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	04/27/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the discharge summary included an accurate and current description of the clinical status of the resident and sufficiently detailed individualized care instructions to ensure that care was coordinated and the resident transitioned safely from one setting to another for one (Resident #2) of three residents reviewed for discharge process. The facility failed to ensure that Resident #2's discharge summary included appropriate clinical information to ensure that the resident received continuous and coordinated care after she discharged to the community AMA (against medical advice) on 04/06/26. This failure could place residents at risk of not receiving ongoing person-centered care, which could lead to worsening of condition or serious harm.Findings included:Record review of Resident #2's Discharge MDS Assessment, dated 04/06/26, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE] and discharged on 04/06/26. The MDS Assessment under Section C-Cognitive Patterns reflected Resident #2 had a BIMS score of 8, which indicated moderate cognitive impairment. The MDS Assessment under Section GG-Functional Abilities (self-care) reflected Resident #2 required supervision assistance with most ADLs. The MDS Assessment under Section I-Active Diagnoses reflected Resident #2's active diagnoses included: hypertension (high blood pressure), wound infection, and risk of malnutrition. Record review of Resident #2's baseline care plan, dated 04/02/26, reflected the resident was receiving antibiotic therapy for a wound infection, pneumonia, and UTI. Interventions included: monitoring vital signs. This document reflected that Resident #2 had behaviors of talking to herself and a moderate risk of eloping. Interventions included: analyzing key times, places, and circumstances. This document reflected Resident #2 had skin issues that included a surgical wound and mild risk for pressure ulcers. Interventions included: wound care. This document also reflected Resident #2 expected to discharge to the community with no documented interventions. Record review of Resident #2's progress notes, dated 04/06/26 at 4:40 p.m. by the SW, reflected the following: [Resident #2] stated she wanted to d/c to [community shelter]. SW informed [Resident #2] that doing so right now would be discharging AMA and medication could not be sent with her. Resident stated she understood and still wanted to d/c. Resident will d/c AMA. Record review of Resident #2's progress notes, dated 04/06/26 at 4:50 p.m. by LVN Y, reflected the following: [Resident #2] continues to refuse care, medication and wound treatment. On this day the resident decided to have arrangements to leave the facility. [Resident #2] left the facility AMA with her belongings, transported safely. Administration, DON, ADON, Social Worker aware of discharge. Record review of Resident #2's physician Discharge summary, dated [DATE], reflected the following: Resident Name: [Resident #2]Attending Physician: [MD]admission Date: 04/02/26discharge date : [DATE]Discharge To: AMAadmission Diagnosis: cellulitis (skin infection) of right lower limb, essential hypertensionCondition upon discharge: (blank)Other information: medications locked up in med room. Personal property taken with resident.Signed by [Medical Records Staff] on 04/07/26Prognosis: (blank)Discharge Diagnosis: (blank)Signed by [NP] on 04/09/26Further review reflected there was no information regarding special instructions or precautions for ongoing care or (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: 675756	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/27/2026
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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	risks associated with discharging AMA. Record review of Resident #2's EHR reflected there was no AMA document completed and signed by staff or the resident per the facility's policy. In an interview on 04/23/26 at 12:40 p.m., the Interim Administrator stated Resident #2 was discharged before he started working at the facility. The Interim Administrator stated he was informed that Resident #2 was only at the facility for a few days before discharging home AMA, and he was not familiar with the resident's condition or reason for discharge. The Interim Administrator stated he was also not familiar with the facility's policy and procedures regarding AMA discharges. An attempted interview on 04/23/26 at 12:57 p.m. with Resident #2's family was unsuccessful due to no response to call. In an interview on 04/23/26 at 1:07 p.m., the SW stated she worked at the facility since July 2025. She stated she did not have much interaction with Resident #2 as the resident was only at the facility for 4 days. The SW stated that on 04/06/26 Resident #2 requested to speak with her and she found the resident waiting by the front door stating that she was ready to leave. The SW stated Resident #2 was admitted to the facility from the hospital, and according to the hospital records Resident #2's home was listed as a community shelter. The SW stated Resident #2 was not diagnosed with dementia or an intellectual disability and had the capacity to make her own decisions. The SW stated Resident #2 had a family member listed in her records for contact but not as her RP. The SW stated she did not contact Resident #2's family prior to her discharge because the contact was initially overlooked; however, she later notified the family. The SW stated she was not aware that Resident #2 was supposed to sign an AMA discharge form at that time; however, the physician discharge summary was completed. The SW stated she was now aware of the AMA discharge form, and it was important to have it signed or an attempt to show that the resident understood and agreed to the AMA discharge process. In an interview on 04/24/26 at 12:40 p.m., the NP stated Resident #2 was alert and oriented and did not have a POA or RP on file. The NP stated it was Resident #2's right to be discharged from the facility and she had the cognition to make her own decisions. The NP initially denied being a part of Resident #2's discharge process and later acknowledged signing the discharge summary 3 days after the resident discharged from the facility. The NP stated he only saw Resident #2 once at the facility and she was being treated with antibiotics for an infection on her leg, which was a treatment that needed to be completed. In an interview on 04/24/26 at 1:56 p.m., the DON stated Resident #2 admitted to the facility from the hospital with a wound that required antibiotics; however, the resident refused care and medications. The DON stated Resident #2 wanted to leave the facility AMA and was able to make that decision based on having the mental capacity and being her own RP. The DON stated the facility's process for AMA discharges included ensuring the resident had a safe place to go, notifying the MD and family if applicable, and explaining to the resident any risks involved with leaving AMA. The DON stated AMA forms also needed to be signed by the IDT and resident as evidence that the process and risks were explained and understood. The DON stated the SW confirmed that Resident #2's home was at the community shelter, and the facility transported her there. Record review of the facility's policy titled Discharge/Transfer Policy, reviewed 04/24/24, reflected in part the following: Policy: The resident will be discharged /transferred (home/another entity) by order of his/her attending physician in accordance with standard practice guidelines. Procedure:1. Obtain a discharge order from the physician2. Notify resident, their legal representative, if any, or an interested family member and document the discharge3. Provide written discharge instructions/education to the resident and family when discharged to a lower level of care, in a language they can understand and document in a medical record. EHR>Discharge>Instructions if discharged to an equal or lower level of care setting to transfer if discharged to a higher level of care such as an acute hospital. 4. Types of discharges:.D. Against Medical Advice (Refer to Discharge (AMA) Procedures) If the resident wishes to leave the community without a physician's order, the community designee will immediately notify the resident's treating physician and schedule a care conference by and between the resident and/or their legal representative and the treating physician. Other personnel may attend as needed. During the care conference, the treating physician will inform (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident of the risks and consequences associated with his/her decision to leave the health care community. If the resident still wishes to leave AND the resident has the ability to make his/her own health care decisions (as documented in the medical record by the treating physician), the community designee shall have the resident complete and execute all required AMA forms.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident received adequate supervision to prevent avoidable accidents for one (Resident #1) of eleven residents reviewed for supervision. The facility failed to ensure Resident #1, who resided on the facility's secured unit, received adequate supervision to prevent him from eloping on two separate occasions. On 04/20/26, Resident #1 eloped from the facility at 2:00 a.m. and was found 2.5 hours later by law enforcement approximately 2 miles away from the facility. On 04/24/26, Resident #1 eloped from the facility at 1:30 a.m. and was found on 04/27/26 at a local hospital where he was being treated for chest pain. An Immediate Jeopardy (IJ) was identified on 04/24/26 at 12:02 p.m. and an IJ Template was provided to the Interim Administrator at 12:45 PM. While the IJ was removed on 04/27/26, the facility remained out of compliance at a scope of isolated with the severity level of no actual harm with potential for more than minimal harm that was not an immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of accidents that could lead to serious injury or harm.Findings included:Record review of Resident #1's admission MDS Assessment, dated 03/12/26, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. The MDS Assessment under Section C-Cognitive Patterns reflected Resident #1 had a BIMS score of 7, which indicated severe cognitive impairment, with inattention and disorganized thinking. The MDS Assessment under Section E-Behavior reflected Resident #1 did not present with wandering behavior. The MDS Assessment under Section GG-Functional Abilities reflected Resident #1 did not have limited range of motion or require any mobility devices. The MDS Assessment under Section GG-Functional Abilities (self-care) reflected Resident #1 required moderate assistance with most ADLs. The MDS Assessment under Section I-Active Diagnoses reflected Resident #1's active diagnoses included: non-Alzheimer's dementia (cognitive disorder that causes decline in memory, thinking, and behavior), hypertension (high blood pressure), and thyroid disorder. Record review of Resident #1's care plan, revised 04/22/26, reflected the resident had cognitive loss due to neurocognitive disorder and dementia. Interventions included: tasks segmentation as needed, explaining procedures and care before performing, and eye contact when speaking. This document reflected that Resident #1 had exit-seeking behaviors. Interventions included: redirection as needed and resident moved closer to the nurses' station for monitoring. Record review of Resident #1's progress notes, dated 04/20/26 at 7:17 a.m. by RN A, reflected the following: [Resident #1] was noticed to be missing from the room around 02.00am. Code green was activated. [Interim Administrator], DON, and ADON were notified. The police were also notified. [Resident #1] was found and returned to the building around 4.30am. Family member aware. Vital signs stable, BP 112/63, P-83, R-18, O2 sat 95% Resident refused skin assessment. The NP was notified. The [Resident #1] states I have been trying to get out of that door everyday [sic] for 20 days and today is the 21st day. When asked how he got out, he said, ?I just got out through the door'. Record review of Resident #1's elopement assessment, dated 04/20/26, reflected the following: Mobility Status: ambulated independentlyEmotional Status: noneMental Status: noneElopement History: attempts to leave one time within last monthBehaviors: nonePlacement History: noneAssessment Information: score 10 (0-10-low risk) Record review of in-service, dated 04/20/26, reflected staff were educated on the facility's policy and procedures regarding missing residents. Record review of in-service, dated 04/20/26, reflected the Floor Technician received one-on-one education on the facility's policy and procedures regarding missing residents. Record review of Resident #1's progress notes, dated 04/24/26 at 4:28 a.m. by LVN C, reflected the following: [LVN C] making rounds and seen that the [Resident #1] wasn't in his room or in his bathroom. [LVN C] notified staff on unit, every room and bathroom was checked and then the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[Floor Tech] said the window in room [XXX] was open. A code green was called and everyone was checking the building parameter and all the rooms within in [sic] the building, Once staff realized [Resident #1] wasn't anywhere to be found, 911 and DON was called. MD notified, several attempts to notified [sic] [RP] was made, [LVN C] left a message on [RP's] voicemail. Record review of Resident #1's progress notes, dated 04/24/26 at 8:48 a.m. by the SW, reflected the following: [SW] called [PD] and asked them to go to the address [Resident #1] believes to be his [home address], to see if [Resident #1] may have gone there as that is where the resident was originally brought to the hospital from . [SW] informed [PD] that their police department had located [Resident #1] at that address previously. [PD] stated they would send officers to the address to look for [Resident #1]. Record review of Resident #1's progress notes, dated 04/24/26 at 9:15 a.m. by the SW, reflected the following: [SW] received a call from [PD] informing [SW] that they went by the address, and [Resident #1] was not there. [PD] stated they would try to stop by again later to see if [Resident #1] makes his way there later. [SW] thanked [PD]. Record review of Resident #1's hospital records, dated 04/24/26, reflected in part the following: Patient name: [[NAME] name]Chief Complaint: Chest PainHistory of Presenting Illness:[AGE] year-old male with past medical history of hypertension depression hyperlipidemia presented to ED with complaints of chest pain. [Resident #1] states he feels chest pressure Also came to the ER for further evaluation. [Resident #1] denied nausea or diaphoresis (excessive, sudden sweating). Reports compliance with his medications lives with the fiance. And uses a cane for walking. On arrival to the ER [Resident #1's] vitals were stableLab work was done and showed hemoglobin (iron-rich protein in red blood cells that transport oxygen throughout the body) of 12 (normal range 12-16), BMP with normal electrolytes and elevated proBNP (blood test used to diagnose or monitor heart failure) of 766 (normal value below 300). [Resident #1] was admitted for the [sic] management.Neurological: alert & oriented to person, place and time. No focal motor deficits (impairments in movement) . In an observation and interview on 04/23/26 at 10:00 a.m., Resident #1 was observed sitting in the dining area being closely monitored by staff. Resident #1 stated he eloped from the facility because he did not feel safe and needed to get back to his house. He was able to provide the surveyor with detailed directions to an address. Resident #1 stated he waited a while for an opportunity to get out of the door on the secured unit when he finally found that it was cracked open after staff exited, and he was able to walk out of the building. Resident #1 stated he walked for 2-3 hours looking for public transportation until he ran into several officers who returned him to the facility. An attempted interview on 04/23/26 at 10:47 a.m. with Resident #1's family was unsuccessful due to no response to call. In an interview on 04/23/26 at 12:15 p.m., the Interim Administrator stated the facility was in the process of hiring a new administrator and he had been covering for about a week. The Interim Administrator stated on 04/20/26 at about 3:00 a.m., he was notified that Resident #1 eloped from the facility. The Interim Administrator stated it was reported that Resident #1 was able to leave the secured unit through a door that did not lock behind staff and the resident was observed walking out of the back door by the Floor Technician. The Interim Administrator stated the Floor Technician ran to get help instead of intervening and following Resident #1, and when staff made it outside, they were unable to locate the resident, so law enforcement was called. The Interim Administrator stated he arrived at the facility at approximately 4:30 a.m. as law enforcement was returning Resident #1. The Interim Administrator stated he immediately had the maintenance director check the locking mechanism on all doors with issues found. The Interim Administrator stated Resident #1 was moved closer to the nurses' station to a room with a window that opened to an enclosed courtyard, and all staff were in-serviced regarding the facility's policy and procedure on elopement. He stated it was the responsibility of all staff to keep the facility secure and supervise residents to prevent elopements and not doing so could place residents at risk of eloping. An attempted interview on 04/23/26 at 1:17 p.m. with RN A, who worked with Resident #1 during the first incident, was unsuccessful due to no response to call. In an interview on 04/23/26 at 2:03 p.m., the Floor Technician stated he was pulling the trash at (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	approximately 2:00 a.m. on the west hall, outside of the secured unit when he saw a man in a gray hoodie exiting the back door. The Floor Technician stated he immediately went to inform one of the aides and after she confirmed that her residents were accounted for, he followed the aide outside to see who it was; however, they did not see anyone. He stated he alerted the staff on the secured unit, and they found that Resident #1 was missing. The Floor Technician stated the exit door was supposed to sound an alarm when opened but the alarm had been turned off by someone. He stated staff would sometimes do this to go out for a break without disturbing the facility or getting locked out. The Floor Technician stated he was employed by the facility and received the same training as all caregivers, including elopement prevention. He stated he received a one-on-one refresher regarding the facility's policy and procedures on elopements after the incident and now understood that he should have followed the resident to re-direct him back into the building. In an interview on 04/24/26 at 9:00 a.m., the Interim Administrator informed the surveyor that Resident #1 eloped from the facility again at approximately 1:30 a.m. and had not been found. The Interim Administrator stated there were additional staff working on the secured unit monitoring the doors, and Resident #1 exited through the window of his previous room. The Interim Administrator stated the window alarm and brackets used to prevent the window from rising more than 6 inches had been broken off, and Resident #1 was able to elope without staff noticing. He stated law enforcement was currently searching for Resident #1. In an interview on 04/24/26 at 12:40 p.m., the NP stated Resident #1 was admitted to the facility's secured unit due to his history of wandering according to his admission clinicals. The NP stated Resident #1 was diagnosed with dementia and neurocognitive disorder, which caused confusion. He stated it was safer for the resident to reside on the secured unit and possibly transition to the general area after a re-assessment later. The NP stated the facility notified him that Resident #1 eloped from the facility on 04/20/26 and his medications were adjusted with closer monitoring. The NP stated he was informed that Resident #1 eloped again this morning and was currently still missing. The NP stated the IDT would have to decide how to proceed once Resident #1 was found. An attempted interview on 04/24/26 at 1:42 p.m. with LVN C, who worked with Resident #1 during the second elopement incident, was unsuccessful due to no response to call. In an interview on 04/24/26 at 1:50 p.m., CNA B stated he worked at the facility for 3 months on the secured unit. CNA B stated he worked overnight (04/23/26-04/24/26) with Resident #1 when he eloped from the facility. CNA B stated Resident #1 was observed sitting in the common areas near the nurses' station eating snacks and writing at approximately 12:30 a.m. and the resident was not showing any signs of exit-seeking. CNA B stated it was not unusual for Resident #1 to be up late writing. CNA B stated he continued to do rounds and check on other residents, then at approximately 1:00 a.m. LVN C alerted all staff on the secured unit that Resident #1 was missing. CNA B stated they started searching in every room for Resident #1 when they found the window opened in the resident's old room. CNA B stated all windows had alarms, but the alarm on that window had been removed so the staff were not alerted. CNA B stated they received routine training on exit-seeking and elopements, especially working on the secured unit and he knew that the residents had to be monitored closely and any changes reported to the charge nurse. CNA B stated he was not always assigned to Resident #1, but the staff worked together to monitor all residents, and Resident #1 did not show any exit-seeking. CNA B stated Resident #1 was quiet and non-aggressive and always asked for paper so that he could sit and write. In an interview on 04/24/26 at 1:56 p.m., the DON stated Resident #1 admitted to the facility from the hospital where he was being assessed after he wandered into his neighbor's house. The DON stated Resident #1 was still new to the facility and the staff were still learning things about him. She stated the resident had now eloped from the facility twice although there were interventions in place and a full staff. The DON stated if a resident exhibited exit-seeking behaviors, they were placed on close monitoring every 15 minutes for 72 hours and only removed if the behavior resolved. She stated if the behavior was not resolved, the monitoring would be increased to one-on-one supervision until a re-assessment and clearance from psych was completed. The DON stated after Resident #1 eloped on (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	designee contacts the appropriate community agencies (Police, Local Health Department and Corporate Administration) and the resident's family and attending physician. 7. Staff will provide the police with all physical identifying information including but not limited to physical appearance, height, weight, age, sex and clothing if known. 8. The search is continued. Two staff members search the surrounding streets by car for a two (2) mile radius around the community. 9. When the Resident is locateda. Charge Nurse completes a head to toe assessment, including vital signs.b. Social Service Designee evaluates the resident for emotional distress.c. Staff provides resident with nutrition, hydration, additional or less clothing as appropriate 10. The Charge Nurse reports any findings to the Director of Nursing and places a call to the attending physician and the appropriate family member or responsible party. 11. Staff will monitor resident for 72 hours for change of condition.a. If changes in condition warrant medical or psychiatric assistance, proper transportation will be set up and the resident will be transferred as appropriate and as ordered by the physician 12. Reporting guidelines will be followed, and the Administrator will contact the Corporate Office for support and will be responsible for public relations issues. Document Requirements in the EHR: Incident/Accident Report. Nursing Notes should reflect an accurate account of situation and outcome. Social Services note needs to address emotional assessment and interventions. Update the Elopement Risk Assessment. Update Care Plan. An Immediate Jeopardy (IJ) was identified on 04/24/26 at 12:02 p.m. The Interim Administrator was notified of an Immediate Jeopardy (IJ) on 04/24/26 at 12:25 p.m., due to the above failures and the IJ template was provided at 12:45 p.m. A Plan of Removal was requested. The facility's Plan of Removal (POR) was accepted on 04/25/26 at 7:46 a.m. and included:[Nursing Facility] Elopement Plan of removal for IJ called on 4/24/2026 at 12:45 PM for the facility's alleged failure to provide adequate supervision for Resident #1 resulted in the resident eloping from the facility on two different occasions, which placed him at risk of serious harm. 1.Staff development coordinator/designee provided education to staff on elopement policy and procedure completed on 4/20/26. Resident #1 was placed on frequent monitoring and moved closer to the nurses' station with a window opening to the courtyard and placed on crisis intervention with psych services on 4/20/26. Resident was seen by psychiatrist via Telehealth on 4/20/26 with medication adjustments made and planned follow up for 4/24/26. 2. When it was discovered Resident #1 was out of facility, charge nurse and staff immediately searched both buildings and grounds then notified DON, Administrator, and police were notified by charge nurse on 4/24/26. Charge nurse notified family member and nurse practitioner for Resident #1. 3. Administrator and Director of Nursing are educated by Regional Director of Operation, and the education is completed on 4/24/2026. 4. Administrator checked all windows and doors in facility upon arrival completed on 4/24/26 with no issues found. Key Staff were provided key fobs to exit unit. 5. Resident #1 remains out of facility. If resident is returned to the facility, resident will be placed on one-on-one supervision until appropriate placement is found. 6. Verified all residents accounted for on 4/24/2026. 7. DON/Designee will in-service/educate all staff on elopement policy and procedure to include notification to DON/Administrator if residents are exit-seeking completed on 4/24/2026. Staff unavailable will be in-serviced prior to the start of their next shift and will not be allowed to work until education is completed. 8. DON/designee to educate staff on interventions post-exit seeking behavior to be completed on 4/24/26. Staff will follow policy for interventions when active exit seeking behavior is observed, such as 15-minute checks or one to one supervision. Staff unavailable will be in-serviced prior to the start of their next shift and will not be allowed to work until education is completed. 9. DON/designee will randomly interview staff three times weekly to ensure competency of education received. 10. An audit of nurses' notes was conducted and completed by nursing management to identify other residents that may be exhibiting exit seeking behaviors. Completed on 4/24/26. 11. DON/designee updated elopement book, kept at the nurses' stations, to include all residents who are identified as being at risk for elopement. To be completed on 4/24/26 12. Elopement risk assessments on new admissions and re-admissions will be monitored in morning clinical meeting every weekday. Care plans will be updated as needed for (continued on next page)

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 04/27/2026
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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	moderate and/or high-risk score. Individual interventions will be added to care plan as needed for higher functioning residents based on elopement risk score and IDT review. 13. Residents that return to the facility after an elopement attempt will be placed on one-to-one observation and referral to psych provider for further recommendations. 14. DON designee will monitor elopement risk assessment completion quarterly with MDS assessment completion and update care plan as needed. 15. Administrator/designee will round on memory care unit daily to ensure windows and doors are locked appropriately. 16. QA Committee meeting held on 4/24/2026 with medical director. The investigator began monitoring 04/25/26-04/27/26 to determine if the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy by: Record review of Resident #1's progress notes, dated 04/20/26 at 5:00 p.m. by the SW, reflected the following: [SW] and Nurse were present as [Resident #1] met with psychiatry via telehealth appointment. [Resident #1] stated he would like to meet with a dietary as well as a chaplain. Psych gave two new medication orders. Depakote Sprinkles 125mg and Zoloft 150mg. [SW] emailed [telehealth representative] to ask if their psychologist could meet with [Resident #1] to assess his decision-making capacity. [Telehealth representative] stated [behavioral health service provider] works with [psychologist] and she would get [SW] in contact with him. [SW] thanked [telehealth representative]. Record review of Resident #1's progress notes, dated 04/22/26 at 9:19 a.m. by the SW, reflected the following: [Resident #1] was moved from [old room] to [new room]. This move brought [Resident #1] closer to the nurse's station in order for closer monitoring to be provided as an intervention for the resident's previous elopement. In an interview on 04/25/26 at 9:15 a.m., the Interim Administrator revealed that all residents in the facility had been accounted for, and daily rounds on all residents would continue. Interviews on 04/25/26-04/27/26 conducted with the Interim Administrator, Assistant Administrator, DONs, ADON, Staffing Coordinator, nurses, and CNAs from North and South building: LVN A (3rd shift/rotating days), CNA B (3rd shift/rotating days), LVN C (3rd shift/rotating days), CNA D (3rd shift/rotating days), CNA E (2nd shift/rotating days), LVN F (1st shift/rotating days), CNA G (1st shift/rotating days), CNA H (2nd shift/rotating days), CNA I (1st shift/rotating days), CNA J (1st shift/rotating days), CNA K (1st shift/rotating), LVN L (1st shift/rotating days), CNA M (2nd shift/rotating days), LVN N (2nd shift/rotating), LVN O (1st shift/rotating), CNA P (2nd shift/rotating), CNA Q (3rd shift/rotating days), RN R (PRN), RN S (3rd shift/rotating days), CNA T (3rd shift/rotating days), LVN U (3rd shift/rotating days), LVN V (1st shift/rotating days), LVN W (3rd shift/rotating days), and RN X (1st shift/rotating) indicated they all participated in in-service trainings regarding the facility's policy and procedures regarding elopement management before the start of their shift. Starting on 04/24/26. All staff were able to state signs of exit-seeking and interventions to prevent it. All staff knew the procedure for a missing resident was to initiate a Code Green which included: alerting all available staff, securing all doors and windows, searching the entire facility, including outside, and notifying the Administrator, DON, MD, and family. All staff knew to notify law enforcement if the resident was not found within 30 minutes. If a resident was observed exiting the building, all staff knew to follow the resident and alert all available staff by yelling Code Green or by cell phone. All nurses were able to state that residents who exhibited signs of exit-seeking would be placed on close monitoring. All nurses knew to notify the Administrator, DON, and family and document all incidents and changes. The Interim Administrator, Assistant Administrator and DONs understood it was their responsibility to implement and monitor the effectiveness of all interventions put in place. Record review of Residents #1, #3, #4, #5, #6, #7, #8, #9, #10, #11, and #12 EHRs reflected they all had appropriate interventions for care needs based on cognition and exit-seeking behaviors. Interviews with Residents #6, #8, and #10, and the RPs of Residents #3, #4, #5, #7, #9, #11, and #12, revealed no concerns regarding the supervision and safety of the residents. Observations on 04/25/26-04/27/26 of Residents #3, #4, #5, #6, #7, #8, #9, #10, #11, and #12, who were all at risk for elopement, revealed all residents were being adequately supervised based on care needs and interventions outlined in care plans. On 04/27/26 at approximately 9:30 a.m., (continued on next page)

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 04/27/2026

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the Regional Nurse informed the surveyor that Resident #1 was located at a local hospital where he was being treated under an [NAME] name. Resident #1 remained at the local hospital, pending return, during monitoring and was unable to be observed or interviewed. Record review of an in-service titled One on One Education Form, dated 04/24/26, reflected The Interim Administrator, Assistant Administrator, and DONs were educated by the Regional Director of Operations on the facility's policy and procedures regarding elopements and exit-seeking behaviors. Record review of an in-service titled Code Green: 1) Missing Person-Notifications, Searching, 2) Secure All Doors, 3) Interventions following exit-seeking behaviors, dated 04/24/26, reflected staff were educated by the staff development nurse on the facility's policy and procedures regarding elopements and exit-seeking behaviors. Record review of a document provided by the Interim Administrator, dated April 2026, reflected the facility initiated daily rounds on the memory care units to ensure that all doors and windows remained secure. Record review of a document provided by the Interim Administrator, dated 04/24/26, reflected a QAPI meeting was held to discuss the correction plan for the facility's deficiency in quality of care. Record review of a document provided by the Interim Administrator, dated April 2026, reflected the DON initiated audits of nurses notes to identify residents exhibiting changes and exit-seeking behaviors. Record review of elopement binders at the nurses' stations reflected they were updated with face sheets and elopement assessments of residents who were considered at risk for elopement. An Immediate Jeopardy (IJ) was identified on 04/24/26 at 12:02 p.m. and an IJ Template was provided to the Interim Administrator at 12:45 PM. While the Interim Administrator was informed on 04/27/26 at 12:46 p.m. that the IJ was removed, the facility remained out of compliance at a scope of isolated with the severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.