STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675756	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026

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 record reviews and interviews, the facility failed to report alleged violations involving abuse, neglect, exploitation, or mistreatment immediately, but no later than 2 hours after the allegation is made for 1 (Resident #1) of 5 residents reviewed for neglect.The facility failed to notify HHSC when Resident #1 was discovered to have been left in a transport van for several hours in the cold. This failure could place residents at risk of neglectful behavior not being investigated.Findings Include:Record review Resident #1's quarterly MDS assessment, dated 01/29/26, reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included kidney failure requiring dialysis, dementia, and paranoid schizophrenia. Resident #1's BIMS score was 6, indicating he had severe cognitive impairment. His Behaviors assessment did not indicate he did not wander. Resident #1's Functional Ability assessment indicated he used a wheelchair for mobility and required assistance with his ADLs. Record review of Resident #1's care plan, dated 9/29/25, reflected he had delirium, had impaired mobility, and required dialysis three times a week. Record review of Resident #1's EHR revealed no progress notes about the incident on 01/29/26, what interventions had been done, and who was notified. In an interview on 03/03/26 at 10:00 AM Resident #1's family member stated they were notified on 01/29/26 around 8:30 PM that Resident #1 was not on the Memory Care unit. When they asked how long he had been missing, staff were unable to give a time frame. Around 9:00 PM the family received a phone call saying that he had been located in the transport van. The family member stated Resident #1 returned from dialysis between 4:30 and 5:00 PM depending on traffic. They stated the resident had been missing for about 4 hours without anyone noticing. Family member stated the temperature on 01/29/26 was in the 30's. In an interview on 03/03/26 at 1:30 PM the Driver stated he did not leave Resident #1 in the van when they returned from dialysis, the resident was taken back to his unit, and the staff were told he had returned. The Driver stated he did not know how Resident #1 got back to the van, he was off duty at 5:00 PM. The Driver stated he was surprised when he was called late at night on 01/29/26 telling him about the incident and that he was suspended pending an investigation. When he returned, he was in-serviced on Transportation Safety and Signing residents out and back in. He stated he documents on the log at the nurse's station, as well has his logbook he carries, which must be signed by the nurse to verify the resident had returned. In an interview on 03/03/26 at 2:05 PM CNA-E stated she was working on 01/29/26 when Resident #1 was found outside in the van. She stated Resident #1 returns from dialysis between 4:30 and 5:00 pm. CNA-E stated it was not unusual for Resident #1 to straight to bed when he returned, dialysis made him tired. CNA-E stated she noted Resident #1 was not in the common area of the unit, nor in his room when she checked around 8 or 8:30 PM. She notified the nurse she could not locate the resident. CNA-E stated all staff began looking for the resident on the unit, when he could not be located, they called the other units to look for him on their units. CNA-E went out to her car and noticed movement inside the van. She tried to open the driver's side door, and it was locked so she went back to get the nurse. CNA-E stated they were able to open the passenger side doors, the resident was sitting in a seat with his seat belt still in place. CNA-E stated staff had to bring out another wheelchair because they could not (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	03/03/2026

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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	get the resident's wheelchair out with the engine off. CNA-E stated when they had the resident back on the unit he was checked by the nurse, he was not cold, he was wearing a heavy jacket and a sweater. CNA-E asked him what happened and Resident #1 stated That [NAME] left me in the van. I thought he was going to come back but he didn't. In an interview on 03/03/26 at 2:40 PM the DON stated she could not recall what date this incident had occurred, but she was called at home and told Resident #1 could not be found in the facility. She advised staff to search the facility grounds while she drove to the facility. The DON stated she received a call that the resident had been found in the transport van. The DON stated she assessed the resident when she arrived, and he was not cold and did not appear to have any complications from being outside. The DON called the Driver and asked him how he had left the resident in the van. The Driver stated he had brought the resident back to the unit around 5:00PM and told staff he was back. The Driver did not know how the resident got back out to the van. The DON stated Resident #1 was capable of taking himself back to the van if he had followed a visitor off the secured unit. In a phone interview on 03/03/26 at 3:10 PM LVN-F she stated she was on duty when Resident #1 was found outside in the van. She stated when he was found she went out to the van and found Resident #1 in a seat and buckled in. The resident was wearing a coat as well. LVN-F stated they were unable to get Resident #1's wheelchair out of the back of the van without the keys, so they used another wheelchair. LVN-F stated she did not believe Resident #1 was capable of getting off the locked unit, wheeling himself out the front of the facility, folding up his wheelchair and placing it in the back of the van, getting in the front of the van, and buckling himself in. With his dementia and physical state, it would be highly unlikely. In an interview on 03/03/26 at 3:25 PM the Administrator stated his investigation into the situation revealed the Driver had returned Resident #1 back to the unit, and the resident managed to get himself back to the van somehow. He felt Resident #1 was capable of doing so. The resident might have followed a visitor off the unit, and the front door is not locked at night, and the van sits right outside the front door in the portico. The Administrator stated he did not report the incident because there was no harm to the resident, and the Driver had brought the resident back to the unit. Record review of the facility's policy Abuse, Neglect, and Exploitation and Misappropriation of Resident Property, dated 02/12/20 reflected: 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, Adult Protective Services (where state law provides for jurisdiction in skilled nursing or assisted living facilities), and in certain cases, local law enforcement, within the following timeframes:a. not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury; or b. not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records review, the facility failed to ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 3 (Residents #2, #3, and #4) of 3 residents reviewed for pressure ulcers.1. The facility failed to provide wound care to Resident#2's Unstageable wound of the left heel, on 01/17/2026 and 01/18/2026.1a. The facility failed to provide wound care to Resident #2's stage 4 pressure wound of the left medial first toe and the left fourth toe on 01/17/2026, 01/23/2026, 01/24/2026, 01/30/2025 and 01/31/2026. 1b. The facility failed to provide wound care to Resident #2's stage 4 pressure wound of the left fourth toe, the left distal medial foot and the left medial first toe on 02/01/2026, 02/07/2026, 02/08/2026 and 02/10/2026.1c. The facility failed to provide wound care to Resident # 2's stageable 4 pressure wounds of the left medial foot and left heel on 02/11/2026, 02/13/2026, 02/14/2026, 02/15/2026 and 02/17/2026. 1d. The facility failed to provide wound care to Resident#2's stage 4 pressure wound of the left medial foot and left heel on 02/20/2026,02/22/2026 and 02/26/2026. 2. The facility failed to provide wound care to Resident#3's end of stage skin failure of the sacrum on 2/01/2026, 02/07/2026, 02/08/2026, 02/10/2026, 02/11/2026, 01/13/2026, 02/14/2026, 02/15/2026 and 02/17/2026.3. The facility failed to provide wound care to Resident #4's [NAME] Terminal wound (an unavoidable skin failure, often appearing as a rapidly developing, pear-shaped, or blackish wound on the sacrum/coccyx, signaling that death is near) on the right ischium on 02/26/2026/25 and 02/28/2026.These failures placed residents at risk of developing new or worsening pressure ulcers, infection, and pain. Findings Include:1.Record review of Resident #2's admission MDS assessment, dated 01/11/2026, reflected she was an [AGE] year-old female who admitted to the facility on [DATE]. Her diagnoses included Pressure ulcer of left heel region, stage 3, and other multiple unstageable pressure ulcers. Resident #2's BIMS score was 03 which indicated severe cognitive impairment. The MDS further revealed Resident #2 had pressure ulcers upon admission/entry to the facility.Record review of Resident #2's care plan, revised on 01/09/25, reflected the following: Problem: [Resident #2] has Skin integrity, impaired severely, related to pressure sores. Goals: Achieve and maintain intact skin as evidenced by no redness, infection, rash, dryness, pruritus. Pressure sore decreased to: Stage 4. Interventions: Debride with transparent adhesive dressings, wet-to-dry dressing, and water therapy .Record review of Resident #2's Order Summary Report, dated 01/13/26, reflected the following: - Cleanse wound ([start 01/08/26 18:54] on day shift [time: shift 1]) and ([start 01/08/26 18:54] as needed anytime) unstageable wound of the left distal medial foot: Cleanse with normal saline or wound cleanser, pat dry, apply betadine, cover with dry dressing.Cleanse wound ([start 01/13/26 15:47] day shift and as needed anytime) unstageable wound of the left medial foot. Cleanse with normal saline pat dry and apply Santyl and xeroform, cover with a superabsorbent dressing with silicone border.Cleanse wound ([start 01/13/26 15:47] day shift and as needed anytime) stage 4 pressure wound of the left medial first toe. Cleanse with normal saline pat dry and apply Santyl and xeroform, cover with a superabsorbent dressing with silicone border.Cleanse wound ([start 01/13/26 15:47] day shift and as needed anytime) stage 4pressure wound of the left forth toe. Cleanse with normal saline pat dry and apply Santyl calcium alginate and cover with a dry dressing.Cleanse wound (start 01/08/26 18:36) on day shift and as needed unstageable wound of the left heel. Cleanse with normal saline pat dry apply betadine and cover with dry dressing.Cleanse wound ([start 01/13/26 15:47] day shift and as needed anytime) unstageable wound of the left heel cleanse with normal saline pat dry and apply Santyl and xeroform, cover with a superabsorbent dressing with silicone border.Cleanse wound ([start shift 1]) and ([start 02/10/26 17:13] as needed anytime) stage 4 pressure wound of the left heel. Cleanse with normal saline, pat dry, apply Silvadene, cover with an abdominal pad and wrap with kerlix.Record review of (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2's Wound Care Administration Record for January 2026 reflected the Wound Care was not documented as being completed on 01/17/2026 and 01/18/2026, for Resident#2's Unstageable wound of the left heel.On 01/17/2026,01/23/2026,01/24/2026,01/30/2025 and 01/31/2026 Resident #2's stage 4 pressure wound of the left medial first toe was not documented as being completed.On 01/17/2026,01/23/2026,01/24/2026,01/30/2025 and 01/31/2026 the facility failed to provide wound care to Resident #2 stage 4 pressure wound of the left fourth toe.On 02/01/2026,02/07/2026,02/08/2026 and 02/10/2026 the facility failed to provide wound care to Resident #2 stage 4 pressure wound of the left fourth toe.On 02/01/2026,02/07/2026,02/08/2026 and 02/10/2026 the facility failed to provide wound care to Resident #2 stage 4 pressure wounds of the left distal medial foot.On 02/01/2026,02/07/2026,02/08/2026 and 02/10/2026 the facility failed to provide wound care to Resident # 2 stage 4 pressure wound of the left medial first toe.On 02/11/2026,02/13/2026,02/14/2026,02/15/2026 and 02/17/2026 the facility failed to provide wound care to Resident # 2 stageable 4 pressure wounds of the left medial foot.On 02/20/2026,02/22/2026 and 02/26/2026 the facility failed to provide wound care to Resident#2 stage 4 pressure wound of the left medial foot.On 02/11/2026,02/13/2026,02/14/2026,02/15/2026 and 02/17/2026 the facility failed to provide wound care to Resident#2 stage 4 pressure wound of the left heel.On 02/20/2026,02/22/2026 and 02/26/2026 the facility failed to provide wound care to Resident#2 stage 4 pressure wound of the left heel.Record review of the progress notes for January and February 2026 there was no documentation of wound treatment.Observation on 03/03/26 at 09:40 AM of Resident #2 at a local Hospital revealed she had wounds on her left heel, open area on her right buttocks and left medial first toe. They were covered with dry dressings. 2.Record review of Resident #3's Quarterly MDS Assessment, dated 01/20/26, reflected Resident#3 was a [AGE] year-old female who initially admitted to facility on 09/19/2023 and readmitted [DATE]. Her diagnoses included open lesions. She had a BIMS score of 07, indicating severe cognitive impairment. Her MDS assessment indicated open lesions other than ulcers.Record review of Resident #3's care plan, dated 02/18/26, reflected the following:Problem: Resident#3 had - Skin integrity, impaired severely,related to End-Stage Skin Failure. Interventions: Thoroughly clean at each dressing change and apply: Dakin's solution Caution: Pack wound to obliterate dead space without damaging tissue ''. Record review of Resident #3's order summary report, dated 12/01/25, reflected the following: - cleanse wound (12/01/25 13:44 shift) on day shift and as needed to end stage skin failure of the sacrum. Cleanse with normal saline, pat dry, apply honey coated absorbent dressing, cover with dry dressing.Cleanse wound ([start 02/17/26 18:58 on daily shift daily time: shift 1) and (start 02/17/26 18:58] as needed end stage skin failure of the sacrum. cleanse with normal saline or wound cleanser, pat dry, apply Dakin's 1/4 strength-soaked gauze, cover with a dry dressing. Record review of Resident #3's wound care administration record for February 2026 reflected there were no entries, and the spaces were documented as Missed for: -02/01/2026,02/07/2026,02/08/2026,02/10/2026,02/11/2026,01/13/2026,02/14/2026,02/15/2026 and 02/17/2026 the facility failed to provide wound care to resident#3 end of stage skin failure of the sacrum. Review of the progress notes for January and February 2026 there was no documentation of wound treatment.Observation and interview on 03/03/26 at 01:55 PM of Resident #3 revealed she was lying in bed. Resident #3 said she had wounds on her bottom, and she got wound care, but she could not tell when. Observation on 03/03/26 at 02:03PM with Wound Care Treatment Nurse, providing Resident #3 with wound care revealed, he disinfected the table and left it dry. He removed gloves, washed hands, and put the supplies together. He washed hands and put on Personal Protective Equipment (PPE). He wheeled the table to Resident #3's bedside. He then washed his hands, put on gloves, removed the old dressing on Resident #3's sacrum. The old dressing was observed to be dated 03/02/26. He removed his gloves, washed hands, and put on new gloves. He cleansed the wound with normal saline, removed his gloves, washed his hands, put on new gloves, applied Dakins 1/4 strength-soaked gauze, and covered with a dry dressing dated 03/03/26.3. Record review of Resident #4's comprehensive MDS assessment dated [DATE] reflected the resident was a (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[AGE] year-old female. Resident #4 was admitted to the facility on [DATE]. Her diagnoses included Peripheral Vascular Disease (a condition that affects the blood vessels outside the heart and brain). Section M indicated open lesion(s)other than ulcers. Resident #4 had a BIMS of 2 indicating her cognition was severely impaired.Record review of Resident #4's order summary report, dated 02/23/26, reflected the following: - cleanse site on day shift as needed Kennedy terminal ulcer (KTU). Cleanse with normal saline or wound cleanser, pat dry, apply Dakin's 1/4 strength-soaked gauze, cover with a dry dressing.Record review of Resident #4's Wound Care Administration Record for February 2026 reflected there were no entries, and the spaces were documented as Missed for: 02/26/2026/25 and 02/28/2026, the facility failed to provide wound care to Resident #4 [NAME] wound on the right ischium.Record review of Resident #4's care plan, revised on 03/03/26, reflected the following:Problem: The resident need hospice care due to terminal condition of cerebrovascular disease. Interventions: Administer treatments as ordered and monitor for skin break down.Observation on 03/03/26 at 02:13 PM of Resident #4 revealed she was lying in bed. Resident #4 was not verbal.Observation on 03/03/26 at 02:13 PM with the Wound Care Nurse, providing Resident #4 with wound care revealed he disinfected the table and left it dry. He removed gloves, washed hands, and put the supplies together. He washed his hands and put on Personal Protective Equipment (PPE) gown and gloves. He wheeled the table to Resident #4's bedside. He then washed his hands, put on gloves, and removed the old dressing on Resident #4's sacrum. The old dressing was observed to be dated 03/02/26. He removed his gloves, washed hands, and put on new gloves. He cleansed the wound with normal saline, removed gloves, washed hands, put on new gloves, applied Dakins 1/4 strength-soaked gauze, and covered with a dry dressing dated 03/03/26.Interview on 03/03/26 at 03:30 PM with the Wound Care Nurse revealed he had not noticed wound care was being missed, because he had not paid attention to treatment administration records. He stated he worked Monday through Thursday and nurses that worked on the halls were responsible of wound care on Friday, Saturday and Sunday, and he mentioned they are same nurses that worked those days. The Wound Care Nurse said the risk of not performing wound care could lead to wounds getting infected or slow healing processes. The Wound Care Nurse said the nurses knew that when he was not in the building, they were responsible for their resident's wound care.An attempt was made to contact LVN A, who was assigned to Resident #2, on 03/03/2026 at 02:51PM by phone; however, there was no answer.An attempt was made to contact LVN B, who was assigned to Resident #3 and #4, on 03/03/2026 at 03:01 PM by phone; however, there was no answer.An attempt was made to contact the Wound Nurse Practitioner 03/03/2026 at 03:35 PM by phone; however, there was no answer.Interview on 03/03/26 at 03:58 PM with the DON revealed her expectation was all wounds were being treated as per physician orders. She stated the wound treatment nurse worked Monday through Friday, but before, he was working Monday through Thursday. She stated that when the wound treatment nurse was not in the facility, the floor nurse was responsible for treatments. She stated nurses are notified when he was absent. The DON said all management teams go through medication administration records and treatment administration records during morning meetings, and they address missing orders and she thinks they missed wound care since they are still learning the new system. The DON said if residents were not receiving wound care as ordered it could lead to increased risk of infection or wounds getting worse.Record review of the facility's an overview of wound care policy, dated July 2018, reflected: Prevention and Treatment Strategies: -Effective prevention and treatment are based upon consistently providing routine and individualized interventions

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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 interviews, observations, and record reviews, the facility failed to ensure residents remained free of accident hazards as possible for 1 (Resident #1) of 5 residents reviewed for quality of care.The facility failed to provide Resident #1, who had dementia, with adequate supervision on 01/29/26 when the resident was left unattended and unsupervised on the facility's van from approximately 4:30 PM until 9:00 PM when temperatures were in the 30 degree Fahrenheit range.The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 01/29/26 and ended on 02/02/26. The facility had corrected the non-compliance before the survey began. This failure could place residents at risk of death, related to cold or heat exposure, discomfort, pain, and anxiety. Findings Include:Record review Resident #1's quarterly MDS assessment, dated 01/29/26, reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included kidney failure requiring dialysis, dementia, and paranoid schizophrenia. Resident #1's BIMS score was 6, indicating he had severe cognitive impairment. His Behaviors assessment did not indicate he did not wander. Resident #1's Functional Ability assessment indicated he used a wheelchair for mobility and required assistance with his ADLs. Record review of Resident #1's care plan, dated 9/29/25, reflected he had delirium, impaired mobility, and required dialysis three times a week. Record review of Resident #1's EHR revealed no progress notes about the incident on 01/29/26, what interventions had been done, and who was notified. Record review of the facility's corrective measures, consisted of staff in-service forms, revealed the Driver had been in-serviced 1:1 by the Administrator on a Transportation Safety Check which included carrying out a final check of the van to ensure no residents remained in the vehicle, having a nurse confirm the resident's return to the unit, a visual inspection of all areas of the van, ensuring the vehicle was turned off and all doors were secured. The nursing staff had been in-serviced on the new process of all residents leaving the unit had to be signed out, and when they returned a nurse had to confirm they were back on the unit. Observation on 03/03/26 at 9:50 AM, revealed the facility transport van was parked under the portico, doors were locked, and the engine was off. No residents were observed to be in the van. In an interview on 03/03/26 at 10:00 AM Resident #1's family member stated they were notified on 01/29/26 around 8:30 PM that Resident #1 was not on the Memory Care unit. When they asked how long he had been missing, staff were unable to give a time frame. The family member stated around 9:00 PM, the family received a phone call saying that he had been located in the transport van. The family member stated Resident #1 returned from dialysis between 4:30 and 5:00 PM depending on traffic. They stated the resident had been missing for about 4 hours without anyone noticing. The family member stated the temperature on 01/29/26 was in the 30's. In an interview on 03/03/26 at 1:30 PM, the Driver stated he did not leave Resident #1 in the van when they returned from dialysis, the resident was taken back to his unit, and the staff were told he had returned. The Driver stated he did not know how Resident #1 got back to the van, he was off duty at 5:00 PM. The Driver stated he was surprised when he was called late at night on 01/29/26 telling him about the incident and that he was suspended pending an investigation. When he returned, he was in-serviced on Transportation Safety and Signing residents out and back in. He stated he documented on the log at the nurse's station, as well as his logbook he carries, which must be signed by the nurse to verify the resident had returned. In an interview on 03/03/26 at 2:05 PM, CNA-E stated she had been working on 01/29/26 when Resident #1 was found outside in the van. She stated Resident #1 had returned from dialysis between 4:30 and 5:00 pm. CNA-E stated it was not unusual for Resident #1 to go straight to bed when he returned; dialysis made him tired. CNA-E stated she had noted Resident #1 was not in the common area of the unit, nor in his room when she checked around 8 or 8:30 PM. She notified the nurse she could not locate the resident. CNA-E stated all staff began looking for the resident on the unit, and when he could not be located, (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	they called the other units to look for him on their units. CNA-E stated she had gone out to her car she noticed movement inside the van. She tried to open the driver's side door, and it was locked so she went back to get the nurse. CNA-E stated they were able to open the passenger side doors, and the resident was sitting in a seat with his seat belt in place. CNA-E stated staff had to bring out another wheelchair because they could not get the resident's wheelchair out of the back with the engine off. CNA-E stated when they had the resident back on the unit, the nurse checked him. She stated he stated he was not cold, he was wearing a heavy jacket and a sweater. CNA-E asked him what happened and Resident #1 stated That [NAME] left me in the van. I thought he was going to come back but he didn't. In an interview on 03/03/26 at 2:40 PM, the DON stated she could not recall what date this incident had occurred, but she was called at home and told Resident #1 could not be found in the facility. She advised staff to search the facility grounds while she drove to the facility. The DON stated she received a call that the resident had been found in the transport van. The DON stated she assessed the resident when she arrived, and he was not cold and did not appear to have any complications from being outside. The DON called the Driver and asked him how he had left the resident in the van. The DON stated The Driver had stated he had brought the resident back to the unit around 5:00PM, and told staff he was back. The Driver did not know how the resident got back out to the van. The DON stated, the next day, she initiated an in-service with the staff about a new process for signing residents out and back in, and a nurse had to verify the resident was back. In a phone interview on 03/03/26 at 3:10 PM with LVN-F, she stated she was on duty when Resident #1 was found outside in the van. She stated when he was found she went out to the van and found Resident #1 in a seat and buckled in. The resident was wearing a coat as well. LVN-F stated they were unable to get Resident #1's wheelchair out of the back of the van without the keys, so they used another wheelchair. LVN-F stated she did not believe Resident #1 was capable of getting off the locked unit, wheeling himself out the front of the facility, folding up his wheelchair and placing it in the back of the van, getting in the front of the van, and buckling himself in. With his dementia and physical state, it would be highly unlikely. In a phone interview on 03/03/26 at 3:20 PM, LVN-G stated when Resident #1 was found in the van, he was buckled into a seat, and his wheelchair was in the back of the van. Resident #1 did not seem to be suffering any ill-effects of being out in the cold. In an interview on 03/03/26 at 3:25 PM, the Administrator stated his investigation into the situation revealed the Driver had returned Resident #1 back to the unit, and the resident managed to get himself back to the van somehow. He felt Resident #1 was capable of doing so. The resident might have followed a visitor off the unit, and the front door is not locked at night, and the van sits right outside the front door in the portico. The facility implemented the following corrective actions following the incident: The Driver was in-serviced on:Transportation Safety Check to includeCarry out final check, no residents in the vehicle Have a staff member confirm the resident's return to the unit. Visual Inspection of all areas of the vehicle.Turn engine offSecure the vehicle. The Driver also was required to carry a daily logbook to record when he takes a resident off a unit, what time he brings them back, and a nurse must sign verifying the resident is back on the unit. Review of the facility's in-service documentation revealed the Nurses and CNAs were in-serviced on: The new procedure of tracking residents when they leave the unit and when they return. Frequent monitoring of residents to ensure a resident is identified as missing quickly. In an interview on 03/03/26 at 5:35 PM, CNA-D stated she had been in-serviced on ensuring residents that left the secured unit are signed out, and signed back in when they return.In an interview on 03/03/26 at 5:38 PM, CNA-H stated she had been in-serviced on making sure anyone who takes a resident off the unit, signs them back in when they return, and checked frequently to ensure all residents are present. In an interview on 03/03/26 at 5:42 PM, LVN-I stated staff had been in-serviced on ensuring residents are back on the unit before signing the Driver's logbook. They are supposed to monitor the residents frequently to ensure anyone missing is quickly identified. If a resident has routine outings like dialysis, to know what time they are normally back. In an interview on 03/03/26 at 5:47 PM, CNA-C stated she had been in-serviced on making sure residents are signed (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	03/03/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	out and back in when they leave the unit, and making sure they are back on the unit. She is also to report when a resident is not back at their normal time. In an interview on 03/03/26 at 5:52 PM, LVN-J stated everyone had been in-serviced to ensure the new procedure for checking residents out and in is followed, They must ensure the resident is on the unit before signing the logbook. They are also to be aware of when a resident is not back at their normal time. In an interview on 03/03/26 at 5:57 PM, CNA-K stated she had been in-serviced on monitoring when patients leave the unit, that they are signed out and back in when they return. She is to be aware of when a resident is late returning to the facility. In an interview on 03/03/26 at 6:00 PM, LVN-L stated she had been in-serviced on the new process of signing residents back in, and she had to see the resident present on the unit before she signed the logbook. She was also to call the Driver if a resident was not back from an appointment at their normal time. In an interview on 03/03/26 at 6:05 PM, LVN-N stated she had been in-serviced on ensuring residents were on the unit before signing for them, and to be aware when a resident was late in returning. Observation on 03/03/26 at 6:10 PM, revealed a clipboard at the nurses' station with residents signed out and in. iIt appears to have been in place since 02/02/26 . In an interview on 03/03/26 at 6:25 PM, LVN-Q stated she had been in-serviced on the new process for tracking residents who leave the unit, and ensuring they are back before signing the logbook. In an interview on 03/03/26 at 7:00 PM, CNA-T stated she had been in-serviced on checking residents out and in from the unit, and notifying the nurse if a resident is not found on the unit. In an interview on 03/03/26 at 7:10 PM, CNA-U stated they were in-serviced on the process of the residents being signed out and in from the unit. The nurse must sign for the resident's return. Review of temperatures for 01/29/26 from World Weather Online revealed the temperature in Zip Code 75115 at 6:00 PM was 36 F, and at 9:00 PM it was 33 F. 75115, [NAME], Texas Historical Weather AlmanacReview of the facility's policy Safety System for Residents, dated 08/14/22, does not address leaving residents outside. It addresses general resident safety.