dysfunction of bladder (a condition where bladder control is lost due to problems with the brain, spinal cord, or nerves that control bladder function, leading to difficulties in emptying or holding urine) and pain. Resident #3'w face sheet reflected MD A was listed as her attending physician. Record review of Resident #3's quarterly MDS assessment dated [DATE] reflected a BIMS score of 00, which indicated severe cognitive impairment and a mood score of 00 which indicated no negative mood issues. Resident #3 had no potential indicators of psychosis, no physical or verbal behavioral symptoms, no rejection or care and no wandering behaviors, fluctuating behaviors of inattention and disorganized thinking and sometimes experienced social isolation. She had no potential indicators of psychosis, physical or verbal behaviors, rejection of care or wandering. Resident #3 required extensive physical assistance of staff for her ADL's and was incontinent of bowel and bladder. She used a wheelchair for mobility and had no range of motion issues. Resident #3 had no indicators of pain and had no falls since the last MDS assessment. Resident #3 received physical and occupational therapy during her last assessment period. Record review of Resident #3's care plan dated 09/07/24 reflected the following problems/issues: 1) Poor balance, 2) Problems with elimination (bowel/bladder), 3) Dysphagia and chewing difficulty, and 4) Pain. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's March 2025 Physician Orders reflected she was prescribed the current labs and medications while under MD A's medical care: TSH, CMP, CBC labs every 12 months (start date 09/27/24), Depakote valproic acid every three months (start 12/27/24), mirtazapine 15 mg 0.5mg at bedtime (start date 02/14/25), divalproex 125 mg twice a day (start date 02/21/25), bupropionER on ce a day (start date 02/12/25), Myrbetriq 50 mgER on ce a day (start date 09/27/24), atorvastatin 40 mg once a day (start 09/27/24), aspirin 81 mg once a day (start date 09/27/24) and amlodipine 10 mg once a day (hold if SBP less than 110 and DBP less than 60) (start date 09/27/24). Record review of Resident #3's clinical chart reflected no evidence of any visit by a physician since her admission on 09/27/24. Review of Resident #3's clinical chart revealed the following physician extender visits by NP B since her admission on 09/27/24: 09/28/25, 10/14/24, 11/09/24, 12/07/24, 01/02/25 and 02/01/25. 4. Record review of Resident #4's face sheet dated 03/26/25 reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE] with active diagnoses of heart failure (occurs when the heart muscle doesn't pump blood as well as it should), diarrhea, pruritus (itching), allergic rhinitis, hypertension, constipation, long term (current) use of anticoagulants, schizophrenia (a chronic mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), thyrotoxicosis (excessive thyroid hormone levels in the bloodstream) and pain. Resident #4's face sheet reflected MD A was listed as her attending physician. Record review of Resident #4's quarterly MDS assessment dated [DATE] reflected a BIMS score of 02, which indicated severe cognitive impairment. Resident #4 had signs/symptoms of delirium which included fluctuating inattention and disorganized thinking and her mood score was a 00 which indicated no negative mood issues. Resident #4 had no potential indicators of psychosis, physical or verbal behaviors, rejection of care or wandering. She required limited supervision/assistance from staff for her ADL's and was continent of bowel and occasionally incontinent of bladder. Resident #4 had no indicators of pain and had no falls since the last MDS assessment. Resident #4 was administered five at-risk drugs-an antipsychotic, an antidepressant, an anticoagulant (a medication to prevent or reduce blood clotting), a diuretic and an anticonvulsant. Resident #4 also received hospice care and occupational therapy during the last assessment period. Record review of Resident #4's care plan 02/27/25 reflected the following problems/issues: 1) Atrial fibrillation (abnormal heart rhythm) and use of anti-coagulants, 2) Use of anticonvulsant, antidepressant and opioid therapy, 3) Renal disease (gradual loss of kidney function) and constipation, 4) Skin breakdown and wound care, 5) Pain and hospice care related to a terminal diagnosis. Record review of Resident #4's March 2025 Physician Orders reflected she was prescribed the current medications while under MD A's medical care: rivaroxaban 15 mg once every evening (start date 02/27/25), olanzapine 5 mg at bedtime (start date 02/27/25), duloxetine 20 mg once a day (start date 02/27/25), divalproex 125 mcg two capsules twice a day (start date 02/27/25), tramadol 50 mg every six hours as needed (start date 02/27/25), thiamine 50 mg once a day (start date 02/27/25), midodrine 5 mg three times a day as needed- administer for SBP less than 90 (start date 02/27/25), trazadone 150 mg once at bedtime (start date 02/27/25), hydroxyzine 10 mg once a day (start date 02/27/25), folic acid 1 mg once a day (start date 02/27/25), docusate sodium 100 mg twice a day (start date 02/27/25), amlodipine 5 mg once a day-hold if SBP greater than 110 and hold if DBP greater than 60 (Start date 02/27/25) and methimazole 5 mg once a day (start date 02/27/25). (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's clinical chart reflected no evidence of any visit by a physician for the past 12 months (03/01/24 through 03/26/25). 5. An interview with MD A on 03/26/25 at 1:34 PM revealed he did not have any documented evidence that he completed face to face visits for Residents #1, #2, #3 and #4. MD A stated he usually did rounds with his nurse practitioner and gave him instructions on what changes to make to treatment. He stated his office was across the street from the facility and if the nursing staff needed him to see a resident in person, he would go and see them. MD A stated, I would say I am falling behind on writing notes; I delegate that to the nurse practitioner. MD A stated he understood the CMS regulations related to face-to-face physician visits, but again stated, I am falling behind. MD A stated he had one physician extender, NP B. He stated it was important for the attending physician to see their assigned resident, for good medical service. For Resident #1, MD A stated she had degenerative arthritis and he was planning on seeing her later in the day (03/26/25) because she needed a steroid shot and ultrasound to do a knee injection. He stated he would complete his physician face to face visit with her at that time. An interview with the Administrator on 03/26/25 at 4:30 PM revealed there was no facility policy related to physician visits and they followed the CMS/HHSC regulatory language. A follow up interview with the Administrator on 03/28/25 at 10:11 AM revealed after investigator intervention, MD A saw Resident #1 on 03/27/25 at his office and provided her a knee injection the resident had been waiting to receive for knee discomfort. The Administrator provided MD A's physician documentation for the visit. 6. Record review of the facility's signed July 2014 Medical Director Agreement with MD A reflected in part, .3. Duties of Physician- a. Physician Leadership (i) Assist the Facility in ensuring that residents and patients have appropriate physician coverage and ensure the provision of physician and health care practitioner services; 3.2 Physician shall perform the Services in a timely and professional manner and in conformity with the highest standards of procedure and ethics. Physician shall comply with Facility's policies and procedures and medical staff bylaws, including, without limitation, those relating to conduct, standards of medical care and record compliance.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on interviews and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for one (Resident #3) of four residents reviewed for pharmacy services. The facility failed to administer Resident #3, who had a diagnosis of dementia, with her morning medications on 03/26/25 and 03/27/25. Both the medication aide and nurse acknowledged they were busy and did not attempt to give them to her again after one refusal. As a result, Resident #3 missed eight different medications both days, including blood pressure readings related to blood pressure medication, as well as two supplements. The failure could place residents at risk for exacerbation of health conditions, worsening of conditions, and physical/emotional discomfort. Findings included: Record review of Resident #3's face sheet dated 03/26/25 reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE] with active diagnoses of senile degeneration of brain (also known as dementia, is a group of conditions that cause a decline in cognitive function and memory and is a progressive and irreversible process that typically occurs in older adults), sequelae of cerebral infarction (also known as an ischemic stroke, is the death of brain tissue (cerebral infarct) due to a lack of blood flow (ischemia) caused by a blockage or narrowing of blood vessels in the brain), chronic kidney disease-stage 3 (a gradual progressive loss of kidney function leading to a buildup of waste and fluid in the body), major depressive disorder (persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities, impacting daily functioning), hyperlipidemia (a condition characterized by elevated levels of lipids (fats) in the blood which can increase the risk of heart disease and stroke), Alzheimer's disease (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior), neuromuscular dysfunction of bladder (a condition where bladder control is lost due to problems with the brain, spinal cord, or nerves that control bladder function, leading to difficulties in emptying or holding urine) and pain. Record review of Resident #3's quarterly MDS assessment dated [DATE] reflected a BIMS score of 00, which indicated severe cognitive impairment and a mood score of 00 which indicated no negative mood issues. Resident #3 had no potential indicators of psychosis, no physical or verbal behavioral symptoms, no rejection or care and no wandering behaviors. Record review of Resident #3's care plan dated 09/07/24 reflected the following problems/issues: 1) Poor balance, 2) Problems with elimination (bowel/bladder), 3) Dysphagia (difficulty swallowing) and chewing difficulty, and 4) Pain. The interventions for her prescribed medications were to administer medications as ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's March 2025 Physician Orders reflected she was prescribed: mirtazapine 15 mg 0.5mg at bedtime (antidepressant-start date 02/14/25), divalproex 125 mg twice a day (anticonvulsant-start date 02/21/25), bupropionER on ce a day (antidepressant-start date 02/12/25), Myrbetriq 50 mgER on ce a day (treats overactive bladder-start date 09/27/24), atorvastatin 40 mg once a day for cholesterol (start 09/27/24), megestrol 5ml by mouth once a day for dementia (start date 02/21/25), aspirin 81 mg once a day (start date 09/27/24), amlodipine 10 mg once a day (blood pressure-hold if SBP less than 110 and DBP less than 60) (start date 09/27/24), polyethylene glycol 17 grams once a day in eight ounces of fluid (start date 12/17/25), 2.0 Cal Med Pass supplement 60 ml four times a day with medication pass for adult failure to thrive (start 12/17/24). Record review of Resident #3's March 2025 MAR reflected she was not administered the following medications on 03/26/25 and 03/27/25 on the morning shift: amlodipine, aspirin, atorvastatin (including no blood pressure recordings), bupropion, multivitamin, divalproex, megestrol, Myrbetriq, polyethylene glycol and med pass supplement. The MAR for the missed med administrations was initialed by MA D as resident refusals. Record review of Resident #3's nursing progress notes revealed no entry for 03/26/25 and 03/27/25 to document the nurse was notified of the medication refusals, why the medication was not given, nor what was done after the resident refused to take the medication and if the doctor was notified. An interview with LVN C on 03/26/25 at 12:47 PM revealed if a medication aide could not administer a medication for whatever reason, then the medication would show on the MAR as not given and the med aide had to tell the charge nurse, then that charge nurse had to document and follow up on it. He said if a medication was not able to be given after three attempts, including for resident refusals, the nurse had to contact the doctor. LVN C stated he liked to notify the doctor after the first refusal especially if it was a high-risk medication, Just to put it on the doctor's radar in case it becomes an issue. An interview with the DON on 03/26/25 at 2:18 PM revealed she did not have an ADON working in the facility, so she had been responsible for all the DON duties and the ADON's duties. In response to Resident #3's medication not being given for two days on the morning shift and documented as refusals, the DON stated, We need to figure out why med aides are clicking not given on these MARs. Maybe they are just going too fast and not clicking the correct reason is why it was not given. An interview with MA D on 03/28/25 at 1:05 PM revealed she was the person who did the med administration pass for Resident #3 on 03/26/25 and 03/27/25 in the morning. She stated Resident #3 did not take the medication when offered both those days and spit it out. MA D stated in the mornings, sometimes Resident #3 refused to let the med aide take her blood pressure and would move her arms around to where she could not get an accurate reading on the machine. MA D stated that with the medications, she crushed them and put them in applesauce but Resident #3 would spit it out. MA D stated, If she is feisty, she will not accept. MA D stated when that happened, she was supposed to let the charge nurse know that an attempt was made and refused. MA D stated there was one other medication aide in the facility who passed medications on the other halls and in the mornings, they had to have their own routine due to the number of medications that had to be administered. MA D stated she typically started administering medications around 6:30 AM-7AM and tried to be finished by 10:00 AM. MA D stated, I have to keep moving. If someone refuses, I got to keep going because I have other meds to give. MA D stated again that her job was to report medication refusals to the charge nurse and it was on the charge nurse to chart it, call the doctor and follow up and decide what to do. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with MA E on 03/28/25 at 1:14 PM revealed she had administered Resident #3's medications that morning (03/28/25) with no issues. She stated sometimes when Resident #3 was mad, she would refuse to let the med aide take her blood pressure and give her medications, but not every day. MA E stated when Resident #3 refused the blood pressure, she would tell her that her family member really wanted her to stay healthy and would like it, and she would normally comply. MA E stated Resident #3 liked sweet things, so when she crushed her medications , she put them in applesauce with a little bit of jelly. MA E said if Resident #3 did refuse her medications during a med pass, the med aide had to document it in the e-chart and then notify the nurse and both of them would try together to encourage the resident to take them. MA E stated it was important for Resident #3 to take her medications as ordered because she needed the blood pressure medication due to her running high at times, and there was another medication to help her calm down and not stress or feel frustrated. An interview with LVN F on 03/28/25 at 2:00 PM revealed she was the charge nurse for Resident #3 and stated MA D did notify her about the medication refusals. LVN F stated, I was busy, but typically we have to document if they refuse. She stated if the resident continued to refuse for a couple of days, which was not typical, then the NP was notified. LVN F stated, As a nurse, I am supposed to document that the med aide tried to administer meds but the patient didn't want them. LVN F stated when that happened, she would normally go to the resident's room and try to encourage them but at the end of the day, it was their right. She said for the past two mornings (03/26/25 and 03/27/25), she did not try to get Resident #3 to take her medications when she was notified of the refusals. LVN F stated, At the time when the med aide let me know [03/26/25], I was in the middle of doing ten things at once. I would have gone in there normally under regular circumstances to try to get her to take it but I was very busy and not able to go in. Same thing yesterday [03/27/25]. Last couple of weeks we have been slammed and busy. An interview with the DON on 03/28/25 at 3:03 PM revealed LVN F was a newer nurse and although she was a good nurse, it was just a mistake and she and she had already begun in-serving the nursing staff. The DON stated her expectation was that when notified of medication refusals, the nurse should notify the physician after two medication refusals. Record review of the facility's policy titled, Medication Administration Guidelines, dated January 2024 reflected, Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices .Procedures .2. Obtain and record any vital signs as necessary prior to medication administration .Documentation .2. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time, the space provided on the MAR for that dosage is initialed and circled .If two consecutive doses of a vital medications are withheld or refused, the physician is notified.

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	03/28/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on observation, interview, and record review, the facility failed to ensure that each resident's drug regimen must be free from unnecessary drugs, without adequate indications for its use for two (Residents #1 and #2) of four residents reviewed for psychotropic medications. The facility failed to ensure Residents #1 and #2 were not prescribed Austedo (a prescription medicine used to treat involuntary movements in adults with tardive dyskinesia (movement disorder characterized by involuntary movements) or Huntington's disease (an illness that causes nerve cells in the brain to decay over time and affects a person's movement, thinking ability, mental health) without adequate indications for its use. The failure could affect residents by placing them at risk for possible adverse side effects, a decreased quality of life and continued use of possible unnecessary medications. Findings included: 1. Record review of Resident #1's face sheet dated 03/26/25 reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE] with active diagnoses of hypertensive chronic kidney disease (occurs when high blood pressure damages the kidneys, leading to impaired kidney function and potentially end-stage renal disease), intervertebral disc degeneration (a condition where the discs between vertebrae in the spine break down or wear down, potentially causing pain, numbness, and weakness) osteoarthritis in right knee (degenerative joint disease), mixed hyperlipidemia (a condition where multiple types of lipids (fats) in the blood are elevated above normal levels), morbid (severe) obesity, overactive bladder, constipation, and allergic rhinitis. Resident #1's face sheet reflected MD A was listed as her attending physician. Resident #1 did not have any diagnoses of mental illness or EPS (involuntary movements and other motor disturbances that can occur as a side effect of certain medications, particularly antipsychotic drugs) and tardive dyskinesia (a chronic movement disorder that can develop as a side effect of long-term use of certain medications, primarily antipsychotic drugs). Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 03, which indicated severe cognitive impairment. Resident #1 had no signs/symptoms of delirium (inattention, disorganized thinking and altered level of consciousness), her mood score was a 00 which indicated no negative mood issues. Resident #1 had no potential indicators of psychosis, physical or verbal behaviors, rejection of care or wandering. Resident #1 was administered three at-risk drugs-an antipsychotic, an antidepressant and a diuretic (medicines that increase the amount of urine you produce). Record review of Resident #1's care plan initiated on 10/02/23 and last updated 01/14/25 reflected the following problem/issues: 1) Psychotropic drug use related to schizophrenia, 2) Impaired physical mobility due to stroke and 3) Dementia, dysphagia (difficulty swallowing) and inability to communicate. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's AIMS assessments dated 01/16/24, 04/17/24, 08/20/24 and 02/20/25 each reflected an assessed score of 0, which indicated no evidence of tardive dyskinesia. The AIMS assessment evaluated and observed for facial and oral movements, extremity movements and trunk movements. Record review of Resident #1's Psychiatric Periodic Evaluation dated 09/13/24 and completed by the PMHNP reflected she was being seen for a monthly routine follow-up evaluation visit due to an original referral from MD A for psychotropic management, intermittent agitation and spontaneous psychosis. The evaluation also indicated she presented as actively delusional, with intermittent anxiety and restlessness. The PMHNP documented, Patient is also noted with involuntary tremors likely due to prolonged use of psychotropics. Upon review, will start patient on Austedo 12 mg XR to target extrapyramidal movements (involuntary movements without one's control) and increase Risperdal to 2mg two tablets for schizophrenia . will monitor closely. The PMHNP's AIMS assessment section in the evaluation reflected Resident #1 had facial and oral movements and upper extremity movements. Prior visits from the PMHNP on 03/28/24, 07/22/24 and 08/12/24 reflected no issues with Resident #1's movements. Record review of Resident #1's March 2025 Physician Orders reflected she was prescribed the following medications related to her mental/cognitive diagnoses: duloxetine 20 mg at bedtime (antidepressant-start date 10/02/23), risperidone 2 mg two tablets at bedtime (anti-psychotic-start date 10/17/24), Austedo XR 36 mg once at bedtime for schizophrenia (start date 09/13/25, end date 03/26/25). Record review of Resident #1's March 2025 MAR reflected she was administered Austedo 17 times from 03/01/25 through 03/28/25 before it was discontinued. Record review of Resident #1's nursing progress notes from 03/01/24 to 09/13/24 (prior to being prescribed Austedo), revealed no mention of the resident having any issues with uncontrolled movements. An observation and interview with Resident #1 on 03/26/25 at 12:20 PM revealed she was eating lunch and was not observed to have any movements or tremors. Due to her limited cognition, she was unable to provide insight on the medication and its use. An interview with the DON on 03/26/25 at 2:18 PM revealed a representative from the company that made the medication Austedo came to give a presentation to nursing management in July/August 2024 and let them know what the medication could be used for. The DON stated after that presentation, the staff noticed some pill rolling (a type of tremor associated with Parkinson's disease named for the way it looks, where a person appears to be rolling a pill or small object between their thumb and index finger) that Resident #1 was doing, Nothing more, it was small, nothing with her limbs or large movements. The DON stated because of that, the decision was made to try her on the medication the representative from Austedo had presented on. However, after Resident #1 was on the medication, the representative left his position and it became complicated to get the medication and it was costly. As a result, the PMHNP decided to use a different medication instead. 2. Record review of Resident #2's face sheet dated 03/26/25 the resident was a [AGE] year-old female who admitted to the facility on [DATE] with active diagnoses of paraplegia, vitamin D deficiency, constipation, essential (primary) hypertension, neuromuscular dysfunction of bladder, gastro-esophageal reflux disease and chronic pain due to trauma. Resident #2's face sheet reflected MD A was listed as her attending physician. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's quarterly MDS assessment dated [DATE] reflected a BIMS score of 08, which indicated moderate cognitive impairment. Resident #2 had fluctuating behaviors of inattention and disorganized thinking and sometimes experienced social isolation. She had no potential indicators of psychosis, physical or verbal behaviors, rejection of care or wandering. Resident #2 required physical assistance of staff for her ADLs, had an indwelling catheter and was frequently incontinent of bowel. She used a wheelchair for mobility and had no range of motion issues. Resident #2 had no indicators of pain and had no falls since the last MDS assessment. Resident #2 was administered three at-risk drugs: an antipsychotic, an antidepressant, an opioid and an anticonvulsant. Record review of Resident #2's care plan initiated 01/21/21 and last revised 03/07/25 reflected the following problems/issues: 1) Use of Xanax due to anxiety, restlessness and fidgeting; 2) History of depression and use of multiple antidepressants, 3) Acute pain from trauma due to paraplegia and spinal cord injury, 4) Use of antihypertensive medications due to elevated blood pressure, 5) Impaired physical mobility and self-care deficits and use of a Foley catheter. Record review of Resident #2's AIMS assessments dated 01/16/24, 04/23/24 and 03/26/25 each reflected an assessed score of 0, which indicated no evidence of tardive dyskinesia. The AIMS assessment evaluated and observed for facial and oral movements, extremity movements and trunk movements. Record review of Resident #1's Psychiatric Periodic Evaluation dated 10/25/24 and completed by the PMHNP reflected she was being seen for a monthly routine follow-up evaluation visit due to an original referral from MD A for reports of resistance to care and a medication check. The PMHNP's AIMS assessment section reflected Resident #2 had no abnormal facial or oral movements, no abnormal extremity movements and no abnormal trunk movements. The PMHNP documented, Patient is presenting with increased tremors, around the mouth, and trunk movement, suggestive of tardive dyskinesia due to prolonged use of anti-psychotics .start patient on Austedo. Record review of Resident #2's March 2025 Physician Orders reflected she was prescribed the following medications related to her mental/cognitive diagnoses: Austedo XR once at bedtime for drug-induced subacute dyskinesia (start date 11/03/24, end date 03/28/25), duloxetine 20 mg twice a day for anxiety (anti-depressant-start 03/07/25), escitalopram 10 mg 1 1/2 tablet at bedtime to equal 15 mg for depression (antipsychotic-start date 03/07/25), lamotrigine 100 mg twice a day for schizoaffective disorder (antiepileptic-start date 01/17/25) and Uzedy 200 mg/0.56 ml subcutaneously once a month on the 27th for schizoaffective disorder (antipsychotic-start date 10/25/24). Record review of Resident #2's March 2025 MAR reflected she was administered Austedo 19 times from 03/01/25 through 03/27/25 before it was discontinued. Record review of Resident #1's nursing progress notes from 03/01/24 to 09/01/24 (prior to being prescribed Austedo), revealed no mention of the resident having any issues with uncontrolled movements. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and observation with Resident #2 on 03/28/25 at 12:45 PM revealed she was sitting in her wheelchair outside her room softly bobbing her head. Resident #2 said that she tended to [NAME] her head when she was feeling anxiety and if she tried to stop while she was feeling anxious, it could make her feel worse inside her head. She said it did not bother her and helped her relax. Resident #2 stated she was not aware she had been prescribed and was taking the medication Austedo for movement issues. Resident #2 said her movements were not uncontrolled, it was just a way to calm down. Resident #2 stated she had been taking Risperdal injections but did not think they were causing her any side effects with movements or tremors. An interview with the DON on 03/28/25 at 11:00 AM revealed Resident #2 used to rock back and forth a while back but got it under control. 3. An interview with LVN C on 03/26/25 at 12:47 PM revealed he was the charge nurse for Residents #1 and #2 and from his observations, neither had any movement issues he was aware of. He was not aware of the medication Austedo both residents were prescribed or what it was for. An interview with the PMHNP on 03/28/25 at 10:13 AM revealed residents who were prescribed antipsychotic medications for a long period of time could develop side effects from prolonged use, such as tremors, rocking, buccal (mouth/cheek) movements, tardive dyskinesia. He stated Austedo was a medication that decreased the side effects of movements which could be difficult for patients. The PMHNP stated he determined the need for Resident #1 and Resident #2 to be prescribed Austedo based off his clinical observations he made during his visits. The PMHNP stated Austedo was very expensive and costly and the pharmacy wanted a pre-authorization every time, which could be hard to get, which was why it was discontinued and another brand was prescribed. The PMHNP stated Resident #2's movements had improved but he was going to prescribe her a new medication called Ingrezza because she was rocking slowly when he saw her earlier in the morning on 03/28/25. He stated, I think it can exhaust the patient. 4. Record review of the facility policy titled, Abnormal Involuntary Movement Scale (AIMS) Evaluations, effective 01/12/18 reflected, To formally evaluate residents for whom dopamine blocking medications have been prescribed to identify symptoms that may indicate the presence of Tardive Dyskinesia .Tardive Dyskinesia: A neurologic disorder characterized by abnormal involuntary movements which may occur as an undesired effect of dopamine blocking medications .7. Only a physician or physician extender shall make a diagnosis of the presence of Tardive Dyskinesia. When such a diagnosis is made, the interdisciplinary team shall work with the resident and family to determine the most appropriate course of treatment, considering both the effects of Tardive Dyskinesia and the patient's psychiatric condition.