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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsburg Village Healthcare Campus	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)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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

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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsburg Village Healthcare Campus	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)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident had a discharge summary that included, but not limited to a recapitulation of the resident's stay, that included but was not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultant results and a final summery of the resident's status to include items, at the time of the discharge that was available to release to authorized persons and agencies, with the consent of the resident or resident's representative for 1 of 3 residents (Resident #1) reviewed for discharge summary. The facility failed to complete a discharge summary for Resident #1. This failure could place residents at risk of not having complete records after permanent discharge from the facility. Findings included:Record review of Resident #1's Discharge MDS assessment, dated 09/11/25, reflected the resident was an [AGE] year-old female, who was admitted to the facility on [DATE] and discharged on 09/11/25 to Nursing Home. Resident #1 entry/discharge reporting - Discharge assessment -return not anticipated. The residents' diagnoses included unspecified dementia (brain disorders that cause a progressive decline in cognitive abilities), hypertension (high blood pressure) and malnutrition. The MDS reflected Resident #1 had severe cognitive impairment with a BIMS score of 03. Record review of Resident #1's care plan, dated 07/24/25, reflected: Care Area/Problem: Discharge Plan. Goal: Resident and/or representative will be assisted in planning for discharge to safest environment over the next 90 days. Interventions: Assess residents overall expectations concerning discharge. Record review of Resident #1's progress notes written by LVN B on 09/11/25 at 6:00 PM reflected: Resident discharged to a Nursing Home per request. All belongings and Medication given upon discharge. Record review of Resident #1's Physician Discharge Summary signed by physician on 09/30/25 reflected Resident #1 discharged to another nursing facility on 09/11/25. Record review of Resident #1's clinical record reflected there was no documented evidence showing that a discharge summary had been completed for Resident #1. Interview on 10/01/25 at 1:51 PM, LVN B revealed she was the nurse assigned to Resident #1 when she discharged on 09/11/25. LVN B stated she documented a progress note regarding the discharge; however, she was not able to complete the discharge summary because she did not know how. She stated the facility had started a new system and she was not able to figure out how to do it. LVN B stated she notified ADON A that she was not able to complete a discharge summary and ADON A told her to just do a progress note. She stated she did not follow up to ensure it was completed. Interview on 10/01/25 at 2:42 PM, ADON A revealed she was the ADON A assigned to Resident #1. She stated a discharge summary should had been completed on Resident #1. She stated the nurse who discharged the resident would be responsible for completing the discharge summary. She stated she was not aware Resident #1 discharge summary was not completed, she stated LVN B never informed her. ADON A stated it would be her responsibility to ensure a discharge summary was completed when Resident #1 was discharged . She stated there was no potential risk to the resident if a discharge summary was not completed. Interview on 10/01/25 at 3:24 PM, the DON revealed discharge summary should be completed by nursing team when the resident discharges. She stated she was not aware Resident #1 did not have discharge summary. The DON stated the nursing team should all be following up to ensure the discharge summary was completed. She stated prior to the new system the discharge summary should be completed within 10 days. She stated there was no potential risk to the resident for not having a discharge summary. Interview on 10/01/25 at 4:37 PM, the Administrator revealed when a resident discharges from the facility the resident should have a discharge summary and a physician discharge summary. He stated the discharge summary should be completed by the nursing team. He stated the expectation was for discharge summary to be developed and completed. Record review of the facility's Discharge / Transfer policy, dated 04/24/24, reflected the following: The resident will be discharged /transferred (home/another entity) by order of his/her attending physician in accordance with standard practice guidelines.2. Notify resident, their legal representative, if any, or an interested family member and document the discharge. 3. Provide written discharge instructions/education to the resident and family when discharged to a lower of care, in a language they can understand and document in a medical record. EHR>Discharge>Instructions if discharged to an equal or lower level of care setting to transfer if discharged to a higher level of care such as an acute hospital.

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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsburg Village Healthcare Campus	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsburg Village Healthcare Campus	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain good personal hygiene for 2 of 5 residents (Residents #5 and #6) reviewed for ADL care. The facility failed to ensure Residents #5 and #6 were provided with timely incontinence care.This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life. Findings included:Record review of Resident #5's quarterly MDS, dated [DATE], reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included hypertension (high blood pressure when blood vessels are consistently too high) and hemiplegia/hemiparesis (paralysis on one side of the body/partial weakness on one side). The resident had severe cognitive impairment with a BIMS score of 7. The resident required substantial to maximal assistance for toilet transfer and toileting hygiene. Record review of Resident #5's care plan dated 08/06/25 reflected: [Resident #5] at risk for problems with elimination (bowel & bladder) Goal: Decrease in number of incontinent episodes by implementation of a scheduled toileting program. Intervention included to observe pattern of incontinence, and initiate toileting schedule or prompted voiding if indicated. Uses brief. Resident #5 is at risk for skin breakdown as evidenced by pressure ulcer risk, incontinent of bowel and always incontinent of bladder, and confined to bed most of the time. Goals: Resident will maintain clean and intact skin and Measures will be taken to prevent skin breakdown. Interventions included: Apply protective or barrier lotion after incontinence. Assist resident to turn and reposition frequently. Inspect skin complete body head to toe every week and document results. Inspect skin daily with care and bathing and report any changes to charge nurse. Keep skin clean, dry, and free of irritants.Record review of Resident #6's quarterly MDS, dated [DATE], reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Heart Failure (a condition in which the heart cannot pump efficiently enough to meet the body's need for blood), Hypertension (high blood pressure when blood vessels is consistently too high), Renal Insufficiency (renal insufficiency refers to the impaired function of the kidneys), Diabetes Mellitus (the body's impaired ability to produce or respond to insulin), Hemiplegia or Hemiparesis (hemiplegia paralysis on one side of the body while hemiparesis indicates partial weakness on one side). The resident had severe cognitive impairment with a BIMS score of 7. The resident had limitation in range of motion for both her upper and lower extremities on one side, and she was dependent on staff for toilet transfer and toileting hygiene. Record review of Resident #6's care plan, printed 10/01/25, reflected: [Resident #6] at risk for problems with elimination (bowel & bladder) related to CVA (stroke), CHF (congestive heart failure), HTN (high blood pressure), as evidenced by usual bowel pattern daily. Goal: Residents elimination status will be maintained or improved. Interventions included Observe pattern of incontinence, and initiate toileting schedule or prompted voiding if indicated. [Resident #6] at risk for/actual skin breakdown related to history of hemiplegia or hemiparesis, history of stroke as evidenced by pressure ulcer risk, incontinent of bowel, always incontinent to bladder, confined to bed most of the time, confined to the chair most of the time, bed mobility: total and extensive, occasionally incontinent. Goal: Measure will be taken to prevent skin breakdown. Interventions included: apply protective or barrier lotion after incontinence, assist resident to turn and reposition frequently, inspect skin complete body head to toe every week and document results, keep skin clean, dry, and free of irritants, treatments and dressings as ordered by physician.Observation and interview on 09/30/25 at 11:35 AM revealed Resident #5 in her room on her bed. She stated her brief was changed, but she could not tell when. The resident's bed linen was soaked with urine. Observation and interview on 09/30/25 at 11:44 AM revealed Resident #6 in her room on her bed. She stated her brief was last changed last night. She stated she was wet. Observation on 09/30/25 at 12:00 PM revealed CNA D providing Resident #5 with incontinence care. He went to the room and explained the procedure to Resident #5. CNA D put supplies together and went to the bedside. He performed hand hygiene before contact with Resident #5. He put on gloves and unfastened the resident's brief. Resident #5 was heavily soaked in urine. He did not cleanse the resident's perineal area (labia majora). He only cleansed the resident's abdominal folds. He then positioned the resident on her side and cleansed her buttocks. Observation on 09/30/25 at 12:15 PM revealed CNA D providing Resident #6 with incontinence care. He went to the room and explained the procedure to Resident #6. CNA D put supplies together and went to the bedside. He performed hand

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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsburg Village Healthcare Campus	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsburg Village Healthcare Campus	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 2 of 5 residents (Residents #5 and #6) observed for infection control. CNA D failed to perform hand hygiene and change gloves while providing Residents #5 and #6 with incontinence care. This failure could affect the residents by placing them at risk for worsening conditions and cross-contamination. Findings included:Record review of Resident #5's quarterly MDS, dated [DATE], reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included Hypertension (high blood pressure when blood vessels is consistently too high) Hemiplegia or Hemiparesis (hemiplegia paralysis on one side of the body while hemiparesis indicates partial weakness on one side). BIMS score of 7 indicating severe cognitive impairment. Her Functional Status revealed she required substantial/maximal assistance for toilet transfer and toileting hygiene. Record review of Resident #5's care plan dated 08/06/25 reflected [Resident #5] at risk for problems with elimination (bowel & bladder) Goal: Decrease in number of incontinent episodes by implementation of a scheduled toileting program. Intervention included to observe pattern of incontinence, and initiate toileting schedule or prompted voiding if indicated. Uses brief. Resident #5 is at risk for skin breakdown as evidenced by pressure ulcer risk, incontinent of bowel and always incontinent of bladder, and confined to bed most of the time. Goals: Resident will maintain clean and intact skin and Measures will be taken to prevent skin breakdown. Interventions included: Apply protective or barrier lotion after incontinence. Assist resident to turn and reposition frequently. Inspect skin complete body head to toe every week and document results. Inspect skin daily with care and bathing and report any changes to charge nurse. Keep skin clean, dry, and free of irritants. Record review of Resident #6's quarterly MDS, dated [DATE], reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Heart Failure (a condition in which the heart cannot pump efficiently enough to meet the body's need for blood), Hypertension (high blood pressure when blood vessels is consistently too high), Renal Insufficiency (renal insufficiency refers to the impaired function of the kidneys), Diabetes Mellitus (the body's impaired ability to produce or respond to insulin), Hemiplegia or Hemiparesis (hemiplegia paralysis on one side of the body while hemiparesis indicates partial weakness on one side). BIMS score of 7 indicating severe cognitive impairment. Her Functional Status revealed limitation in range of motion on the upper and lower extremity on one side, evaluation indicated she was dependent on staff for toilet transfer and toileting hygiene. Record review of Resident #6's care plan, printed 10/01/25, reflected [Resident #6] at risk for problems with elimination (bowel & bladder) related to CVA (stroke), CHF (congestive heart failure), HTN (high blood pressure), as evidenced by usual bowel pattern daily. Goal: Residents elimination status will be maintained or improved. Interventions included Observe pattern of incontinence, and initiate toileting schedule or prompted voiding if indicated. [Resident #6] at risk for/actual skin breakdown related to history of hemiplegia or hemiparesis, history of stroke as evidenced by pressure ulcer risk, incontinent of bowel, always incontinent to bladder, confined to bed most of the time, confined to the chair most of the time, bed mobility: total and extensive, occasionally incontinent. Goal: Measure will be taken to prevent skin breakdown. Interventions included: apply protective or barrier lotion after incontinence, assist resident to turn and reposition frequently, inspect skin complete body head to toe every week and document results, keep skin clean, dry, and free of irritants, treatments and dressings as ordered by physician.Observation on 09/30/25 at 12:00 PM, revealed CNA D providing Resident #5 with incontinence care. He went to the room and explained the procedure to Resident #5. CNA D put supplies together and went to the bedside. He performed hand hygiene before contact with Resident #5; he put on gloves and unfastened the resident's brief. Resident #5 was heavily soaked in urine. He did not cleanse the peri area. He was only observed cleansing the abdominal folds and positioned the resident on her side and cleansed the buttocks. He did not change gloves or wash hands after handling soiled linen. He used the same gloves to put a clean brief. Observation on 09/30/25 at 12:15 PM, revealed CNA D providing Resident #6 with incontinence care. He went to the room and explained the procedure to Resident #6. CNA D put supplies together and went to the bedside. He performed hand hygiene before contact with Resident #6; he put on gloves and unfastened the resident's brief. Resident #6 was heavily soaked in urine. The brief, draw sheet and the mattress cover were soaked with urine. He did not cleanse the peri area for Resident#6, he only cleaned the abdominal folds; he