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	05/28/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 4 residents (Resident #1) reviewed for ADL care.The facility failed to provide Resident #1 with incontinence care every two hours and as neededThis failure could place residents at risk for loss of dignity, risk for infections, and a decreased quality of life. Findings included:Record review of Resident #1's quarterly MDS assessment, dated 05/18/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had a diagnosis which included cerebrovascular accident, (commonly known as a stroke, which occurs when blood flow to a part of the brain is interrupted or reduced, depriving brain tissue of oxygen and nutrients). Resident #1 was cognitively intact with a BIMS score of 14, and she was always incontinent of bowel and bladder.Record review of Resident #1's Care Plan, dated 05/12/26, reflected Resident #1 was at risk for problems with bowel and bladder incontinence. The care plan reflected: Goal: Incontinent of bladder and bowel with occasional awareness of need to defecate . intervention: Complete bladder and bowel incontinence risk. Check and change, keep clean and dry During an observation and interview on 05/28/26 at 5:26 AM, revealed Resident #1 was in her room in bed. Resident #1 said the last time she was changed was at 11:00 PM. She stated staff came to her room at 1:00 AM, but they did not change her brief. She stated she could not tell whether she was wet. She stated she had called to be pulled, and they came they pulled her up and left the room. After they left the room, she said she slept until the morning. When she awakened, she stated she was heavily wet with urine. She denied having any skin issues. The resident did not have odors. During an observation on 05/28/26 at 5:30 AM, CNA A and CNA B entered Resident #1's room to provide the resident with incontinence care. After explaining the procedure to Resident #1, they both washed their hands, put on gloves, and put their supplies together. CNA A and CNA B then unfastened the resident's brief. Resident #1's brief and draw sheet were heavily soaked with urine and the draw sheet was stained with bowel movement (feces). The resident's skin was intact.During an interview on 05/28/26 at 5:47 AM, CNA B, who worked the 10:00 PM-6:00 AM shift, revealed CNA A was the assigned aide for Resident #1. CNA B stated she was supposed to assist CNA A with Resident #1 because the resident required two staff to assist her. She said she last saw Resident #1 at 1:00 AM when she helped the nurse pull the resident up in bed. She stated she did not see Resident #1 again until this morning when CNA A called her to assist with changing Resident #1 when incontinent care was observed. She stated she was aware they were supposed to do rounds every two hours and as needed, but she was busy with her residents. She stated failure to round and change a resident every two hours could lead to residents having skin breakdown and infection. CNA B stated they were trained to do rounds every two hours, and she did on residents assigned to her.During an interview on 05/28/26 at 5:55 AM, CNA A, who worked the 10:00 PM-6:00 AM shift, revealed she was the CNA assigned to Resident #1. She said she last changed the Resident #1 around 1:00 AM and the resident required two staff to assist her, but she could not recall who helped her. She stated she was aware they were supposed to do rounds every two hours and as needed, but she was busy with other residents and waited for help. She stated (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	failure to round and change the resident every two hours could lead to the resident having skin breakdown. CNA A stated they were trained to do rounds every two hours.During an interview on 05/28/26 at 6:39 AM, LVN C, who worked the 10:00 PM-6:00 AM shift, revealed she had been to Resident #1's room, at around 1:00 AM because the resident had her call light on. She said CNA B helped her pull Resident #1 up in bed, and she did not notice Resident #1 was wet. She said it was her responsibility to go behind the CNAs to ensure they were rounding every two hours and changing residents timely. She said she could not recall CNA A asking her for assistance. She stated CNAs were supposed to perform incontinence care rounds every two hours and as needed. She stated residents were at risk of skin irritation and urinary tract infections if they were left wet for long periods.During an interview on 05/28/26 at 10:58 AM, the ADON revealed her expectation was the CNAs performed rounds every two hours and as needed, and the nurses were responsible for monitoring the CNAs during their shifts. She stated the risk of not performing every two-hour rounds was it could lead to skin breakdown.During an interview on 05/28/26 at 11:19 AM, the DON revealed her expectation was CNAs performed rounds every two hours and as needed, and the nurses were responsible for monitoring the CNAs during their shifts to ensure residents were checked for wetness. She stated if a resident required two-person assistance, she expected the CNAs to call nurses for assistance with care. She stated the risk of not performing two-hour rounds was it could lead to skin breakdown and infections. The DON stated she had done training with staff on providing incontinence care every two hours.Record review of the facility's Perineal Care policy, revised April 2024, reflected the following: .Staff will provide perineal care in accordance with the standard of practice to prevent skin breakdown and infection .

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 residents (Resident #1) reviewed for infection control.CNA A and CNA B failed to perform hand hygiene while providing incontinence care to Resident #1.This failure could place residents her at risk for cross-contamination. Findings included: Record review of Resident #1's quarterly MDS assessment, dated 05/18/26, reflected a [AGE] year-old female, who was admitted to the facility on [DATE]. Resident #1 had a diagnosis which included cerebrovascular accident, (commonly known as a stroke, which occurs when blood flow to a part of the brain is interrupted or reduced, depriving brain tissue of oxygen and nutrients). The resident's cognition was intact with a BIMS score of 14, and she was incontinent of bowel and bladder. Record review of Resident #1's Care Plan, dated 05/12 /26, reflected Resident #1 was at risk for problems with bowel and bladder incontinence. The care plan reflected: Goal: Incontinent of bladder and bowel with occasional awareness of need to defecate . intervention: Complete bladder and bowel incontinence risk. Check and change, keep clean and dry During an observation on 05/28/26 at 5:30 AM, CNA A and CNA B entered Resident #1's room to provide the resident with incontinence care. After explaining the procedure to Resident #1, CNAs A and B washed their hands, put on gloves, and put their supplies together. The CNAs then unfastened the resident's brief. CNA B cleansed the resident's abdominal folds and perineal area (area between the genitals and anus). Next, CNA B removed her gloves and put on new gloves without washing her hands. The CNAs then positioned Resident #1 on her side, and CNA B cleansed the resident's buttocks and thighs. Resident #1's brief and the draw sheet under the resident were soaked with urine, and the draw sheet was stained with bowel movement (feces). While wearing the same gloves, CNA B picked up a clean brief and clean linen. CNA B then put the linen on the bed, and the clean brief was placed on Resident #1. CNA A removed the soiled linen and put it in a plastic bag. CNA A and CNA B then removed their gloves and put on new gloves without washing their hands. CNA B applied petroleum jelly to Resident #1's legs and hands. CNA B then removed her gloves and left Resident #1's room without performing hand hygiene.During an interview on 05/28/26 at 5:47 AM, CNA B revealed she forgot to perform hand hygiene when she provided care to Resident #1. CNA B stated she was expected to wash her hands before contact with a resident, between care if her gloves were soiled, and after care, but she forgot. CNA B said she was supposed to complete hand hygiene and change gloves during incontinence care to prevent cross contamination. She stated failure to wash her hands before and between care and after removing her gloves could lead to cross contamination and infection. During an interview on 05/28/26 at 5:55 AM, CNA A revealed she forgot to perform hand hygiene when she changed her gloves while providing Resident #1 with care. CNA A said she was expected to wash her hands before contact, between care if her gloves were soiled, and after care. CNA A said she was supposed to complete hand hygiene with glove changes during incontinence care to prevent cross contamination. She said failure to wash her hands before and between care and after removing her gloves could lead to cross contamination and infection.During an interview on 05/28/26 at 10:58 AM, the ADON revealed she expected staff to complete hand hygiene before contact with residents, during care, after care, and when they changed gloves during incontinence care. The ADON stated CNA A and CNA B were supposed to complete hand hygiene and change their gloves while providing Resident #1 with incontinence care to prevent cross contamination and infection. The ADON stated the nursing staff were offered an in-service training on hand hygiene/infection control.During an interview on 05/28/26 at 11:19 AM, the DON revealed she expected staff to complete hand hygiene before and after incontinence care. She said CNA A and CNA B were supposed to perform hand hygiene before contact, during care since Resident #1 had a bowel movement, after care, and when (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	moving from dirty to clean. She also said they should perform hand hygiene when they changed their gloves. She said staff were expected to perform hand hygiene to prevent the spread of infection. The DON stated the nursing staff were offered an in-service training on hand hygiene/infection.Record review of the facility's Hand Hygiene for Staff and Residents policy, dated July 2024, reflected: .The purpose of this procedure is to reduce the spread of infection with proper hand hygiene '1.Hand hygiene is done:BeforeA. Resident contactAfter:A. Contact with soiled or contaminated articles, such as articles that are contaminated with body fluids.B. Resident contact.D. Toileting or assisting others with toileting, or after personal grooming.H. Removal of medical/surgical or utility gloves.