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	03/26/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to immediately consult with the resident's physician; and notify, consistent with his or her authority, the resident representative when there was an accident involving the resident which resulted in injury and had the potential for requiring physician intervention for 1 of 5 residents (Resident #1) reviewed for change in condition. LVN L failed to immediately consult with Resident #1's physician and failed to notify the resident's family when Resident #1 fell hard against a rail in the hallway hitting his face/head and torso, which resulted in immediate bleeding to the resident's cheek on 03/22/26 at 7:30 AM. The resident's family noticed a change in the resident's mental status at 5:00 PM and noted a bloody bandage on the resident's face. The family had the resident transported to the hospital where he found to have sustained a right adrenal hematoma, a Grade 3 laceration of the liver through segments 5 and 6, and two rib fractures. On 03/25/2026 at 5:10 PM an IJ was identified. While the IJ was removed on 03/26/2026 at 4:21 PM, the facility remained out of compliance at a severity level of no actual harm with a potential for more than minimal harm, that was not immediate jeopardy at a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure placed the resident at increased risk for complications from a head injury, hospitalization and death due to delayed physician intervention. Findings included:Record review of Resident #1's admissions MDS assessment, dated 01/07/26, revealed he was an [AGE] year-old male, was admitted on [DATE]. He had a BIMS score of 00, indicating the resident was unable to complete the interview (severely impaired cognition). Resident #1 had no behaviors or moods of sadness, hopelessness or worrying at the time of admission. The MDS Assessment, under Section GG-Functional Abilities, reflected Resident #1 required supervision and touching assistance for toileting hygiene, transfers, mobility, and ambulating. He required partial assistance with eating and ADLs. Further review of this document, under Section H-Bladder and Bowel, reflected Resident #1 had occasional urinary incontinence, and always continent of bowel. Section I-Active Diagnoses, Anemia (iron deficiency), Hypertension (high blood pressure), diabetes mellitus (changes in blood sugar levels), Alzheimer's Dementia (brain disorder with symptoms often involving severe behavioral changes, movement disorders, or language dysfunction rather than just memory loss), and Non-Alzheimer's Dementia (brain disease causing cognitive decline not related to Alzheimer's.) Section N Medications indicated resident received high risk medications for anti-psychotic and antidepression.Record review of Resident #1's baseline care plan dated 01/01/2026 reflected that the resident had severe cognitive impairment, he was Spanish-speaking only, and he was able to communicate his needs. The baseline care plan reflected Resident #1 had impaired functional abilities related to his impaired cognition, and he required some assistance from staff.Record review of Resident #1's care plan dated 01/07/2026 reflected the following:Communication.Resident will communicate basic needs to staff daily Spanish speaking only.Resident will demonstrate improved ability to understand speech. as needed Speak in a way that minimizes inability to understand. Anticipate needs. Fall/wandering, last updated on 03/24/2026. Resident at Risk for Falls resident (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	safety will be maintained.Assess contributing factors related to fall history, Resident at risk of falls while wandering in and out of other residents' rooms. Assistance with standing and moving from one place to the next as needed. 03/02/2026. Wandering, 01/08/2026. Identify pattern of wandering: Is wandering purposeful, aimless, or escapist, is the resident looking for something, does it indicate the need for more exercise. redirect; Frequent visual checks.mental health diagnosis.Record review of Resident #1's physician order dated 01/01/2026 by NP-A reflected an order for Haloperidol 1 mg tablet for anxiety.1 tab by mouth at bedtime, admit to long term care, vitals, and weekly weights on day shift. Record review of Resident #1's physician order dated 01/01/2026 by NP-A for Trazadone Hydrochloride 100 mg. for insomnia.1 table by mouth at bedtime 9:00 PM. This order was discontinued on 03/03/2026.Record review of Resident #1's physician orders dated 03/03/2026 reflected an order by NP-A, Lorazepam 0.5 mg for agitation, 1 tablet by mouth every 12 hours as needed 2 times a day . The Lorazepam was discontinued on 03/13/2026 by NP-A. Record review of Resident #1's sign out sheet reflected he was out with family, 03/22/2026, at 5:45 PM. Record review of Resident #1's progress notes by LVN-I, dated 03/22/2026 at 11:38 PM, reflected: Resident was sent to the hospital on day shift for change of condition of N/V per family request. DON-T communicated with this nurse [LVN-I] instructed that his face sheet and medication lists should be faxed to RN-J (phone number provided). Transmittal confirmation was received ok. Residents are placed on LOA and all medications on hold. Record review of Resident #1's skin assessment dated [DATE] was completed by Staff Development Nurse reflected he had an abrasion to his head. HIs peri-wound margins and surrounding tissue was normal. Resident was not experiencing any pain and the MD had had assessed the wound or was notified and no new orders. The family was not notified Additional notes: Per nurse on duty resident ambulatory, attempted to swing at nurse, lost his balance, and fell hitting side rail. causing abrasion to right temple, first aid provided. The skin assessment was initiated by Staff Development Nurse on 03/24/2026 at 10:54 AM and concluded at 03/24/2026 at 11:00 AM. Record review of Resident #1's progress note dated 03/24/2026 at 11:05 AM by DON-T titled nursing incident reflected there was a late entry for 03/22/2026 at 07:30 AM which reflected the following: per report from primary nurse, resident was roaming in and out of rooms this morning requiring frequent redirection. During such times, residents were redirected from the room at approximately 7:00 AM and became aggressive. He attempted to swing and hit the nurse causing him to lose his balance and fall against the handrail on his left side. Per report he sustained a small abrasion to left temple area, no other injuries noted by primary nurse. Resident was ambulatory after fall and functioning at baseline. Nurse will provide frequent monitoring s/p fall. Completed 03/24/2026 11:24 AM.Record review of Resident #1's progress note dated 03/24/2026 at 11:24 AM by DON-T reflected late entry for 03/22/2026 07:30 AM. Per report from primary nurse [LVN-L], resident was roaming in and out of rooms this morning requiring frequent redirection. During that time resident was redirected from another resident's room at approximately [7:00 AM] and became aggressive, [Resident #1] attempted to swing and hit the nurse causing him to lose his balance and fall against the handrail on his left side. Per report he sustained a small abrasion to left temple area, no other injuries noted by primary nurse [LVN-L]. Resident was ambulatory after fall and functioning at baseline. Nurse ill provides frequent monitoring s/p fall. Record review of Resident #1's fall risk assessment completed by ADON-B on 03/24/2026 at 11:41 AM, reflected that Resident #1 was at risk of falls, and his last fall was on 03/22/2026. ADON-B wrote that Resident #1 had no changes in cognitive status in the last 90 days He displayed altered perception (inaccurate, or unfamiliar interpretation of reality.) .ambulates with no problems and does not use any devices for mobility assistance. Other behaviors observed included disorganized speech, restlessness, changes in mental function, wandering, abusive and resistant to care. Resident #1's was independent with toileting and always continent. Resident #1 blood pressure was not assessed due to being discharged from the facility. There were no completed assessments in the resident's medical records completed by LVN-L regarding the fall on 03/22/2026.by ADON-B for Resident #1's fall on 03/22/2026 at 7:00 AM reflected LVN-L had not (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	completed the required, immediate, comprehensive post-fall assessment (head-to-toe assessment, neurological checks, and vital signs), resulting in ADON-B completing the assessment after the resident was admitted to the hospital 2 days later. LVN-L failed to document any resident assessments or care notes in the file of Resident #1 on 03/22/2026, reflected Record review of Resident #1's incident report dated 03/24/2026 at 12:15 PM was completed by Staff Development Nurse for an incident that occurred on 03/22/2026 at 7:00 AM. The assessment reflected that Resident #1 had a fall in the hallway of the memory unit. LVN-L was present and reported to DON-T on 03/24/2026. Observations reflected that he was moderately impaired, and independently ambulatory. A neurological assessment was completed, and facility findings indicated origin was established, and the injury was not preventable. Facility comments, Resident roaming in and out of rooms, during redirection from [room] resident became aggressive and attempted to swing and hit nurse [LVN-L] causing him to lose his balance and fall against side rail, hitting his left side, sustaining abrasion to left temple area it is important to note that Staff Development Nurse electronically signed the report that she conducted the observations, actions, findings, case report, and reporting, and that the MD, DON-T, and RP were notified on 03/22/2026 at 7:30 AM by LVN-L. The resident was at the hospital at the time of this report. Record review of Resident #1's EHR for the date of 03/22/2026, revealed missing clinical assessments consistent with the falls: Vital signs, fall assessment, post fall monitoring, neurological assessment (alert and function) and post neurological, pain assessments, and functioning and supervision after the fall as well as any changes to his condition. Record review of Resident #1's hospital records reflected he was admitted to the hospital on [DATE] with the chief complaint by the RP that he fell (initial encounter), and fall initial encounter was not resolved. Resident #1 condition was fair and stable. Resident #1 sustained injuries to the right 6th and 7th lateral rib fractures (Right 6th and 7th lateral rib fractures are common chest wall injuries, usually caused by blunt trauma. And sharp pain.), right adrenal hematoma (An adrenal hematoma is a collection of blood within the adrenal gland, often resulting from trauma, severe infection, or anticoagulant use.), and grade 3 Liver laceration involving segments 5 and 8 (These are shallower tears, often less than 3 cm(metric unit used to measure dimensions and size.) deep, or smaller blood clots. Admissions indicators reflected [Resident #1's] past medical history of HTN (High blood pressure), DM (disorder of high blood sugar), CKD (slow progressing conditions of kidney failure). stage 2, and Alzheimer's dementia, who presented s/p, reported fall at his nursing home residence. A comprehensive trauma evaluation identified the injuries above, and the [Resident #1] was admitted to the PCU for pulmonary monitoring, serial hemoglobin monitoring, and pain control measures.During an interview on 03/24/2026 at 9:45 AM with the Administrator, he reported receiving a call from RN-J on 03/22/2026 at 7:04 PM. He then forwarded RN-J's phone number to DON-T to follow up with the hospital nurse for information. He was not aware that Resident #1 had changes per RP and transported the resident to the hospital by the family. The Administrator reported that nursing staff were expected to immediately assess the residents for changes in condition after an incident and observed injuries and follow notification protocols to MD and supervisors to ensure the resident received immediate care. The Administrator did not respond to the risk of not reporting. During an interview with the DON-T on 03/24/2026 at 9:50 AM she stated that LVN- L did not report that Resident #1 fell, sustained an injury to his cheek. DON-T said Resident #1 was signed out by the family and transported to the hospital. DON-T stated LVN-L reported following that resident had an incident obtaining abrasions to his temple on 03/22/2026. DON-T stated LVN-L did not report the incident to her; she was notified by the Administrator after receiving a call from RN-J. LVN-L failed to document the assessments in Resident 1's EHR. DON-T stated that LVN-L will receive one on one training for reporting, and corrective action would be taken. The DON-T stated the protocol of resident injuries and changes in condition includes assessing the resident head-to-toe before moving him/her, checking for obvious injuries, complete neurological checks including assessing eyes for alertness and focus. DON-T stated that the risk of not completing an assessment after an incident with an (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	injury could cause further harm to the residents. During a phone interview on 03/24/2026 at 10:52 AM with the Hospital Social Worker, she stated Resident #1 was brought to the hospital by the family and admitted after a reported fall on 03/22/2026. She stated that Resident #1 sustained injuries of a grade 3 liver laceration and right sided rib fractures. She stated Resident #1 was currently receiving treatment for injuries in PCU (progressive care unit). She reported that Resident #1 did not have an anticipated date of discharge. She stated she would have the assigned NP to contact the surveyor. During an interview on 03/24/26 at RN-M at 1:31 PM, stated she worked at the facility as a PRN staff until recently being hired full time. RN-M was not working on 03/22/2026. She observed a note in Resident #1's EHR that he was transported to the hospital by his family. RN-M stated that when a resident falls, the nurse should assess the resident for injuries, notify the MD for additional guidance and orders. Notify the Family, Admin, and DON. She stated that failing to assess, document, and notify the MD, RP, and DON could result in residents not receiving treatment and additional injuries. During an interview on 03/24/2026 at 1:35 PM, CNA-J stated that she worked at the facility for almost 2 years. She worked with Resident #1 from 2:00 PM to 10:00 PM on 03/22/2026. CNA-J stated that she was told on 03/23/2026 that the resident was at the hospital. She stated that the resident was observed on 03/22/2026 wandering throughout the facility. She said the resident was not acting like he was in pain, nor did he verbalize having pain. She had not received any reports of the residents being monitored for neuros and special supervision. She was notified on 03/23/2026 that Resident #1 fell on [DATE] during the morning shift. She said all changes with the resident's normal baseline should be reported to the charge nurse immediately to ensure the resident was assessed and MD notified for further observation and care to ensure the resident's safety. CNA-J said she did not observe any changes in his normal baseline. During an interview on 03/24/2026 at 2:35 PM with ADON-B, stated that she completed the fall assessment upon being notified by the DON-T on 03/24/2026 after the surveyor entrance. Resident #1 fell on [DATE]. The nurse was expected to complete a series of assessments for injury, vitals, neurological status, supervision, monitoring, change in condition notification, and reporting of the resident's ongoing condition. She stated that when a resident has a head injury from fall, the nurse should notify the MD, RP, DON, and ADON immediately for further guidance and updates to ensure the resident was provided timely and immediate care. Residents are usually sent to the hospital for further assessments and acute procedures. The ADON stated it was her responsibility to ensure that assessments and notifications of incidents were conducted in a timely manner. She stated that the risk of not reporting an incident and changes could result in further injuries to the residents. During an attempted phone interview on 03/24/2026 at 6:45 PM with LVN-L resulted in the surveyor leaving a voice message with call back information and request to return. During an interview on 03/24/2026 at 6:56 PM with CNA-O, she stated that she worked from 2:00 PM to 10:00 PM on the memory unit. She was not assigned to Resident #1. She did not know who was assigned. She denied observing Resident #1's fall, yet she was notified by staff that the resident fell. She observed the resident during her shift wandering. She observed no changes in his abilities. She stated that resident falls should be reported immediately to the charge nurse to assess the resident for injuries and report to the MD, DON, and RP. She stated that failing to report an incident could place the resident at risk of increased pain and injuries that were not addressed immediately. During an interview on 03/24/26 at 7:30 PM with LVN I, she said she works from the 6:00 PM to 6:00 AM shift with Resident #1. LVN-I was notified by LVN L that Resident #1 had fallen, and the family transported him to the hospital's ER. The DON later notified her to send a medication list to RN-J. During an interview with LVN-L on 03/25/2026 at 8:03 AM, he stated that on 03/22/2026 at approximately 7:30 AM, Resident #1 was wandering in and out of another resident's room. LVN-L stated he escorted Resident #1 out of the room more than once, and the resident became angry and fell while attempting to hit him, by swinging hard. The nurse reported that the resident swung and tried to hit him, lost his balance, and fell and hit his head hard and torso (trunk of the body) on the rail in the hallway. He stated that after Resident #1's fall, he observed an (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	abrasion to the right side of his head by the temple and cheek area. He immediately helped the resident off the floor, cleaned the area, and bandaged. Then he completed vitals, skin assessment, fall assessment, and neuro assessments with regular observations. LVN-L stated the resident was not in pain, and he had not observed any changes in the resident's baseline. LVN-L reported that the skin assessment had not revealed any other injuries. LVN-L stated the family visited later at approximately 12:00 PM. He stated that at 5:21 PM, Resident #1's RP and Family Member A approached the nursing station, with Family Member S on the phone via 3-way calling. Family Member S was inquiring about injury and bloody bandage on Resident #1's head, and observations of increased confusion during their visit. LVN-L told the family that Resident #1 fell and hit his head on the rail in the hallway earlier this morning. Family Member S asked LVN-L why the family was not notified of the fall and injury. LVN-L told Family Member S that he was monitoring and assessing Resident #1 for changes. Family Member S reported concerns with Resident #1's changes in alertness and confusion. LVN-L apologized for not reporting the incident to the family, as he was not aware that he needed to notify the family. LVN-L ensured the family that Resident #1 was fine and had been assessed and was being monitored for changes. LVN-L said Family Member S asked if they could sign Resident #1 out and take him to the hospital for further evaluation. LVN-L told the family that they could sign the resident out on leave, because it would take over 2 hours if he contacted transportation to arrive and transport, and his assessment revealed no concerns with changes in condition, alertness, pain, nor alertness that would cause him to be sent out to the hospital via emergency transport. LVN-L signed Resident #1 out at 03/22/2026 to the family on leave. LVN-L told this surveyor that he was not aware that Resident #1 sustained injuries of right adrenal hematoma, a Grade 3 laceration of the liver through segments 5 and 6, and two rib fractures until he received a call from DON-T on 03/24/2026. LVN-L stated that he did not notify the MD, ADON, or DON, however he did notify the weekend supervisor (LVN-G). LVN-L could not recall what time, and stated that she came on the unit, but did not assess the resident. He said he could not recall her name. LVN-L stated with 60 residents on the unit and ongoing behaviors he was busy and failed to document the incident, assessments, call MD and RP. He did not call for assistance from other clinical staff. He stated that he failed to notify MD, DON-T, ADM, and RP, and document assessments after an incident and this placed the resident at risk of additional health complications and injuries. During a hospital visit with Resident #1 on 03/25/2026 at 9:55 AM, Resident #1 could not be interviewed as he was asleep. Resident #1 was observed lying on his back with his eyes closed asleep. Surveyor observed spirometer (a handheld device used to measure lung capacity and airflow speed.) on his bedside table, breakfast tray. A fall mat was located on the left side of the bed. The family was not at the hospital during the interview. The surveyor attempted to locate and interview the MD and assigned nurse, but neither were available. During an attempted interview on 03/25/2026 at 10:05 AM, the Hospital Social Worker revealed she could not provide any information due to confidentiality. During an interview on 03/25/2026 at 11:00 AM, Resident #1's Family Member S stated the resident had a fall on 03/22/2026, and he was observed by the RP and FM at 03/22/2026 at 5:00 PM with a bloody band aid on his cheek. FM stated that the RP nor family were notified that he fell on [DATE]. During a visit with Resident #1 the RP observed a bloody band-aid on his right cheek. She stated that Resident #1 could not provide the details due to his dementia. Family Member S and Family Member A contacted LVN-L on a conference call for further information and details. Family Member S inquired about the injury to Resident #1's face, and LVN-L stated that Resident #1 fell that morning, when asked to leave another resident's room. LVN-L told Family Member S that Resident #1 became angry, swung at the nurse, and fell hitting his face on the railing then falling to the floor. LVN-L stated to Family Member S that he was not aware of the need to report the incident to the family. Family Member S asked LVN-L if Resident #1 was monitored for neurological changes, because the RP reported that the resident was confused and different. LVN-L stated that the resident was fine. Family Member S asked LVN-L could Resident #1 go to the hospital. Family Member S said the nurse told her that the resident was fine, and there were no (continued on next page)

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Family Member S spoke with the DON, and she minimized the injuries reported by the hospital. Family Member S said she was disheartened when the facility failed to provide the immediate needed care to Resident #1 after a fall and not informing the family of the injury to his face. During an interview on 03/25/2026 at 12:33 PM, CNA-P stated she had worked at the facility for two years. She was not working on 03/22/2026. CNA-P was informed that Resident #1 was in the hospital after falling on Sunday. She attended training for dementia patients. The training conducted for the staff that worked directly with residents on the Memory care included how to de-escalate agitated residents, report incidents immediately to the nurse and Administrator. The nurse will assess the residents for injuries, confusion, vitals, and report to the MD and family. Resident altercations interventions included step between the residents, redirect, offer a snack as a diversion. If this does not work, she will notify the nurse supervisor. In the event there are multiple alterations and behaviors outburst, the unit supervisors will be called for assistance. She works with Resident #1, and he has not been aggressive. She stated that he responds to redirection by staff, diversion of television, group activity, or snacks. She said he does not fight the residents, only the staff. When the staff prevents him from entering a room, he will be aggressive. She has not received any reports of him hitting any other staff, During an interview with LVN B on 03/25/2026 at 12:36 PM she stated that she was working on 03/22/2026 with LVN-L. LVN-B said she did not observe the resident fall. She was notified by LVN-L during the shift that the resident fell and that the family was signing him out to be transported to the hospital for further evaluations. LVN-B stated that all nursing should assess the residents for injuries prior to moving the resident. If the resident can't move, then notify MD for further guidance and orders. She observed the resident wandering throughout the facility with no concerns prior to family arriving to visit. During an interview on 03/25/2026 at 12:59 PM, with Staff Development Nurse staff that conduct training and development. She has been working here for a year. She stated that a recent training was conducted by NP-O, for dementia. The training consisted of identifying the stages of dementia, behaviors, observations, and reporting of increased agitation, wandering, altercations, personal space, and other areas. She stated the training addressed activities, supervision, interventions, redirections, and other tools to use. She stated that all staff complete dementia training at the time of hiring. Staff Development Nurse was notified by DON on 03/24/2026 that Resident #1 fell and had an abrasion to his right cheek. The family transported him to the ER. Staff Development Nurse completed the skin assessment on 03/24/2026 once being notified by the DON that he was in the hospital. She stated that nursing and facility protocol requires the nurse to assess the resident after a fall for injuries, vitals, treatments, first aide, notify provider, responsible party, and if charge nurse notify ADON and DON. The provider and DON give the staff guidance. She said the risk to the residents for not reporting immediately, assessing changes could result in severe injuries. Staff Development Nurse was responsible for ensuring PRN staff receive updated training in person or online. During an interview on 03/25/2026 at 1:38 PM, LVN-G (Weekend Supervisor) stated that she was the supervisor on duty 03/22/2026. LVN-G conducted unit rounds every 2 hours. LVN-G said she was not notified by LVN-L during unit rounds nor received a call reporting that Resident #1 had fallen on 03/22/2026 at 7:00 AM. LVN-G said the nurses were expected to notify the weekend supervisor immediately to assist, oversee, and monitor the Assessments, resident changes, MD orders, and to maintain resident safety. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LVN-G said then the nurse notifies the MD for further guidance. Once the MD was notified of the incident, the DON and RP were notified. She stated that failing to report the incident places the residents at risk for serious illnesses and injuries.During an attempted phone interview on 03/25/2026 at 2:30 PM, neither MD-B and NP-W were available at the time. The surveyor left a message with the receptionist to have them call me regarding Resident #1. During an interview on 03/31/2026 at 8:49 AM, NP-A stated that the facility staff did not provide notification of Resident #1's fall details, until 03/24/2026. He stated on 03/24/2026 a facility nurse (could not recall name or position) notified him that the resident was transported to the hospital by the family. NP-A stated that he had no contact with the family or hospital following Resident #1's admission. NP-A stated that he expects immediate notification when a resident falls with head injury to send out to ER for further evaluation. The risk to the patient when MD's not notified could result in serious internal injuries. Review of the facility's policy titled Change in a Resident's Condition or Status, revised 02/13/2023, reflected in part the following: The primary goal of identifying Acute Changes of Condition (ACOCs) is to enable staff to evaluate and manage a patient at the community and avoid transfer to a hospital or emergency room (ER). To achieve this goal, the community's staff and practitioners must recognize an ACOC (is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains. (and identify its nature, severity, and cause(s). The practitioner needs a detailed description of the patient's condition to determine whether a Symptom is problematic or simply a normal or expected variant. Care-giving staff should describe and document the nature, extent, and severity of symptoms, abnormalities, and condition changes clearly and in sufficient detail to help Practitioners distinguish their potential causes and consequences .A brief review of the patient's known medical history (e.g., synopsis of a recent hospital course) is vital. This was determined to be an IJ on 03/25/2026 at 5:10 PM. The Administrator and DON were notified. The Administrator was provided the IJ Template on 03/25/2026 at 5:19 PM. The following Plan of Removal submitted by the facility was accepted on 03/26/2026 at 6:19 PM:Plan of removal for IJ-F580-State alleges facility failed to ensure physician was notified of injury post fall on one resident.IJ called at 5:10PM facility for F580.Medical Director Notified at 5:20PM.Ad hoc [created for a particular purpose] QA completed to address notification protocols of family and physician for incident/accidents and change of condition.[Resident #1] is currently out of facility.Immediate Correction/Client protectionDON/designee to educate licensed nurses on proper notification of physician and family for incident/accidents to include any resident change of condition. Completion date 03/25/2026DON/designee to educate licensed nurses to notify DON and administrator of all incident/accidents and change of condition that require hospital transfer. Completion date 03/25/2026.DON/designee performed assessments on all residents with falls in the past 30 days to ensure proper notifications and assessments in place. Completion date: 03/25/2026MDS/designee updated care plans for all residents with falls in the last 30 days. Completion date 03/25/2026All licensed nurses will be educated on incident/accident protocols, to include notification of DON, Administrator, physician and family and resident assessment prior to working their next assigned shift. DON/designee will complete this. Completion date: 03/25/2026MonitoringDON and/or designee will monitor residents with falls daily to ensure notifications were appropriately made to physician and family.Administrator to review with the DON weekly to ensure continued compliance.Results of all audits will be brought to the QAPI committee by DON to review for continued recommendations and compliance.This protocol will be covered on new-hire orientation by DON/designee. Record review of in-service training dated 02/19/2026 and 02/23/2026 titled Navigating Cognitive Changes: Dementia, Delirium, and AMS for clinical staff reflected in part: identifying changes in conduction, comprehending the stages of Dementia, understanding Delirium, and AMS (a change in mental function. It stems from certain illnesses, disorders and injuries affecting your brain.) Detecting change in SMI Patients.developing and implementing resident intervention protocols, assessing, reporting, documenting, and notifying providers. Record review of CNA-O's personnel file reflected CNA O's date of hire was 0

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	675756	A. Building B. Wing	03/26/2026

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 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 observations, interviews, and record reviews, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but 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 not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures, for 1 of 1 resident (Resident #1) reviewed for reportable incidents of abuse and neglect.LVN-L failed to report an allegation of abuse and neglect immediately to the Administrator, physician, and family for further actions and guidance after Resident #1 fell on [DATE] sustaining an abrasion to his head, and progressive changes in health that resulted in hospitalization and diagnosis as followed: A right adrenal hematoma, a Grade 3 laceration of the liver through segments 5 and 6, and two fractured ribs. This facility failure could place residents at risk for abuse and neglect. Findings included:Record review of Resident #1's admissions MDS assessment, dated 01/07/2026, revealed he was an [AGE] year-old male, was admitted on [DATE]. He had a BIMS score of 00, indicating the resident was unable to complete the interview (severely impaired cognition). Resident #1 had no behavior or moods at the time of admission. The MDS Assessment, under Section GG-Functional Abilities, reflected Resident #1 required supervision and touching for toileting hygiene, transfers, mobility, and ambulating. He required partial assistance with eating and ADL's Further review of this document, under Section H-Bladder and Bowel, reflected Resident #1 had occasional urinary incontinence urine, and always continent for bowel. Section I-Active Diagnoses, Anemia (iron deficiency), Hypertension (high blood pressure), diabetes Mellitus (changes in blood sugar levels), Alzheimer's Dementia (brain disorder with symptoms often involving severe behavioral changes, movement disorders, or language dysfunction rather than just memory loss, and Non-Alzheimer's Dementia (brain disease causing cognitive decline not related to Alzheimer's.) Section N Medications indicated residents received high risk medications anti-psychotic and antidepression.Record review of Resident #1's baseline care plan dated 01/01/2026 reflected: He was severely impaired cognitively, with goals to improve. Resident #1 was Spanish speaking only and able to communicate his needs. Resident had impaired functional abilities related to impaired cognition and requires some assistance from staff. Improve mobility, evaluate for speech and physical therapy.Record review of Resident #1's care plan dated 01/07/2026 reflected: Communication.Resident will communicate basic needs to staff daily Spanish speaking only.Resident will demonstrate improved ability to understand speech. as needed Speak in a way that minimizes inability to understand. Anticipate needs. Fall/wandering, last updated on 03/24/2026. Resident at Risk for Falls resident safety will be maintained.Assess contributing factors related to fall history, Resident at risk of falls while wandering in and out of other residents' rooms. Assistance with standing and moving from one place to the next as needed. 03/02/2026. Wandering, 01/08/2026. Identify pattern of wandering: Is wandering purposeful, aimless, or escapist, is the resident looking for something, does it indicate the need for more exercise. redirect; Frequent visual checks.mental health diagnosis.Record review of Resident #1's progress note by LVN-I, dated 03/22/2026 at 11:38 PM, reflected: Resident was sent to the hospital on day shift for change of condition of N/V per family request. DON-T communicated with this nurse [LVN-I] instructed that his face sheet and medication lists should be faxed to RN-J (phone number provided). Transmittal confirmation was received ok. Resident is placed on [leave of absence] and all medications on hold.Record review of Resident #1's hospital records reflected he was admitted to the hospital on [DATE] with the chief complaint by the (continued on next page)

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	675756	A. Building B. Wing	03/26/2026

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RP that he fell (initial encounter), and fall initial encounter was not resolved. Resident #1 sustained injuries to the right 6th and 7th lateral rib fractures (Right 6th and 7th lateral rib fractures are common chest wall injuries, usually caused by blunt trauma. And sharp pain.), right adrenal hematoma (Adrenal hematoma is a collection of blood within the adrenal gland, often resulting from trauma, severe infection, or anticoagulant use.), and grade 3 Liver laceration involving segments 5 and 8 (These are shallower tears, often less than 3 cm (metric unit used to measure dimensions and size.) deep, or smaller blood clots. A comprehensive trauma evaluation identified the injuries above, and the [Resident #1] was admitted to the PCU for pulmonary monitoring, serial hemoglobin monitoring, and pain control measures.Record review of Resident #1's progress note dated 03/24/2026 at 11:05 AM by DON-T titled nursing incident -Late entry for 03/22/2026 at 07:30 AM reflected per report from primary nurse, resident was roaming in and out of rooms this morning requiring frequent redirection. During such time resident was redirected from room at approximately 7:00 AM and became aggressive, he attempted to swing and hit the nurse causing him to lose his balance and fall against the handrail on his left side. Per report he sustained a small abrasion to left temple area, no other injuries noted by primary nurse. Resident was ambulatory after fall and functioning at baseline. Nurse will provide frequent monitoring s/p fall. Completed 03/24/2026 11:24 AM.During an interview on 03/24/2026 at 9:45 AM with the Administrator, he reported receiving a call from hospital RN-J on 03/22/2026 at 7:04 PM. He then forwarded RN-J's phone number to DON-T to follow up with the hospital nurse for information. During an interview with the DON-T on 03/24/2026 at 9:50 AM she stated that once she was notified of the fall by RN-J she did not submit a report to HHSC. DON-T said that she contacted RN-J on 03/22/2026 (time unknown). At the time of the call, RN-J informed her that Resident #1 fell at the facility earlier that day and was transported by the family for further evaluation. DON-T stated that the hospital nurse reported that Resident #1 had fallen at the facility and sustained an abrasion to the right side of cheek, a bruised liver, and rib fractures. This report caused no concerns of abuse and neglect. During a hospital visit with Resident #1 on 03/25/2026 at 9:55 AM, Resident #1 could not be interviewed as he was asleep. Resident #1 was observed lying on his back with his eyes closed asleep. The surveyor attempted to locate and interview the MD and assigned nurse, but neither were available to provide medical updates.During a second interview on 03/24/2026 at 9:45 AM with the Administrator, he said he was later informed by DON-T that Resident #1 sustained injuries to the liver and fractures to his ribs. The Administrator stated that he had not reported the incident to HHSC, because the fall was witnessed, and the family transported the resident to the hospital at their discretion. During a second interview with DON-T on 03/26/2026 at 3:50 PM, DON-T said she contacted LVN-L the assigned LVN on 03/24/2026 at 11:24 AM revealing that Resident #1 fell on [DATE] at the facility, sustaining an abrasion to his cheek. The family was concerned and wanted the resident evaluated at the hospital and signed the resident out. DON-T stated that residents are at risk of continued abuse and neglect when allegations are not reported and investigated to confirm the findings. DON-T stated that she did not report the incident to HHSC once she completed further assessments and interviews, abuse and neglect was ruled out. Record review of the facility's Duty to Report Violations Internally and to Applicable Agencies policy, dated October 2022, reflected the following: All residents, family members, visitors, and others are encouraged to report actual or suspected incidents of resident abuse, neglect, exploitation, and/or misappropriation of resident property without fear of retaliation. 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 or the DON of the incident. The person receiving the report or designee must (continued on next page)

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	675756	A. Building B. Wing	03/26/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document all incidents of alleged abuse/neglect on incident reports, which are to forwarded directly to the Abuse Coordinator.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.Record review of the facility's Fall Management policy, dated 01/12/2022, reflected the following: Purpose: 1. The community will identify each resident who is at risk for falls and will plan care and implement interventions to manage falls. The community will manage falls by providing an environment that is free from potential hazards.2.The qualified staff will complete the Fall Risk Data Collection upon admission and quarterly with fall or change of condition.3.A resident fall management program will be implemented that educates staff in creative, functional strategies while recognizing resident's rights and their need to maintain the highest practical level of function.Definitions:A fall can be defined as when a resident is found on the floor, a resident slides to the floor unassisted, a resident rolls off the bed or chair onto the floor, a resident falls off or out of equipment/apparatus used for therapy or a transfer. A fall also includes when a resident trips or slips and complains of or sustains bodily injury or an episode where a resident lost his or her balance and would have fallen, were it not for staff intervention (intercepted fall). A fall may also be reported by a resident, visitor, or family member.Procedures:1.The qualified staff assesses all residents for fall risk through the admission Nursing Assessment form upon admission, quarterly, and with a significant change.2.Upon determination that the resident is at risk, the qualified staff creates an individualized plan of care that includes the appropriate preventative interventions to reduce potential for fall.3.Part of the management program is the implementation of visual identifiers for those residents at risk.4.If a fall occurs, the qualified staff assesses for injury from the fall, immediately investigates the reason and determines the intervention to prevent future falls - complete the Incident/Accident Report in the EHR.5.The physician and family are notified.6.All reports of resident falls within the community are monitored through the QAPI process within the community at the Standards of Care Meeting.7.Data is also reported in the community's monthly QAPI Meeting.

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	675756	A. Building B. Wing	03/26/2026

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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 interview and record review, the facility failed to have evidence allegations of neglect were thoroughly investigated and documented for 1 of 1 resident (Resident #1) reviewed for neglect. The Administrator failed to conduct a thorough investigation after being notified by the hospital on [DATE] that Resident #1 had sustained serious bodily injury after a fall on 03/22/2026 at the facility which LVN L had failed to report to the Administrator and had failed to notify the physician and the resident's family member. These failures could place residents as risk for abuse and neglect by not investigating allegations of abuse, neglect, exploitation, or mistreatment. Findings included: Record review of Resident #1's admissions MDS assessment, dated 01/07/2026, revealed he was an [AGE] year-old male, was admitted on [DATE]. He had a BIMS score of 00, indicating the resident was unable to complete the interview (severely impaired cognition). Section GG-Functional Abilities, reflected Resident #1 required supervision and touching for toileting hygiene, transfers, mobility, and ambulating. He required partial assistance with eating and ADL's Further review of this document, under Section I-Active Diagnoses, Anemia (iron deficiency), Hypertension (high blood pressure), diabetes Mellitus (changes in blood sugar levels), Alzheimer's Dementia (brain disorder with symptoms often involving severe behavioral changes, movement disorders, or language dysfunction rather than just memory loss, and Non-Alzheimer's Dementia (brain disease causing cognitive decline not related to Alzheimer's.)Record review of Resident #1's baseline care plan dated 01/01/2026 reflected: He was severely impaired cognitively. Spanish speaking only and able to communicate his needs. Resident had impaired functional abilities related to impaired cognition and requires some assistance from staff. Improve mobility, evaluate for speech and physical therapy.Record review of Resident #1's care plan dated 01/07/2026 reflected: Communication.Resident will communicate basic needs to staff daily Spanish speaking only.Resident will demonstrate improved ability to understand speech. as needed Speak in a way that minimizes inability to understand. Anticipate needs. Fall/wandering, last updated on 03/24/2026. Resident at Risk for Falls resident safety will be maintained.Assess contributing factors related to fall history, Resident at risk of falls while wandering in and out of other residents' rooms. Assistance with standing and moving from one place to the next as needed. 03/02/2026. Wandering, 01/08/2026. Identify pattern of wandering: Is wandering purposeful, aimless, or escapist, is the resident looking for something, does it indicate the need for more exercise. redirect; Frequent visual checks.mental health diagnosis.Record review of Resident #1's progress note by LVN-I, dated 3/22/2026 at 11:38 PM, reflected: Resident was sent to the hospital on day shift for change of condition of N/V per family request. DON-T communicated with this nurse [LVN-I] instructed that his face sheet and medication lists should be faxed to RN-J (phone number provided). Transmittal confirmation was received ok. Resident is placed on LOA and all medications on hold. Record review of Resident #1's hospital records reflected he was admitted to the hospital on [DATE] with the chief complaint by the RP that he fell (initial encounter), and fall initial encounter was not resolved. Resident #1 sustained injuries to the right 6th and 7th lateral rib fractures (Right 6th and 7th lateral rib fractures are common chest wall injuries, usually caused by blunt trauma. And sharp pain.), right adrenal hematoma (Adrenal hematoma is a collection of blood within the adrenal gland, often resulting from trauma, severe infection, or anticoagulant use.), and grade 3 Liver laceration involving segments 5 and 8 (These are shallower tears, often less than 3 cm (metric unit used to measure dimensions and size.) deep, or smaller blood clots. A comprehensive trauma evaluation identified the injuries above, and the [Resident #1] was admitted to the PCU for pulmonary monitoring, serial hemoglobin monitoring, and pain control measures.Record review of Resident #1's progress note dated 03/24/2026 at 11:05 AM by DON-T titled nursing incident -Late entry for 03/22/2026 at 07:30 AM reflected per report from primary nurse, resident was roaming in and out of rooms this morning requiring frequent redirection. During such time resident was redirected (continued on next page)

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	675756	A. Building B. Wing	03/26/2026

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	from room at approximately 7:00 AM and became aggressive, he attempted to swing and hit the nurse causing him to lose his balance and fall against the handrail on his left side. Per report he sustained a small abrasion to left temple area, no other injuries noted by primary nurse. Resident was ambulatory after fall and functioning at baseline. Nurse will provide frequent monitoring s/p fall. Completed 03/24/2026 11:24 AM.Record review of facility all staff in-service dated 03/25/2026, completed by DLVN, the staff development coordinator titled Incidents and Accidents: Reporting, allegations of abuse to the Administrator immediately for investigating and reporting. The staff were tested on their knowledge. During a second interview on 03/24/2026 at 9:45 AM with the Administrator, he reported that after being notified that Resident #1 was hospitalized for a witnessed on 03/22/2026. Administrator stated he was later informed that Resident #1 sustained injuries to the liver and fractures to his ribs. The Administrator stated that he had not investigated the incident. However, he said further follow-up that included staff interviews of Resident #1's fall on 03/24/2026 ruled out abuse. During an interview with the DON-T on 03/24/2026 at 9:55 AM she stated that once she was notified that Resident #1 was in the hospital for a fall RN-J she did not investigate the incident, due to the hospital report that the resident was not experiencing any changes other than the bruised liver and fractured ribs. During a second interview with DON-T on 03/26/2026 at 3:50 PM, she stated that after further follow up and interviews she was provided more information about the incident by the assigned nurse, LVN-L on 03/24/2026 and 3/25/2026 and hospital records that Resident #1 had sustained internal injuries of adrenal hematoma, fractures of the right 6th and 7th lateral ribs (Right 6th and 7th lateral rib fractures are common chest wall injuries, usually caused by blunt trauma. and sharp pain.), right adrenal hematoma (Adrenal hematoma is a collection of blood within the adrenal gland, often resulting from trauma, severe infection, or anticoagulant use.), and grade 3 Liver laceration involving segments 5 and 8 (These are shallower tears, often less than 3 cm). DON-T said she proceeded to follow up with the staff that was on duty 03/22/2026, RN-J on 03/22/2026, FM-S and FM-A on 03/24/2026, contact with the MD, LVN-L, and other staff, ruled out abuse or neglect. DON-T stated that failing to investigate allegations of abuse, neglect, resident rights, and exploitation could result in further injuries and abuse to the resident.During a second interview with the Administrator on 03/26/2026 at 3:59 PM, he stated that once DON-T was notified that Resident #1 had fallen, she proceeded to review EHR records, contacting LVN-L, and interview LVN-B, CNA-O, LVN-G, RP, FM-S. and RN-J for more information, and the incident findings ruled out abuse and neglect of Resident #1.Record review of the facility's Abuse, Neglect and Exploitation and Misappropriation of Resident Property Internal Investigation Guidelines Event and Concern Form, policy dated 06/23/2017, 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.

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	675756	A. Building B. Wing	03/26/2026

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Williamsburg Village Healthcare Campus	941 Scotland Dr Desoto, TX 75115

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 of 8 residents (Resident #1) reviewed for quality of care. LVN L failed to complete an immediate, comprehensive post-fall assessment to include neurological checks after Resident #1 had a fall when the resident swung hard towards LVN L in an attempt to hit him on 03/22/2026 at 7:30 AM, which resulted in the resident losing his balance and hitting his face/head and torso against a rail in the hallway. The resident had bleeding on his cheek which LVN L put a bandage on; however, LVN L did not notify the physician of the fall nor did he notify the resident's family. The family noticed a change in the resident's mental status on 03/22/2026 and saw the bloody bandage on the resident's cheek. The family had the resident transported to the hospital where he was found to have sustained a right adrenal hematoma, a Grade 3 laceration of the liver through segments 5 and 6, and two rib fractures. LVN L's failure to provide treatment and care in accordance with professional standards of practice resulted in Resident #1 not receiving appropriate treatment and care for approximately 10 hours.On 03/25/2026 at 5:10 PM an IJ was identified. While the IJ was removed on 03/26/2026 at 4:21 PM, the facility remained out of compliance at a severity level of no actual harm with a potential for more than minimal harm, that was not immediate jeopardy at a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. The failure could affect residents currently residing in the facility, resulting in them not receiving the necessary care needed to maintain optimal health and placing them at risk for injury or deterioration in their condition. Findings included:Record review of Resident #1's admissions MDS assessment, dated 01/07/2026, revealed he was an [AGE] year-old male, was admitted on [DATE]. He had a BIMS score of 00, indicating the resident was unable to complete the interview (severely impaired cognition). Resident #1 had no behavior or moods at the time of admission. The MDS Assessment, under Section GG-Functional Abilities, reflected Resident #1 required supervision and touching for toileting hygiene, transfers, mobility, and ambulating. He required partial assistance with eating and ADL's Further review of this document, under Section H-Bladder and Bowel, reflected Resident #1 had occasional urinary incontinence urine, and always continent for bowel. Section I-Active Diagnoses, Anemia (iron deficiency), Hypertension (high blood pressure), diabetes Mellitus (changes in blood sugar levels), Alzheimer's Dementia (brain disorder with symptoms often involving severe behavioral changes, movement disorders, or language dysfunction rather than just memory loss, and Non-Alzheimer's Dementia (brain disease causing cognitive decline not related to Alzheimer's.) Section N Medications indicated residents received high risk medications anti-psychotic and antidepression. Record review of Resident #1's baseline care plan dated 01/01/2026 reflected: he was severely impaired cognitively, with goals to improve. Resident #1 was Spanish speaking only and able to communicate his needs. Resident #1 had impaired functional abilities related to impaired cognition and requires some assistance from staff. Improve mobility, evaluate for speech and physical therapy.Record review of Resident #1's care plan dated 01/07/2026 reflected: Fall/wandering, last updated on 03/24/2026. Resident at Risk for Falls resident safety will be maintained.Assess contributing factors related to fall history, Resident at risk of falls while wandering in and out of other residents' rooms. Assistance with standing and moving from one place to the next as needed. 03/02/2026. Wandering, 01/08/2026.Resident safety will be maintained.Orient to surroundings; Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book.; Identify pattern of wandering: Is wandering purposeful, aimless, or escapist, is the resident looking for something, Does it indicate the need for more exercise.redirect; Frequent visual checks.mental health diagnosis. Record review of Resident #1's MD order dated 01/01/2026 by NP-A reflected an order for (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Haloperidol 1 mg tablet for anxiety.1 tab by mouth at bedtime, admit to long term care, vitals, and weekly weights on day shift. Record review of Resident #1's MD order dated 01/01/2026 by NP-A for Trazadone Hydrochloride 100 mg. for insomnia.1 table by mouth at bedtime 9:00 PM. This order was discontinued on 03/03/2026.Record review of Resident #1's sign out sheet reflected he was out with family, 03/22/2026, at 5:45 PM.Record review of Resident #1's progress note by LVN-I, dated 3/22/2026 at 11:38 PM, reflected: Resident was sent to the hospital on day shift for change of condition of N/V per family request. DON-T communicated with this nurse [LVN-I] instructed that his face sheet and medication lists should be faxed to RN-J (phone number provided). Transmittal confirmation was received ok. Resident is placed on LOA and all medications on hold. Record review of Resident #1's skin assessment dated [DATE] at 11:00 AM conducted by Staff Development Nurse. The peri wound was normal. MD notified. Additional notes: Per nurse on duty resident ambulatory, attempted to swing at nurse, lost his balance, and fell hitting side rail. causing abrasion to right temple, first aid provided. The assessment skin evaluations, wound identification, and summary of each section was initiated at 10:54 AM and concluded at 03/24/2026 at 11:00 AM. This assessment was completed after the resident was hospitalized . Record review of Resident #1's progress note dated 03/24/2026 at 11:05 AM by DON-T titled nursing incident -Late entry for 03/22/2026 at 07:30 AM reflected per report from primary nurse, resident was roaming in and out of rooms this morning requiring frequent redirection. During such time resident was redirected from room at approximately 7:00 AM and became aggressive, he attempted to swing and hit the nurse causing him to lose his balance and fall against the handrail on his left side. Per report he sustained a small abrasion to left temple area, no other injuries noted by primary nurse. Resident was ambulatory after fall and functioning at baseline. Nurse will provide frequent monitoring s/p fall. Completed 03/24/2026 11:24 AM.Record review of Resident #1's fall risk assessment dated [DATE] at 11:41 AM by ADON-B for Resident #1's fall on 03/22/2026 at 7:00 AM reflected LVN-L had not completed the required, immediate, comprehensive post-fall assessment (head-to-toe assessment, neurological checks, and vital signs), resulting in ADON-B completing once the resident was taken to the hospital 2 days later. LVN-L failed to document any resident assessments or care notes in the file of Resident #1 on 03/22/2026, reflected Resident #1 was a fall risk with his last fall being 03/22/2026. Resident #1 had a total of 1 to 2 falls since being admitted . ADON-B wrote that Resident #1 had no changes in cognitive status in the last 90 days. Cognition: displays altered perception, Resident #1 ambulates without a problem and without devices. Disorganized speech, restlessness, varying mental function, wanders, abusive and resistance to care. Resident #1's incontinent status reflected that he was independent and incontinent. Resident #1 pressure was not assessed due to him being at the hospital at the time of this assessment.Record review of Resident #1's incident report dated 03/24/2026 at 12:15 PM was completed by Staff Development Nurse for an incident that occurred on 03/22/2026 at 7:00 AM. The assessment reflected that Resident #1 had a fall in the hallway of the memory unit. LVN-L was present and reported to DON-T on 03/24/2026. Observations reflected Resident #1 was moderately impaired, and independently ambulatory. A neurological assessment was completed, and facility findings indicated origin was established and the injury was not preventable. Facility comments, Resident roaming in and out of rooms, during redirection from [room] resident became aggressive and attempted to swing and hit nurse [LVN-L] causing him to lose his balance and fall against side rail, hitting his left side, sustaining abrasion to left temple area it is important to note that Staff Development Nurse electronically signed the report that she conducted the observations, actions, findings, case report, and reporting, and that the MD, DON-T, and RP were notified on 03/22/2026 at 7:30 AM and DON-T by LVN-L. The resident was at the hospital at the time of this report. Record review of Resident #1's EHR dated 03/22/2026, revealed missing clinical assessments consistent with the falls: Vital signs, fall assessment, post fall monitoring, neurological assessment (alert and function) and post neurological, pain assessments, and functioning and supervision after the fall as well as any changes to his condition. Record review of Resident #1's hospital records (continued on next page)

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	675756	A. Building B. Wing	03/26/2026

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	reflected he was admitted on [DATE] with family with complaints that he fell (at the nursing facility initial encounter). Resident #1's condition was fair and stable. Resident #1 sustained injuries to the right 6th and 7th lateral rib fractures (Right 6th and 7th lateral rib fractures are common chest wall injuries, usually caused by blunt trauma. And sharp pain.), right adrenal hematoma (Adrenal hematoma is a collection of blood within the adrenal gland, often resulting from trauma, severe infection, or anticoagulant use.), and grade 3 Liver laceration involving segments 5 and 8 (These are shallower tears, often less than 3 cm (metric unit used to measure dimensions and size.) deep, or smaller blood clots. Admissions indicators reflected [Resident #1's] past medical history of HTN (High blood pressure), DM (disorder of high blood sugar), CKD (slow progressing conditions of kidney failure.) stage 2, and Alzheimer's dementia who presented s/p reported fall at his nursing home residence. A comprehensive trauma evaluation identified the injuries above, and the [Resident #1] was admitted to the PCU for pulmonary monitoring, serial hemoglobin monitoring, and pain control measures.Record review of CNA-O one on one training dated 03/25/2026 reflected Acknowledgment of abuse and reporting requirements, incident of abuse, and neglect, as well as reporting any such incidents to the abuse prevention coordinator, community administrator, and DON. CNA-O signed receipt of the training on reportable to the State by facilities.Review of Facility policy titled Fall Management reviewed on 10/16/2025 reflected in part the following: Purpose: The community will identify each resident who is at risk for falls and will plan care and implement interventions to manage falls. The community will manage falls by providing an environment that is free from potential hazards. Procedures: If a fall occurs, the qualified staff assesses for injury from the fall, immediately investigates the reason, and determines the intervention to prevent future falls - complete the incident/accident report in the EHR. The physician and family are notified.During an interview on 03/24/2026 at 9:45 AM with the Administrator, he reported receiving a call from RN-J on 03/22/2026 at 7:04 PM. He then forwarded RN-J's phone number to DON-T to follow up with the hospital nurse for information. He was not aware of the fall or that the RP transported the resident to the hospital. The Administrator reported that nurses are expected to assess the residents after a fall and notify the MD to ensure the proper nursing protocols for falls were followed. During an interview with the DON-T on 03/24/2026 at 9:50 AM she stated that LVN- L did not report that Resident #1 fell, sustained an injury to his cheek. DON-T said the Resident was signed out by the family and transported to the hospital. DON-T stated LVN-L reported following fall protocols on 03/22/2026 during a phone interview 03/24/2026. LVN-L reported assessing Resident #1 before moving him off the floor. DON-T stated LVN-L did not report that he had not documented the assessments in the EHR. DON-T stated that LVN-L will receive one on one training for reporting, and corrective action would be taken. The DON-T stated the protocol for a witnessed fall with an injury to the head includes assessing the resident head-to-toe before moving him/her, check for obvious injuries, complete neurological checks including assessing eyes for alertness and focus. DON-T stated the risk of not completing an assessment before moving a resident after an unwitnessed fall or a fall with an injury could cause further harm to the residents. During a phone interview on 03/24/2026 at 10:52 AM with HSW, revealed Resident #1 was brought to the hospital by the family and admitted after a reported fall on 03/22/2026. HSW stated that Resident #1 sustained injuries of a grade 3 liver laceration and right sided rib fractures. HSW stated Resident #1 was currently receiving treatment for injuries in PCU (progressive care unit). HSW reported that Resident #1 did not have an anticipated date of discharge. HSW stated she would have the assigned NP to contact the surveyor. During an interview on 03/24/26 at RN-M at 1:31 PM, stated she worked at the facility as a PRN staff until recently being hired full time. RN-M was not working on 03/22/2026. She observed a note in Resident #1's EHR that he was transported to the hospital by his family. RN-M stated that when a resident falls, the nurse should assess the resident for injuries, notify the MD for additional guidance and orders. Notify the Family, Admin, and DON. She stated that failing to assess, document, and notify the MD, RP, and DON could result in residents not receiving treatment and additional injuries.During an interview on 03/24/2026 at 1:35 PM with CNA-J stated (continued on next page)

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	675756	A. Building B. Wing	03/26/2026

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the hallway earlier this morning. Family Member S asked LVN-L why the family was not notified of the fall and injury. LVN-L told Family Member S that he was monitoring and assessing Resident #1 for changes. Family Member S reported concerns with Resident #1's changes in alertness and confusion. LVN-L apologized for not reporting the incident to the family, as he was not aware that he needed to notify the family. LVN-L ensured the family that Resident #1 was fine and had been assessed and was being monitored for changes. LVN-L said Family Member S asked if they could sign Resident #1 out and take him to the hospital for further evaluation. LVN-L told the family that they could sign the resident out on leave, because it would take over 2 hours if he contacted transportation to arrive and transport, and his assessment yielded no concerns regarding hospital resident's alertness LVN-L signed out at 03/22/2026 to the family on leave. LVN-L told this surveyor that he was not aware that Resident #1 sustained injuries of right adrenal hematoma, a Grade 3 laceration of the liver through segments 5 and 6, and two rib fractures until he received a call from DON-T on 03/24/2026. LVN-L stated that he did not notify the MD, ADON, or DON, however he did notify the weekend supervisor. LVN-L could not recall what time, and stated that she came on the unit, but did not assess the resident. He said he could not recall her name. LVN-L stated with 60 residents on the unit and ongoing behaviors he was busy and failed to document the incident, assessments, call MD and RP. He did not call for assistance from other clinical staff. He stated that failing to notify MD, DON-T, Administrator, and RP, and document assessments after an incident placed the resident at risk of additional health complications and injuries. During a hospital visit with Resident #1 on 03/25/2026 at 9:55 AM, Resident #1 could not be interviewed as he was asleep. Resident #1 was observed lying on his back with his eyes closed asleep. Surveyor observed spirometer (a handheld device used to measure lung capacity and airflow speed.) on his bedside table, breakfast tray. A fall mat was located on the left side of the bed. The family was not at the hospital during the interview. The surveyor attempted to locate and interview the MD and assigned nurse, but neither were available. During an attempted interview on 03/25/2026 at 10:05 AM, the hospital SW revealed she could not provide any information due to confidentiality. On 03/25/2026 at 10:15 AM, while visiting the hospital, the surveyor requested Resident #1's physical records onsite to determine the resident's current medical condition: Right 6th and 7th lateral rib fractures (usually caused by blunt trauma. And sharp pain.), right adrenal hematoma (is a collection of blood within the adrenal gland, often resulting from trauma, severe infection, or anticoagulant use.), and grade 3 Liver laceration involving segments 5 and 8 (These are shallower tears, often less than 3 cm (metric unit used to measure dimensions and size.) deep, or smaller blood clots. During an interview on 03/25/2026 at 11: 00 AM, Resident #1's Family Member S stated the resident had a fall on 03/22/2026, and he was observed by the RP and FM at 03/22/2026 at 5:00 PM with a bloody band aid on his cheek. FM stated that the RP nor family were notified that he fell on [DATE]. During a visit with Resident #1 the RP observed a bloody band-aid on his right cheek. She stated that Resident #1 could not provide the details due to his dementia. Family Member S and Family Member A contacted LVN-L via conference-3-ways call for further information and details. Family Member S inquired about the injury to her Resident #1's face, and LVN-L stated that Resident #1 fell this morning, when asked to leave a resident room. LVN-L told Family Member S that Resident #1 became angry, swung at the nurse, and fell hitting his face on the railing then falling to the floor. LVN-L stated to Family Member S that he was not aware of the need to report the incident to the family. Family Member S asked LVN-L if Resident #1 was monitored for neurological changes, because the RP reported that the resident was confused and different. LVN-L stated that the resident was fine. Family Member S asked LVN-L could Resident #1 went to the hospital. Family Member S said the nurse told her that the resident was fine, and there were no changes. Family Member S asked if the family could sign Resident #1 out on leave and transport him to the hospital for an evaluation. LVN-L told Family Member S that the family could transport the resident to hospital, because if he called non-emergency transportation to transfer the residents to the hospital, it would take 2 or more hours before they arrived. The RP and Family Member A signed Resident #1 out for leave and (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	transported to the ER. Family Member S stated that Resident #1 sustained injuries of abrasion to right cheek, bruised liver, and fractures of the rib. She stated that the facility staff had not followed up with the family about the hospitalization or to address the incident. Family Member S stated that she went to the facility to pick up Resident #1's personal items and told them he would be discharged home with family from the hospital. Family Member S spoke with the DON, and she minimized the injuries reported by the hospital. Family Member S said she was disheartened when the facility failed to provide the immediate needed care to Resident #1 after a fall and informing the family of the injury to his face. During an interview on 03/25/2026 at 12:33 PM with CNA-P she has worked at the facility for 2 years. She was not working on 03/22/2026. CNA-P was informed that Resident #1 was in the hospital after falling on Sunday. She attended training for dementia patients. The training for memory included [NAME] to de-escalate agitated residents, report incidents immediately to the nurse and administrator. The nurse will assess the residents for injuries, confusion, vitals, and report to the MD and family. altercation, step in, redirect, offer a snack. If this does not work, she will notify the nurse supervisor. In the event there are multiple alterations and behaviors outburst, the unit supervisors will be called for assistance. She works with Resident #1, and he has not been aggressive. She stated that he responds to redirection by staff, diversion of television, group activity, or snacks. She said he does not fight the residents, only the staff. When the staff prevents him from entering a room, he will be aggressive. She has not received any reports of him hitting any other staff, During an interview on 03/25/2026 at 12:59 PM, with Staff Development Nurse staff that conduct training and development. She has been working here for a year. She stated that a recent training was conducted by NP-O, for dementia. The training consists of identifying the stages of dementia, behaviors, observations, and reporting of increased agitation, wandering, altercations, personal space, and other areas. She stated the training addresses activities, supervision, interventions, redirections, and other tools to use. She stated that all staff complete dementia training at the time of hiring. LNV-D was notified by DON on 03/24/2026 that Resident #1 fell and had an abrasion to his right cheek. The family transported him to the ER. She completed the skin assessment. She stated that nursing and facility protocol requires the nurse to assess the resident after a fall for injuries, vitals, treatments, first aide, notify provider, responsible party, and if charge nurse notify ADON and DON. The provider and nurse DON's give the staff guidance. She said the risk to the residents for not reporting immediately, assessing changes could result in severe injuries. Staff Development Nurse was responsible for ensuring PRN staff receive updated training in person or online. During an interview on 03/25/2026 at 1:38 PM, with LVN-G weekend supervisor, stated that she was the supervisor on duty 03/22/2026. LVN-G conducted unit rounds every 2 hours. LVN-G said she was not notified by LVN-L during unit rounds nor received a call reporting that Resident #1 had fallen on 03/22/2026 at 7;00 AM. LVN-G said the nurses were expected to notify the weekend supervisor immediately to assist oversee and monitor the Assessments, resident changes, MD orders, to maintain resident safety. LVN-G said then the nurse notifies the MD for further guidance. Once the MD was notified of the incident, the DON and RP were notified. She stated that failing to report the incident places the resident at risk for serious illnesses and injuries.During an attempted phone interview on 03/25/2026 at 2:30 PM with MD-B and NP-W neither were available at the time. The surveyor left a message with the receptionist to have them call me regarding Resident #1. During an interview on 03/31/2026 at 8:49 AM with NP-A, he stated that the facility staff did not provide notification of Resident #1's fall details, until 03/24/2026; He stated on 03/24/2026 a facility nurse (could not recall name or position) notified him that the resident was transported to the hospital by the family. NP-A stated that he had no contact with the family or hospital following Resident #1's admission. NP-A stated that he expects immediate notification when a resident falls with head injury to send out to ER for further evaluation. The risk to the patient when MD's not notified could result in serious internal injuries. During an interview on 03/26/2026 at 9:55 AM with DON-T, stated that LVN-L did not notify DON that Resident #1 fell on [DATE] until she reached out on 03/24/2026 via phone. The DON stated the protocol for a witnessed (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	fall with an injury was to assess the resident head-to-toe before moving him/her, check for obvious injuries, complete neurological checks including assessing eyes for alertness and focus. The DON stated the risk of not completing an assessment before moving a resident after a witnessed fall or a fall with an injury could be causing further harm to the resident. The Administrator and DON were notified of Immediate Jeopardy (IJ) on 03/25/2025 at 5:10 PM, due to the above failures and the IJ Template was provided at 5:19 PM. The following Plan of Removal submitted by the facility and accepted on 03/26/2026 at 6:19 PM and included:Plan of removal for IJ-F684-State alleges facility failed to ensure proper assessment and documentation on one resident post fall.1. IJ called at 5:10PM facility for F684.2. Medical Director Notified at 5:20PM.3. Ad hoc [as need] QA completed to address notification protocols of family and physician for incident/accidents and change of condition to include proper assessments and documentation.4. [Resident #1] is currently out of facility.5. Immediate Correction/Client protectiona. DON/designed to educate licensed nurses on proper assessments and documentation for incident/accidents to include any resident change of condition. Completion date 03/25/2026.b. DON/designee to educate licensed nurses to notify DON and administrator of all incident/accidents and change of condition that require hospital transfer. Completion date 03/25/2026. c. DON/designee performed assessment on all residents with falls in the past 30 days to ensure proper notifications and assessments in place. Completion date: 03/25/2026.d. MDS/designee updated care plans for all residents with falls in the last 30 days. Completion date 03/25/2026.e. All licensed nurses will be educated on incident/accident protocols, to include notification of DON, Administrator, physician and family and resident assessment and documentation prior to working their next assigned shift. DON/designee will complete this. Completion date: 03/25/2026.6. Monitoring:a. DON and/or designee will monitor residents with falls daily to ensure notifications, assessments, and documentation are in place.b. Administrator to review with the DON weekly 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 POR included the following: Record review of facility all staff in-service dated 03/25/2026, completed by Staff Development Nurse, the staff development coordinator titled Incidents and Accidents: Reporting, Investigating, and Notifying the provider, ADON, DON, Administrator and Family.to do list by ADON: Patient falls, and patient transferring to hospital. Change in condition: assessing, documenting and reporting to physician and family., recognizing change in condition, and when to notify physician of a change in condition all staff in-services received a posttest over the following materials: behavior health monitoring, fall prevention, and Dementia, changes in condition, reporting and documenting resident abuse, neglect, changes and incidents immediately to provider, DON, RP, and Administrator.On 03/26/2026 the investigator began monitoring (12:17 PM through 4:00 PM) to determine if the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy by: Observations, interviews, and record reviews on 03/26/2026 9:00 AM-11:00 AM of Residents #1, 2, 3, 4, and 5 were all a fall risk and stated they had no concerns regarding falls, assistance, and supervision. Residents EHR reflected plans, interventions and documentation addressing the resident falls. Record reviews of Residents #1, #2, #3, #4, and #5 EHR fall a