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	02/13/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure all alleged violations involving abuse and neglect were reported immediately or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury to the State Survey Agency for one of two incidents reviewed for reporting.The facility failed to report an allegation of neglect when Resident #1 alleged that her leg had been broken during a transfer from her bed to the wheelchair on 12/23/25 due to the facility staff not using a mechanical lift.This failure could affect residents by resulting in a delay of identification of abuse or neglect and lack of timely follow-up on recommended interventions to prevent harm, or impairment. Findings included: Record review of Resident #1's MDS dated [DATE] reflected the resident was a [AGE] year-old female resident whose most recent admission entry was on 04/10/25. Resident #1 had a BIMS of 10 which indicated she had moderately impaired cognition. The residents' diagnoses included stroke, end stage renal disease, and there was no diagnosis of dementia or Alzheimer's disease. The MDS also reflected that the resident did not have inattention, disorganized thinking or altered level of consciousness and she did not exhibit any type of behaviors. Resident #1 used a wheelchair for mobility and required substantial/maximal assistance which indicated the helper did more than half the effort. The resident did not attempt to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed due to medical conditions or safety concerns. The MDS further reflected that the resident did not have any pain. Review of Resident #1's facesheet printed on 02/13/26 reflected her original admission date was on 08/14/19.Record review of Resident #1's care plan with an original date of 02/12/26 reflected the resident needed to be lifted mechanically using a Hoyer lift (mechanical device designed to safely transfer patients with limited mobility between beds, chairs or toilets using a sling-and-mast system) with two or more persons support due to impaired mobility. Interventions included to provide extensive assistance with bed mobility and lift mechanically using mechanical lift with two or more persons support from staff. Record review of Resident #1's hospital records dated 12/23/25 reflected the following: .Reason for admission: Left distal femur fracture.[Resident #1].with residual left-sided weakness, bedbound.Patient presented to ED with left knee pain that started today during transferring to her dialysis, patient said that her foot got stuck then her leg was twisted during transfer, pain was severe 10/10, pain increased with minimal movement, it was associated with recurrent vomit.Femur x-ray showed acute comminuted fracture of distal left femur.Principal Problem:Closed fracture of left distal femurAssessment: Patient did not have a fall, her leg got twisted during transfer to dialysis.possible surgery in the morning.Active Problems:.Osteoporosis.Review of the dialysis Nursing Progress Notes Report dated 12/23/25 documented by the Dialysis RN reflected the following: Pt came in with c/o severe pain to her left knee, painful to touch. Pt unable to move her foot. Pt requested to call EMS to send her to ER. Called nursing home and spoken [sic] to the clerk re: (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pt complaints. [DON] of [nursing home] called, spoken [sic] with her and inform her of pt complaints. Tx not started. MD informed. Pt left via stretcher at 1150hrs, pt was crying out loud d/t pain to her knee. Record review of Resident #1's progress notes dated 12/24/25 at 5:15 AM documented by the DON reflected the following: contacted [facility] nursing staff for update on resident return. Per [facility] charge nurse [LVN C], she contacted nurse caring for resident at [First Hospital] on 9th floor and was informed [Resident #1] has a femur fracture and was transferred from [First Hospital] to [Second Hospital] for higher level of care due to injury sustained while at the dialysis center. According to [Second Hospital] primary nurse [Resident #1] sustained LLE injury during transfer from WC to dialysis chair. Resident stated her left leg was twisted during transfer and was unable to continue dialysis due to pain/discomfort to LLE and requested to be sent to emergency department Record review of Resident #1's progress notes dated 12/24/25 at 5:46 AM documented by LVN C reflected the following: Resident transfer to [Second Hospital] from her dialysis appt. Resident was admitted for left femur fx, nurse stated she twisted her leg at dialysis when trying to put her in dialysis chair. DON notified, ADON notified.Record review of Resident #1's progress notes dated 12/24/25 at 3:17 PM documented by the DON reflected the following: LATE ENTRY FOR 12/23/25 11:45 AM: spoke with [Dialysis RN] regarding need for transfer to hospital from dialysis center due to complaints of left knee pain. Nurse stated resident was unable to transfer to chair due to pain in LLE after transfer attempt. Resident stated knee was twisted, during transfer attempt at dialysis center and requested to be transported to emergency department for evaluation and treatment. Resident transfer to [Second Hospital] from her dialysis appt. Resident was admitted for left femur fx, nurse stated she twisted her leg at dialysis when trying to put her in dialysis chair. DON notified, ADON notified.Interview on 02/12/26 at 9:39 AM with Resident #1's family revealed the resident had to undergo femur surgery because it had broken during a transfer from her bed to the wheelchair. The resident's family said they were told by the resident that there were some male staff that helped her from the bed to the chair and the guy turned her the wrong way. The resident told the family she reported to the staff that her leg was hurt but she had been taken to dialysis anyways where she again reported to the dialysis staff, she thought the facility staff had broken her leg . The family further stated Resident #1 had requested to go to the hospital because she was not able to get out of her wheelchair at the dialysis center because of her pain. Observation and interview on 02/12/26 at 10:22 AM with Resident #1 revealed she was sitting in her wheelchair in her room at the nursing facility, with padded foot protectors on each foot. The resident stated she could not walk or move her legs and had not been able to in a long time. Resident #1 was asked about the incident (12/23/25) when her leg was broken and she said there were several staff in her room but could not remember how many. Resident was able to recall one of the female aides was chubby (later identified as CNA A) and a bald male (later identified as CNA B). The resident said she was normally transferred via Hoyer lift but the day of the incident the staff that included a tall bald man had picked her up with their hands and transferred her over to the wheelchair and during the transfer, her left leg had gone through CNA B's legs and twisted. Resident #1 said her left leg immediately began to hurt and she told the staff I think you broke my leg to which the male staff (CNA B) responded with I didn't break your leg. The resident said she had only seen the male staff (CNA B) once or twice and did not know if he still worked at the facility. Resident #1 said once she was put in her wheelchair she was just put in the van and taken to dialysis, which was located across from the facility. The resident said once she arrived at the dialysis center, she told the dialysis staff her left leg hurt, and she wanted to go to the hospital because she thought it was broken. Resident #1 said she was never transferred out of her wheelchair at (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the dialysis center because she was in so much pain. Resident #1 stated I never told anyone the incident happened at the dialysis center; I haven't lost my mind yetInterview on 02/12/26 at 10:53 AM with LVN J revealed she worked the morning of 12/23/25 and all she knew was that the DON had gotten a call from Resident #1's dialysis center and told the DON the resident was being sent to the emergency room because the resident had complained of leg pain. LVN J said Resident #1 was always required to be a Hoyer lift transfer and she did not know who assisted the resident out of bed that day and no one had reported anything to her. LVN J further stated she did not ask Resident #1 what happened to her leg when she returned from the hospital. Interview on 02/12/26 at 11:24 AM with a Dialysis Case Manager revealed he was not there when Resident #1 arrived at the dialysis center and complained about her leg pain. The Dialysis Case Manager said once the resident had gotten out of the hospital and returned to dialysis he asked her what happened and Resident #1 told him that while the nursing home staff were transferring her from the bed to the wheelchair her leg and a staff member's leg had gotten tangled together and she immediately had felt pain to her left leg. The Dialysis Case Manager said he heard (did not say by who) the nursing facility had tried to blame the dialysis center for the incident but he was also told Resident #1 had never transferred out of her wheelchair because she had been in too much pain so she sent to the hospital. Interview on 02/12/26 at 12:03 PM with the ADON revealed she had had been told, did not say by who, that Resident #1 had been taken to her dialysis appointment and they later had gotten a call from the dialysis center who said the resident had been transferred to the hospital because she had complained of leg pain. The ADON said LVN C called the hospital for a follow-up on Resident #1 and LVN C was told the incident happened at the dialysis center. The ADON further stated she never talked to Resident #1 about the transfer incident and the DON had spoken to the dialysis center. The ADON also said Resident #1 required a Hoyer lift for all transfers as far as she could recall. Interview on 02/12/26 at 12:13 PM with the DON said Resident #1 left the facility via a third-party transport to her dialysis appointment. Once the resident was at the dialysis center, the facility got a call from their nurse (Dialysis RN) who said Resident #1's said her leg was hurting and had requested to go the hospital. The DON said the LVN C had talked to a hospital nurse who told LVN C Resident #1 had been dropped at dialysis. The DON said she spoked to Resident #1, but did not say when, and the resident told the DON the incident happened at the nursing facility when she had been transferred by a tall black man that was light skinned, and the DON stated there was no one at the facility that matched that description. The DON then said Resident #1 stated two men had transferred her to the chair but the resident never told the DON the incident had happened at the nursing facility. The DON was asked if she had called the dialysis center to ask if Resident #1 had fallen or been dropped there and the DON said No, what for, there would be no reason because they (dialysis center) did not offer any information. The DON further stated she spoke with the facility staff that worked with Resident #1, and they all told her nothing happened. She stated there was no incident to lead them to believe it had happened at the nursing facility. Interview on 02/12/26 at 6:28 PM with the Dialysis RN revealed the day Resident #1 arrived at the dialysis center (12/23/25) it had been reported to her by the dialysis techs (Dialysis Tech D) that the resident had been noted crying in the dialysis center lobby. The Dialysis RN said one of the dialysis techs took Resident into the room where they residents are in their dialysis chairs and notified her the resident was crying and complaining of pain. The Dialysis RN said Resident #1 was normally very quiet, pleasant and with little to no complaints and never had any concerns with her cognition so the resident would have been able to tell them what happened. The Dialysis RN said she saw Resident #1 crying, so she asked her what happened and the resident said the nursing home aides had twisted her (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	leg when they transferred her into her wheelchair. The Dialysis RN said she assessed the resident and when she touched her left knee, the resident cried out in a lot of pain, she could not move her leg and the resident requested to be sent out to the hospital. Per her assessment, the Dialysis RN said she thought Resident #1 had a leg fracture and described her pain being at a 10/10. When EMS arrived and tried to put her on the stretcher, the Dialysis RN said the resident screamed out in pain as she could not straighten her leg. The Dialysis RN the Dialysis Nurse Manager called the nursing facility to let them know the resident had been sent to the hospital and the DON had called back and spoke to the Dialysis RN. The Dialysis RN said she told the DON what the resident had told her happened at the nursing facility and the DON asked the Dialysis RN to send Resident #1 back to the facility so they could do an in-house x-ray but she told the DON they had to send the resident to hospital due to her severe leg pain. The Dialysis Nurse further stated Resident #1 told her the nursing facility had tried to blame the incident on the dialysis center but there was no incident at the center, and their nurse manager and techs were witness to how the resident arrived at the dialysis center and she never told the DON the incident happened at the dialysis center. Interview on 02/13/26 at 9:45 AM with CNA A revealed she never asked CNA B to help her transfer Resident #1 with a Hoyer sling and drawsheet, nor did she recall the resident stating she was in pain. Interview on 02/13/26 at 10:00 AM with CNA B revealed he had never worked with Resident #1 but CNA A had called him to assist with a transfer (12/23/25). CNA B said he did not work at the facility full time but only worked as they needed him. CNA B said he was told Resident #1 was already late for dialysis and the Hoyer lift was broke so he, CNA A and two other aides, later identified as CNA E and CNA F all transferred the resident from the bed to the wheelchair using the Hoyer sling under the resident and a draw sheet. CNA B said he did not notice during the transfer but once the resident was in her wheelchair, she complained of leg pain. CNA B said the other aides tried to console the resident and then told him (CNA B) that Resident #1's pain was part of the resident's condition because the resident did not walk. CNA B further stated he did not report the resident's pain to the nurse because he was not the resident's aide and would have expected the other aides to report any incidents because they worked with the resident. Interview on 02/13/26 at 10:27 AM with CNA E revealed she denied Resident #1 was transferred to her wheelchair with a sling and a draw sheet, the day of the incident, 12/23/25. CNA E said she did not recall any other details from that date. Interview on 02/13/26 at 10:56 AM with CNA F revealed she did not work at the facility full time and only as needed, and she did not recall any resident transferred with a Hoyer sling and draw sheet. Interview on 02/13/26 at 2:21 PM with the Dialysis Tech revealed he was working the day Resident #1 arrived at the dialysis center complaining of leg pain. The Dialysis Tech said another tech, did not recall which one, had alerted him that Resident #1 was crying in the lobby of the dialysis center, so he went to get the resident and took her back to where the residents got dialysis. Resident #1 told the Dialysis Tech said Resident #1 was crying and stated the nursing staff had twisted her knee during her transfer to the wheelchair. The Dialysis Tech said he tried to reposition the resident in her chair as she still had a Hoyer sling under her and the resident began to scream and cry, stating she was in severe pain. At the time the Dialysis Tech said he called the Dialysis RN to assess the resident and Resident #1 told her the same story about how the nursing facility staff had twisted her knee. The Dialysis Tech said Resident #1 was normally very calm and pleasant and had never complained of any pain during her dialysis treatments and they had never had any concerns with her cognition during her treatments. The Dialysis Tech said Resident #1 was never moved into a dialysis chair because of her severe pain. Interview on 02/13/26 at 2:28 PM with the Dialysis Nurse Manager revealed she was with another patient when she heard (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 crying, so she went over to the resident to ask what was wrong and the resident said the nursing facility staff hurt her leg during the transfer to the wheelchair. The Dialysis Nurse Manager asked Resident #1 if she had reported the pain to the nursing facility staff and the resident said, yes I told them I was in pain, and they just told me I had to go to dialysis, so they put me in the van and brought me to the clinic (dialysis). At that time the Dialysis RN began to assess the resident and because she was crying in pain, they decided to call 911 and have her sent out for further evaluation. The Dialysis Nurse Manager said Resident #1 was very alert and oriented and normally calm during her dialysis treatments. The Dialysis Nurse Manager said Resident #1 was never transferred to the dialysis chair because any little movement caused the resident so much pain. The Dialysis Nurse Manager said she called to speak with a facility nurse, and did not recall who, to let them know Resident #1 would be sent to the hospital and the DON later called and spoke with the Dialysis RN. She further stated that at no point did she or any of the dialysis staff tell the facility the incident had occurred at the dialysis center. Interview on 02/12/26 at 4:11 PM with the Administrator revealed the incident with Resident #1 was not a reportable incident because it happened at the dialysis center and not the nursing facility. Record review of the facility's policy titled Abuse, Neglect, and Exploitation and Misappropriation of Resident Property reviewed 02/2020 reflected the following: Purpose The purpose of this policy is to ensure that all healthcare facilities comply with federal and state regulations regarding (i) protecting facility patients and residents from abuse, neglect, exploitation and misappropriation of resident property, and (ii) timely investigation of and reporting to state and local agencies all allegations of abuse, neglect, exploitation and misappropriation of resident property. All managed healthcare facilities and all management company staff members or third parties providing services to such facilities and/or their residents.3.2 All facility staff members have a duty to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to the Administrator of the facility, who serves as the Abuse Coordinator. In the Administrator's absence, the Director of Nursing (DON) or another designee will be appointed to function as the interim Abuse Coordinator. Upon learning of a suspected incident of resident abuse, neglect, exploitation, and/or misappropriation of resident property, the Charge Nurse or her Department Manager or Supervisor must immediately notify the Abuse Coordinator the DON of the incident. The person receiving the report or designee must document all incidents of alleged abuse/neglect on incident reports, which are to forwarded directly to the Abuse Coordinator.3.3 Upon receiving an allegation abuse, neglect, exploitation or misappropriation, the Abuse Coordinator will a) notify the Regional Director of Operations and Regional Nurse Consultant, b) initiate an investigation into the allegation, c) in conjunction with the Regional Director of Operations and Regional Nurse Consultant determine whether the allegation is reportable under federal and state regulations, and d) if the allegation is reportable, report such allegation to the State Regulatory Agency,.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have evidence that all alleged violations of abuse, neglect, exploitation, misappropriation of resident property, exploitation, and mistreatment, including injuries of unknown source were thoroughly investigated for one (Resident #1) of 3 residents reviewed for neglect.The facility failed to thoroughly investigate an allegation of neglect when Resident #1 alleged that she sustained a fractured left femur (the bone of the thigh) during a transfer in which staff did not use a mechanical lift as care planned.This failure could place residents at risk of abuse and neglect.Findings included: Record review of Resident #1's MDS dated [DATE] reflected the resident was a [AGE] year-old female resident whose most recent admission entry was on 04/10/25. Resident #1 had a BIMS of 10 which indicated she had moderately impaired cognition. The residents' diagnoses included stroke, end stage renal disease, and there was no diagnosis of dementia or Alzheimer's disease. The MDS also reflected that the resident did not have inattention, disorganized thinking or altered level of consciousness and she did not exhibit any type of behaviors. Resident #1 used a wheelchair for mobility and required substantial/maximal assistance which indicated the helper did more than half the effort. The resident did not attempt to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed due to medical conditions or safety concerns. The MDS further reflected that the resident did not have any pain. Review of Resident #1's facesheet printed on 02/13/26 reflected her original admission date was on 08/14/19.Record review of Resident #1's care plan with an original date of 02/12/26 reflected the resident needed to be lifted mechanically using a Hoyer lift (mechanical device designed to safely transfer patients with limited mobility between beds, chairs or toilets using a sling-and-mast system) with two or more persons support due to impaired mobility. Interventions included to provide extensive assistance with bed mobility and lift mechanically using mechanical lift with two or more persons support from staff. Record review of Resident #1's hospital records dated 12/23/25 reflected the following: .Reason for admission: Left distal femur fracture.[Resident #1].with residual left-sided weakness, bedbound.Patient presented to ED with left knee pain that started today during transferring to her dialysis, patient said that her foot got stuck then her leg was twisted during transfer, pain was severe 10/10, pain increased with minimal movement, it was associated with recurrent vomit.Femur x-ray showed acute comminuted fracture of distal left femur.Principal Problem:Closed fracture of left distal femurAssessment: Patient did not have a fall, her leg got twisted during transfer to dialysis.possible surgery in the morning.Active Problems:.Osteoporosis.Review of the dialysis Nursing Progress Notes Report dated 12/23/25 documented by the Dialysis RN reflected the following: Pt came in with c/o severe pain to her left knee, painful to touch. Pt unable to move her foot. Pt requested to call EMS to send her to ER. Called nursing home and spoken [sic] to the clerk re: pt complaints. [DON] of [nursing home] called, spoken [sic] with her and inform her of pt complaints. Tx not started. MD informed. Pt left via stretcher at 1150hrs, pt was crying out loud d/t pain to her knee. Record review of Resident #1's progress notes dated 12/24/25 at 5:15 AM documented by the DON reflected the following: contacted [facility] nursing staff for update on resident return. Per [facility] charge nurse [LVN C], she contacted nurse caring for resident at [First Hospital] on 9th floor and was informed [Resident #1] has a femur fracture and was transferred from [First Hospital] to [Second Hospital] for higher level of care due to injury sustained while at the dialysis center. According to [Second Hospital] primary nurse [Resident #1] sustained LLE injury during transfer from WC to dialysis chair. Resident stated her left leg was twisted during transfer and was unable to continue dialysis due to pain/discomfort to LLE and requested to be sent to emergency department (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress notes dated 12/24/25 at 5:46 AM documented by LVN C reflected the following: Resident transfer to [Second Hospital] from her dialysis appt. Resident was admitted for left femur fx, nurse stated she twisted her leg at dialysis when trying to put her in dialysis chair. DON notified, ADON notified.Record review of Resident #1's progress notes dated 12/24/25 at 3:17 PM documented by the DON reflected the following: LATE ENTRY FOR 12/23/25 11:45 AM: spoke with [Dialysis RN] regarding need for transfer to hospital from dialysis center due to complaints of left knee pain. Nurse stated resident was unable to transfer to chair due to pain in LLE after transfer attempt. Resident stated knee was twisted, during transfer attempt at dialysis center and requested to be transported to emergency department for evaluation and treatment. Resident transfer to [Second Hospital] from her dialysis appt. Resident was admitted for left femur fx, nurse stated she twisted her leg at dialysis when trying to put her in dialysis chair. DON notified, ADON notified.Interview on 02/12/26 at 9:39 AM with Resident #1's family revealed the resident had to undergo femur surgery because it had broken during a transfer from her bed to the wheelchair. The resident's family said they were told by the resident that there were some male staff that helped her from the bed to the chair and the guy turned her the wrong way. The resident told the family she reported to the staff that her leg was hurt but she had been taken to dialysis anyways where she again reported to the dialysis staff, she thought the facility staff had broken her leg. The family further stated Resident #1 had requested to go to the hospital because she was not able to get out of her wheelchair at the dialysis center because of her pain. Observation and interview on 02/12/26 at 10:22 AM with Resident #1 revealed she was sitting in her wheelchair in her room at the nursing facility, with padded foot protectors on each foot. The resident stated she could not walk or move her legs and had not been able to in a long time. Resident #1 was asked about the incident (12/23/25) when her leg was broken and she said there were several staff in her room but could not remember how many. Resident was able to recall one of the female aides was chubby (later identified as CNA A) and a bald male (later identified as CNA B). The resident said she was normally transferred via Hoyer lift but the day of the incident the staff that included a tall bald man had picked her up with their hands and transferred her over to the wheelchair and during the transfer, her left leg had gone through CNA B's legs and twisted. Resident #1 said her left leg immediately began to hurt and she told the staff I think you broke my leg to which the male staff (CNA B) responded with I didn't break your leg. The resident said she had only seen the male staff (CNA B) once or twice and did not know if he still worked at the facility. Resident #1 said once she was put in her wheelchair she was just put in the van and taken to dialysis, which was located across from the facility. The resident said once she arrived at the dialysis center, she told the dialysis staff her left leg hurt, and she wanted to go to the hospital because she thought it was broken. Resident #1 said she was never transferred out of her wheelchair at the dialysis center because she was in so much pain. Resident #1 stated I never told anyone the incident happened at the dialysis center; I haven't lost my mind yetInterview on 02/12/26 at 10:53 AM with LVN J revealed she worked the morning of 12/23/25 and all she knew was that the DON had gotten a call from Resident #1's dialysis center and told the DON the resident was being sent to the emergency room because the resident had complained of leg pain. LVN J said Resident #1 was always required to be a Hoyer lift transfer and she did not know who assisted the resident out of bed that day and no one had reported anything to her. LVN J further stated she did not ask Resident #1 what happened to her leg when she returned from the hospital. Interview on 02/12/26 at 11:24 AM with a Dialysis Case Manager revealed he was not there when Resident #1 arrived at the dialysis center and complained about her leg pain. The Dialysis Case Manager said once the resident had gotten out of the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospital and returned to dialysis he asked her what happened and Resident #1 told him that while the nursing home staff were transferring her from the bed to the wheelchair her leg and a staff member's leg had gotten tangled together and she immediately had felt pain to her left leg. The Dialysis Case Manager said he heard (did not say by who) the nursing facility had tried to blame the dialysis center for the incident but he was also told Resident #1 had never transferred out of her wheelchair because she had been in too much pain so she sent to the hospital. Interview on 02/12/26 at 12:03 PM with the ADON revealed she had had been told, did not say by who, that Resident #1 had been taken to her dialysis appointment and they later had gotten a call from the dialysis center who said the resident had been transferred to the hospital because she had complained of leg pain. The ADON said LVN C called the hospital for a follow-up on Resident #1 and LVN C was told the incident happened at the dialysis center. The ADON further stated she never talked to Resident #1 about the transfer incident and the DON had spoken to the dialysis center. The ADON also said Resident #1 required a Hoyer lift for all transfers as far as she could recall. Interview on 02/12/26 at 12:13 PM with the DON said Resident #1 left the facility via a third-party transport to her dialysis appointment. Once the resident was at the dialysis center, the facility got a call from their nurse (Dialysis RN) who said Resident #1's said her leg was hurting and had requested to go the hospital. The DON said the LVN C had talked to a hospital nurse who told LVN C Resident #1 had been dropped at dialysis. The DON said she spoked to Resident #1, but did not say when, and the resident told the DON the incident happened at the nursing facility when she had been transferred by a tall black man that was light skinned, and the DON stated there was no one at the facility that matched that description. The DON then said Resident #1 stated two men had transferred her to the chair but the resident never told the DON the incident had happened at the nursing facility. The DON was asked if she had called the dialysis center to ask if Resident #1 had fallen or been dropped there and the DON said No, what for, there would be no reason because they (dialysis center) did not offer any information. The DON further stated she spoke with the facility staff that worked with Resident #1, and they all told her nothing happened and there was no incident to lead them to believe it had happened at the nursing facility. The DON was asked if she had interviewed CNA B at the time of the incident and she also stated no. The DON was asked if she had obtained statements from the staff and she said yes I wrote them on a notepad somewhereInterview on 02/12/26 at 6:28 PM with the Dialysis RN revealed the day Resident #1 arrived at the dialysis center (12/23/25) it had been reported to her by the dialysis techs (Dialysis Tech D) that the resident had been noted crying in the dialysis center lobby. The Dialysis RN said one of the dialysis techs took Resident into the room where they residents are in their dialysis chairs and notified her the resident was crying and complaining of pain. The Dialysis RN said Resident #1 was normally very quiet, pleasant and with little to no complaints and never had any concerns with her cognition so the resident would have been able to tell them what happened. The Dialysis RN said she saw Resident #1 crying, so she asked her what happened and the resident said the nursing home aides had twisted her leg when they transferred her into her wheelchair. The Dialysis RN said she assessed the resident and when she touched her left knee, the resident cried out in a lot of pain, she could not move her leg and the resident requested to be sent out to the hospital. Per her assessment, the Dialysis RN said she thought Resident #1 had a leg fracture and described her pain being at a 10/10. When EMS arrived and tried to put her on the stretcher, the Dialysis RN said the resident screamed out in pain as she could not straighten her leg. The Dialysis RN the Dialysis Nurse Manager called the nursing facility to let them know the resident had been sent to the hospital and the DON had called back and spoke to the Dialysis RN. The Dialysis RN said she told the DON what the resident (continued on next page)

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	675756	A. Building B. Wing	02/13/2026

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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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had told her happened at the nursing facility and the DON asked the Dialysis RN to send Resident #1 back to the facility so they could do an in-house x-ray but she told the DON they had to send the resident to hospital due to her severe leg pain. The Dialysis Nurse further stated Resident #1 told her the nursing facility had tried to blame the incident on the dialysis center but there was no incident at the center, and their nurse manager and techs were witness to how the resident arrived at the dialysis center and she never told the DON the incident happened at the dialysis center. Interview on 02/13/26 at 9:45 AM with CNA A revealed she never asked CNA B to help her transfer Resident #1 with a Hoyer sling and drawsheet, nor did she recall the resident stating she was in pain. Interview on 02/13/26 at 10:00 AM with CNA B revealed he had never worked with Resident #1 but CNA A had called him to assist with a transfer (12/23/25). CNA B said he did not work at the facility full time but only worked as they needed him CNA B said he was told Resident #1 was already late for dialysis and the Hoyer lift was broke so he, CNA A and two other aides, later identified as CNA E and CNA F all transferred the resident from the bed to the wheelchair using the Hoyer sling under the resident and a draw sheet. CNA B said he did not notice during the transfer but once the resident was in her wheelchair, she complained of leg pain. CNA B said the other aides tried to console the resident and then told him (CNA B) that Resident #1's pain was part of the resident's condition because the resident did not walk. CNA B further stated he did not report the resident's pain to the nurse because he was not the resident's aide and would have expected the other aides to report any incidents because they worked with the resident. Interview on 02/13/26 at 10:27 AM with CNA E revealed she denied Resident #1 was transferred to her wheelchair with a sling and a draw sheet, the day of the incident, 12/23/25. CNA E said she did not recall any other details from that date. Interview on 02/13/26 at 10:56 AM with CNA F revealed she did not work at the facility full time and only as needed, and she did not recall any resident transferred with a Hoyer sling and draw sheet. Interview on 02/13/26 at 2:21 PM with the Dialysis Tech revealed he was working the day Resident #1 arrived at the dialysis center complaining of leg pain. The Dialysis Tech said another tech, did not recall which one, had alerted him that Resident #1 was crying in the lobby of the dialysis center, so he went to get the resident and took her back to where the residents got dialysis. Resident #1 told the Dialysis Tech said Resident #1 was crying and stated the nursing staff had twisted her knee during her transfer to the wheelchair. The Dialysis Tech said he tried to reposition the resident in her chair as she still had a Hoyer sling under her and the resident began to scream and cry, stating she was in severe pain. At the time the Dialysis Tech said he called the Dialysis RN to assess the resident and Resident #1 told her the same story about how the nursing facility staff had twisted her knee. The Dialysis Tech said Resident #1 was normally very calm and pleasant and had never complained of any pain during her dialysis treatments and they had never had any concerns with her cognition during her treatments. The Dialysis Tech said Resident #1 was never moved into a dialysis chair because of her severe pain. Interview on 02/13/26 at 2:28 PM with the Dialysis Nurse Manager revealed she was with another patient when she heard Resident #1 crying, so she went over to the resident to ask what was wrong and the resident said the nursing facility staff hurt her leg during the transfer to the wheelchair. The Dialysis Nurse Manager asked Resident #1 if she had reported the pain to the nursing facility staff and the resident said, yes I told them I was in pain, and they just told me I had to go to dialysis, so they put me in the van and brought me to the clinic (dialysis). At that time the Dialysis RN began to assess the resident and because she was crying in pain, they decided to call 911 and have her sent out for further evaluation. The Dialysis Nurse Manager said Resident #1 was very alert and oriented and normally calm during her dialysis treatments. The Dialysis Nurse Manager said Resident #1 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was never transferred to the dialysis chair because any little movement caused the resident so much pain. The Dialysis Nurse Manager said she called to speak with a facility nurse, and did not recall who, to let them know Resident #1 would be sent to the hospital and the DON later called and spoke with the Dialysis RN. She further stated that at no point did she or any of the dialysis staff tell the facility the incident had occurred at the dialysis center. Interview on 02/12/26 at 4:11 PM with the Administrator revealed the incident with Resident #1 was not a reportable incident because it happened at the dialysis center and not the nursing facility. Record review of the facility's policy titled Abuse, Neglect, and Exploitation and Misappropriation of Resident Property reviewed 02/2020 reflected the following: Purpose The purpose of this policy is to ensure that all healthcare facilities comply with federal and state regulations regarding (i) protecting facility patients and residents from abuse, neglect, exploitation and misappropriation of resident property, and (ii) timely investigation of and reporting to state and local agencies all allegations of abuse, neglect, exploitation and misappropriation of resident property. All managed healthcare facilities and all management company staff members or third parties providing services to such facilities and/or their residents.3.3 Upon receiving an allegation abuse, neglect, exploitation or misappropriation, the Abuse Coordinator will.b) initiate an investigation into the allegation.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (Resident #1) reviewed for accidents. The facility failed to ensure a mechanical lift was used to transfer Resident #1 from her bed to the wheelchair on 12/23/25 when they were getting the resident up to go to the dialysis center. During the transfer, the resident reported that her leg got twisted which caused her severe pain. The resident was then sent to the dialysis center where she complained of severe pain and was transferred to the hospital where she was diagnosed with a comminuted fracture (a severe injury where a bone breaks into three or more fragments, typically caused by high-impact trauma), which required surgery. An IJ was identified on 02/12/26. The IJ template was provided to the facility on [DATE] at 4:22 PM. While the IJ was removed on 02/13/26, the facility remained out of compliance at a scope of isolated and a severity level potential for more than minimal harm that was not immediate jeopardy, due to the facility's need to implement corrective systems. This failure could place residents at risk for accidents that could lead to serious injury or harm. Findings included:Record review of Resident #1's MDS dated [DATE] reflected the resident was a [AGE] year-old female resident whose most recent admission entry was on 04/10/25. Resident #1 had a BIMS score of 10 which indicated she had moderately impaired cognition. The residents' diagnoses included stroke, end stage renal disease, and there was no diagnosis of dementia or Alzheimer's disease. The MDS also reflected that the resident did not have inattention, disorganized thinking or altered level of consciousness and she did not exhibit any type of behaviors. Resident #1 used a wheelchair for mobility and required substantial/maximal assistance which indicated the helper did more than half the effort. The resident did not attempt to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed due to medical conditions or safety concerns. The MDS further reflected that the resident did not have any pain. Review of Resident #1's facesheet printed on 02/13/26 reflected her original admission date was on 08/14/19Record review of Resident #1's care plan with an original date of 02/12/26 reflected the resident needed to be lifted mechanically using a Hoyer lift (mechanical device designed to safely transfer patients with limited mobility between beds, chairs or toilets using a sling-and-mast system) with two or more persons support due to impaired mobility. Interventions included to provide extensive assistance with bed mobility and lift mechanically using mechanical lift with two or more persons support from staff. Record review of Resident #1's hospital records dated 12/23/25 reflected the following: .Reason for admission: Left distal femur fracture.[Resident #1].with residual left-sided weakness, bedbound.Patient presented to ED with left knee pain that started today during transferring to her dialysis, patient said that her foot got stuck then her leg was twisted during transfer, pain was severe 10/10, pain increased with minimal movement, it was associated with recurrent vomit.Femur x-ray showed acute comminuted fracture of distal left femur.Principal Problem:Closed fracture of left distal femurAssessment: Patient did not have a fall, her leg got twisted during transfer to dialysis.possible surgery in the morning.Active Problems:.Osteoporosis.Review of the dialysis Nursing Progress Notes Report dated 12/23/25 documented by the Dialysis RN reflected the following: Pt came in with c/o severe pain to her left knee, painful to touch. Pt unable to move her foot. Pt requested to call EMS to send her to ER. Called nursing home and spoken [sic] to the clerk re: pt complaints. [DON] of [nursing home] called, spoken [sic] with her and inform her of pt complaints. Tx not started. MD informed. Pt left via stretcher at 1150hrs, pt was crying out loud d/t pain to her knee. Record review of Resident #1's progress notes dated 12/24/25 at 5:15 AM (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	documented by the DON reflected the following: contacted [facility] nursing staff for update on resident return. Per [facility] charge nurse [LVN C], she contacted nurse caring for resident at [First Hospital] on 9th floor and was informed [Resident #1] has a femur fracture and was transferred from [First Hospital] to [Second Hospital] for higher level of care due to injury sustained while at the dialysis center. According to [Second Hospital] primary nurse [Resident #1] sustained LLE injury during transfer from WC to dialysis chair. Resident stated her left leg was twisted during transfer and was unable to continue dialysis due to pain/discomfort to LLE and requested to be sent to emergency department Record review of Resident #1's progress notes dated 12/24/25 at 5:46 AM documented by LVN C reflected the following: Resident transfer to [Second Hospital] from her dialysis appt. Resident was admitted for left femur fx, nurse stated she twisted her leg at dialysis when trying to put her in dialysis chair. DON notified, ADON notified.Record review of Resident #1's progress notes dated 12/24/25 at 3:17 PM documented by the DON reflected the following: LATE ENTRY FOR 12/23/25 11:45 AM: spoke with [Dialysis RN] regarding need for transfer to hospital from dialysis center due to complaints of left knee pain. Nurse stated resident was unable to transfer to chair due to pain in LLE after transfer attempt. Resident stated knee was twisted, during transfer attempt at dialysis center and requested to be transported to emergency department for evaluation and treatment. Resident transfer to [Second Hospital] from her dialysis appt. Resident was admitted for left femur fx, nurse stated she twisted her leg at dialysis when trying to put her in dialysis chair. DON notified, ADON notified.Interview on 02/12/26 at 9:39 AM with Resident #1's family revealed the resident had to undergo femur surgery because it had broken during a transfer from her bed to the wheelchair. The resident's family said they were told by the resident that there were some male staff that helped her from the bed to the chair and the guy turned her the wrong way. The resident told the family she reported to the staff that her leg was hurt but she had been taken to dialysis anyways where she again reported to the dialysis staff, she thought the facility staff had broken her leg. The family further stated Resident #1 had requested to go to the hospital because she was not able to get out of her wheelchair at the dialysis center because of her pain. Observation and interview on 02/12/26 at 10:22 AM with Resident #1 revealed she was sitting in her wheelchair in her room at the nursing facility with padded foot protectors on each foot. The resident stated she could not walk or move her legs and had not been able to in a long time. Resident #1 was asked about the incident (12/23/25) when her leg was broken and she said there were several staff in her room but could not remember how many. Resident was able to recall one of the female aides was chubby (later identified as CNA A) and a bald male (later identified as CNA B). The resident said she was normally transferred via Hoyer lift but the day of the incident the staff that included a tall bald man had picked her up with their hands and transferred her over to the wheelchair and during the transfer, her left leg had gone through CNA B's legs and twisted. Resident #1 said her left leg immediately began to hurt and she told the staff I think you broke my leg to which the male staff (CNA B) responded with I didn't break your leg. The resident said she had only seen the male staff (CNA B) once or twice and did not know if he still worked at the facility. Resident #1 said once she was put in her wheelchair she was just put in the van and taken to dialysis, which was located across from the facility. The resident said once she arrived at the dialysis center, she told the dialysis staff her left leg hurt, and she wanted to go to the hospital because she thought it was broken. Resident #1 said she was never transferred out of her wheelchair at the dialysis center because she was in so much pain. Resident #1 stated I never told anyone the incident happened at the dialysis center; I haven't lost my mind yetInterview on 02/12/26 at 10:53 AM with LVN J revealed she worked the morning of 12/23/25 and all she knew was that the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	said, yes I told them I was in pain, and they just told me I had to go to dialysis, so they put me in the van and brought me to the clinic (dialysis). At that time the Dialysis RN began to assess the resident and because she was crying in pain, they decided to call 911 and have her sent out for further evaluation. The Dialysis Nurse Manager said Resident #1 was very alert and oriented and normally calm during her dialysis treatments. The Dialysis Nurse Manager said Resident #1 was never transferred to the dialysis chair because any little movement caused the resident so much pain. The Dialysis Nurse Manager said she called to speak with a facility nurse, and did not recall who, to let them know Resident #1 would be sent to the hospital and the DON later called and spoke with the Dialysis RN. She further stated that at no point did she or any of the dialysis staff tell the facility the incident had occurred at the dialysis center. Interview on 02/18/26 at 10:42 AM with the Transportation Operations Manager revealed he spoke with the transportation driver, and he did not recall Resident #1 but also did not recall anything out of the ordinary with any patient the driver had transported during that time. The Transportation Operations Manager further stated there was nothing documented for the day of 12/23/25. Record review of the facility's policy titled Mechanical Lifts (Hoyer/Sit-to-Stand) reviewed on 05/2023 reflected the following: PolicyResidents will be assisted with the Activities of Daily Living, utilizing lifts according to manufacturers' guidelines. Procedure:1. Mechanical Lift Pre-Operations Checka. Understand why Resident needs lift.3. Report any change in condition to Charge Nurse.Record review of the facility's policy titled Change of Condition revised on 02/2023 reflected the following:.1. As part of the Interdisciplinary team, Certified Nursing Assistants (CNAs).are expected to report findings that might represent ACOC's.This was determined to be an Immediate Jeopardy (IJ) on 02/12/26 at 4:11 PM. The Administrator, Assistant Administrator, and DON were notified. The Administrator was provided with the IJ template on 02/12/26 at 4:22 PM. The following Plan of Removal submitted by the facility was accepted on 02/13/26 at 9:48 AM: Plan of removal for IJ-F689-State alleges facility failed to ensure each resident received adequate supervision to include prevention of accidents during mechanical transfer/ two person assists.1. IJ called at 4:22PM at facility for F689.2. Medical Director Notified at 4:30pm.3. Ad hoc QA completed to address employee transfer techniques using mechanical lifts.4. Immediate Correction/Client protectiona. DON/designee to educate all clinical staff on mechanical lift transfers to include 2 persons assist. Completion date 2-12-26.b. DON/designee to educate all clinical staff to notify nurse of any pain or change of condition during transfers. Completion date 2-12-26.c. DON/designee performed assessment on all residents requiring mechanical lift transfers to ensure safety. Completion date: 2-12-26d. Residents who require mechanical lift transfers will be added to ADL Kardex by DON/designee. Completion date 2-12-26e. MDS/designee updated care plans for all residents requiring mechanical lift transfers. Completion date 2-12-26f. All clinical staff will be educated on proper transfer techniques to include mechanical lifts prior to working their next assigned shift. This will be completed by DON/designee. Completion date: 2-12-26.5. Monitoringa. DON and/or designee will monitor residents requiring mechanical lifts for transfers 3 times weekly to ensure compliance.b. Administrator to review with the DON the 3 times weekly monitoring to ensure continued compliance.c. Results of all audits will be brought to QAPI committee by DON to review for continued recommendations and compliance.d. This protocol will be covered on new-hire orientation by DON/designee.Monitoring of the Plan of Removal included the following:Record review of the facility's resident mechanical audit revealed there were 39 residents that required a mechanical lift for transfers. Observation on 02/12/26 and on 02/13/26 of Residents #1, #2, and #3 during a Hoyer lift transfer revealed there were 2 staff members present, there were no concerns about the procedure of using the Hoyer lift, and the resident did not express pain (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	02/13/2026

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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	or discomfort during the process. Record review of Residents #1, #2, #3, #4, and #5's clinical record revealed their plan of care had been updated in the computer system and an alert came on the screen that identified the residents as a Hoyer lift transfer and staff were to acknowledge before they could proceed with documentation. Record review of the in-services dated 02/12/26 reflected nursing staff were re-educated on mechanical lift transfers process and procedure, resident pain management, and change of condition and what to do in case those concerns are noted. Record review on 02/13/26 of the competency evaluations revealed nursing staff were checked off on their performance of using a mechanical lift. Interviews on 02/13/26 from 9:53 AM to 3:31 PM with aides from various shifts were able to describe the process and procedure on how to use the mechanical lift with no less than 2 staff members, they knew they could look in the computer plan of care to identify which resident required a mechanical lift, if a resident complained of discomfort or pain they were to stop the transfer, ensure the resident was safe and notify the charge nurse. Those staff members included CNA A, CNA E, CNA F, CNA H, CNA K, CNA L, CNA M, CNA N, CNA P, CNA R, CNA S, CNA W, and CNA X. Interviews on 02/13/26 from 9:53 AM to 3:31 PM with nurses from various shifts were able to describe the process and procedure on how to use the mechanical lift with no less than 2 staff members. The nurses knew to look at the resident's care plan to identify which residents required a mechanical lift during a transfer. The nurses said if a resident complained of pain or discomfort during the transfers, they were to stop the transfer and notify them so the resident could be assessed. During the assessment they would check the resident for pain and identify the location of the pain and give PRN pain medications or call the physician for further instructions if the pain medication was not effective. Those staff members included the ADON, DON, LVN C, LVN G, LVN I, LVN J, LVN O, LVN Q, LVN T, LVN U, LVN V, and LVN Y. The Administrator was informed the Immediate Jeopardy was removed on 02/13/26 at 4:34 PM. The facility remained out of compliance at a scope of pattern and severity level of no actual harm with the potential for more than minimal harm that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.