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	12/11/2024

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview and record review, the facility failed to ensure residents had a right to be treated with respect and dignity for 1 of 3 residents (Resident #189) reviewed for dignity. The facility failed to ensure Resident #189's catheter urine collection bag had a privacy cover. This failure could place residents with catheters at risk for a loss of dignity, decreased self-worth and decreased self-esteem. Findings included: Record review of Resident #189's face Sheet, dated 12/11/24, reflected the resident was a [AGE] year-old male who was admitted on [DATE]. Review of Resident #189's MDS dated [DATE] reflected the resident's cognition was moderately impaired with a BIMS score of 07. Active diagnosis included Indwelling catheter (including suprapubic catheter and nephrostomy tube), ostomy, cancer, hypertension, benign prostatic hyperplasia, renal insufficiency, obstructive uropathy, diabetes mellitus, fractures, and stroke. Section GG reflected resident required partial/moderate assistance with toileting hygiene and toilet transfers. Section H indicated indwelling catheter. Review of Resident #189's care plan dated 12/11/24 reflected resident at risk for problems with elimination related to history of urinary tract infection. Goals included residents' elimination status will be maintained or improved over the next 90 days. Decrease in number of incontinent episodes by implementation of a scheduled toileting program over the next 90 days. Interventions included Monitor signs for symptoms of urinary tract infection. Observe pattern of incontinence, and initiate toileting schedule or prompted voiding if indicated. Uses brief. Resident with urinary catheter related to anatomical or functional diagnosis. Goal included resident will be free complications of indwelling catheter over the next 90 days. Interventions included care/changing of urinary catheter as ordered. Confer with physician regarding the continued need of urinary catheter, consider the risks and benefits of continuing the long-term use of an indwelling urinary catheter and remove it as soon as possible if indicated. Monitor urine appearance, amount, odor, clarity. (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 12/11/2024
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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #189's order summary report dated 12/11/24 reflected the resident had an order for: 1. Foley Catheter 16 Fr (CATHETER) 1 Urethral every shift Bulb size 10cc ***PROVIDE CATHETER CARE, MONITOR FOR SECURITY STRAP AND PRIVACY BAG PLACEMENT*** 2. Catheter as Needed CLOGGED /DISLODGED Change foley catheter (change drainage bag with catheter change) CDC recommendation: Change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised 3. Catheter every shift Assess for bladder distention, small frequent voids, dribbling, resident complaint of bladder feeling full. Complications can include an increased risk of urinary tract infection, blockage of the catheter with associated bypassing of urine, expulsion of the catheter, pain, discomfort, and bleeding, if present notify MD. Observation and interview on 12/08/24 at 2:07 PM revealed Resident #189's catheter bag was laying on the floor on the side of the bed without a privacy bag. Resident #189 stated he knew his catheter bag did not have a privacy bag; however, he was usually in his room most of the time. Resident #189 stated he felt uncomfortable with his catheter revealing the contents of his urine especially when he had visitors. Observation and interview on 12/10/24 at 2:37 PM revealed Resident #189's catheter bag did not have a privacy bag. Observation and interview on 12/11/24 at 2:07 PM revealed Resident #189's catheter bag was laying on the floor on the side of the bed without a privacy bag. Observation and interview on 12/11/24 at 2:15 PM with LVN K revealed Resident #189 was usually in bed, in his room most of the day so his catheter bag was rarely seen by the community. LVN K stated it was important to have a privacy bag to protect his dignity, and that any nursing staff could place a privacy bag. Interview on 12/11/24 at 2:20 PM with ADON C revealed she was not aware Resident #189 was without a privacy cover, and she stated catheter bags should be covered at all times for privacy. ADON C stated all nursing staff were responsible for ensuring urine collection bags were covered and not on the floor at all times. Interview on 07/25/24 at 6:00 PM with DON revealed she was not notified by the that Resident #189's catheter was found without a privacy bag and was on the floor. The DON stated all catheter bags were to be covered with a privacy bag to protect resident privacy and dignity. The DON stated her expectation was for all nursing staff to ensure catheter bags were covered and hanging properly to allow the fluid to drain properly by flow of gravity. Record review of the facility's Care and Removal of an Indwelling Catheter policy, dated 01/12/20, reflected: Staff will provide care of an indwelling catheter in accordance with standard practice guidelines. Evaluate the need for catheter care, provide privacy, and assist resident to a comfortable position.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation and interview, the facility failed to ensure residents received services in the facility with reasonable accommodation of resident needs and preferences for 1 of 35 residents (Resident #55) reviewed for call light access. The facility failed to ensure Resident #55 had access to her call light. This failure could place residents at risk of not being able to call for assistance when needed. Findings included: Record review of Resident #55's undated Face Sheet reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included legal blindness, muscle wasting, and difficulty swallowing. Record review of Resident #55's quarterly MDS assessment, dated 11/06/24, reflected a BIMS score was not completed due to her medical conditions. Her Functional Status assessment reflected she required substantial assistance with all of her ADLs. Record review of Resident #55's care plan, dated 09/24/24, reflected she had a self-care deficit and required assistance by staff. Observation on 12/09/24 at 10:59 AM revealed Resident #55 sitting in her wheelchair, and her call light cord was on the floor behind her and under the bed. Observation and interview on 12/10/24 at 9:09 AM revealed Resident #55 was sitting in her wheelchair, with her feet on a stool, and her call light was on the floor behind her and under the bed. Resident #55 stated she just yelled for help when she needed it, or waited for someone to come check on her. She stated she did not know where her call light was. Interview on 12/10/24 at 9:38 AM with LVN E revealed she did not know why the CNAs had not placed Resident #55's call light where she could reach it when they put her in her wheelchair. LVN E stated she would monitor the resident and ensure her call light was clipped to her clothing. Review of the facility's Call Lights Answering policy, dated 01/19/23, reflected: .The staff will provide an environment that helps meet the needs of the resident by answering call lights appropriately. .7. When leaving the room, be sure the call light is placed within the resident's reach.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41781 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 the necessary services to maintain good personal hygiene for 3 of 8 residents (Residents #23, #55 and #81) reviewed for ADL care. 1. The facility failed to ensure Residents #23 and #55 received grooming assistance to remove unwanted facial hair. 2. The facility failed to ensure staff provided consistent showers/baths for Resident #81. These failures could place residents at risk of not receiving hygiene care which could cause skin breakdown, a loss of dignity and self-worth. Findings included: 1. Record review of Resident #23's Quarterly MDS assessment, dated 11/09/24, reflected the resident was an [AGE] year-old-female who initially admitted on [DATE] and readmitted on [DATE]. The resident had diagnoses of anemia (condition in which the blood doesn't have enough health red blood cells and hemoglobin to carry oxygen through the body), heart failure, hypertension (condition in which the force of the blood against the artery walls is too high), and hyperlipidemia (elevated levels of lipids like cholesterol in the blood). The resident had severe cognitive impairment and required partial to moderate assistance of one person for personal hygiene. Record review of Resident #23's Comprehensive Care Plan, dated 12/11/24, revealed the resident had an ADL self-care performance deficit related to a disease (dementia) in which the resident required one-staff participation with personal hygiene because the resident had a general loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life. Observation and interview on 12/08/24 at 11:49 AM revealed Resident #23 had more than 10 long black and gray facial hairs approximately 0.5 inches in length on her chin area. Resident #23 stated she wanted to have her facial hair removed. Observation and interview on 12/10/24 at 09:12 AM revealed Resident #23 had more than 10 long black and gray facial hairs approximately 0.5 inches in length on her chin area. Resident #23 did not recall when she was last showered. Record review of Resident #23's shower sheets, progress notes, and personal hygiene tasks for 11/01/24 through 12/10/24 in the electronic health record on 12/11/24 at 10:10 AM revealed there was no documentation of shaving refusals recorded. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/10/24 at 9:17 AM with CNA A revealed Resident #23's shower days were on Mondays, Wednesdays, and Fridays. CNA A stated residents' facial hairs were removed on their shower days. CNA A stated she was the only CNA working on the secured unit on 12/08/24 during her shift. CNA A said when only one CNA worked the floor with the one nurse on the unit that no showers would be completed that shift. CNA A stated it was the CNA's responsibility to provide personal hygiene (including removing facial hair) on the residents. CNA A said it was a dignity issue for the residents to have facial hair. CNA A also stated she was last in-serviced on ADLs in the last month. CNA A said the expectation was that residents were clean and free of facial hair. Interview on 12/10/24 at 9:37 AM with LVN B revealed CNAs were responsible for shaving the residents when they showered them. LVN B stated that the nurses were supposed to monitor the residents' showers and personal hygiene and ensure that facial hair was removed when showers were given to residents by the CNAs. LVN B stated it was a dignity issue for the residents to have facial hair. Interview on 12/10/24 at 10:10 AM with ADON C revealed the facility expectation was that resident's facial hair should be removed on their bath days. ADON C stated that it was the CNAs responsibility to remove the facial hair when they showered residents on their shower days three times per week. ADON C said that it was the nurses' responsibility to ensure that the residents were showered, and facial hair removed. ADON C also stated that it was a dignity issue if a resident's facial hair was not removed. Interview on 12/10/24 at 4:55 PM with DON revealed the staff had a shower schedule to follow. The DON stated that it was a dignity issue for women to have facial hair. The DON also said it was the CNA's responsibility to shower and remove the resident's facial hair. The DON stated it was the charge nurses' responsibility to monitor the residents shower schedule and ensure that showers and facial hair removal were being completed. The DON finished by stating she was in-servicing all direct care staff on ADLs today. Record review of Resident #55's undated Face Sheet reflected the resident was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses which included legal blindness, and muscle weakness. Record review of Resident #55's quarterly MDS assessment, dated 11/06/24, reflected her BIMS score was not calculated, and her Functional Status reflected she required staff assistance with all of her ADLs, including personal hygiene. Record review of Resident #55's care plan, dated 03/24/23, reflected she had a self-care deficit requiring the assistance of staff for her ADLs. She had a preference for bed baths instead of showers. There was no documentation of Resident #55 being non-compliant with her hygiene. Observation and interview on 12/08/24 at 10:59 AM revealed Resident #55 had facial hair, consisting of a mustache and chin hair. Resident #55 stated she preferred not to have facial hair as it was embarrassing. She stated she could not recall the last time she had been shaved, but she did get bathed 2-3 times a week. Observation on 12/09/24 at 2:31 PM revealed Resident #55's facial hair remained in place. Observation on 12/10/24 at 11:30 AM revealed Resident #55 's facial hair remained in place. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/10/24 at 11:35 AM with LVN E revealed the CNAs were responsible for showering residents, which included shaving facial hair if needed. She stated she relied on the CNAs to do their job and she didn't necessarily follow up to ensure the residents are showered and shaved. LVN-E stated Resident #55 should have been bathed on 12/09/24 according to the shower schedule but she was unsure if the resident had been showered. Interview on 12/10/24 at 2:05 PM ADON-D stated the CNAs are responsible for resident hygiene, which included shaving residents that want their facial hair to be removed. She stated female residents should not have to request their facial hair be shaved, most females would not like to have facial hair. Interview on 12/10/24 at 4:55 PM the DON stated all residents should be shaved as part of their hygiene process if the resident allowed it. Record review of the facility's Hair Care-Combing and Shaving, policy, revised 01/12/20, reflected the following: POLICY Statement: Hair care, combing, and shaving will be provided for residents in accordance with standard practice guidelines 2. Record review of Resident #81's face sheet, dated 12/10/24, reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE]. Record review of Resident #81's Admission MDS Assessment, dated 10/03/24, reflected she did not have a BIMS score calculated (a term used to screen and identify a resident's cognition). She had not rejected care and required partial/moderate assistance with showers and baths. Her active diagnoses included stroke (when blood flow to a part of the brain is interrupted, leading to brain cell death), Alzheimer's Disease (a type of brain disorder that causes problems with memory, thinking and behavior), and Depression (characterized by persistent feelings of sadness and loss of interest in activities once enjoyed). Record review of Resident #81's Care Plan, initiated on 09/27/24, reflected: Care Area/Problem: Self Care Deficit, Related To: History of Cardiovascular Disease Onset .Goal: Resident will maintain or improve self care area of dressing, grooming hygiene and bathing over the next 90 days .Interventions: Prefers Bath in AM . Record review of Resident #81's Physical Functioning Instructions report for November 2024 reflected under the category Bathing for the following dates a code of 8 was entered under the PF- Supp column indicating ADL activity itself did not occur: 11/07/24, 11/08/24, 11/09/24, 11/10/24, 11/11/24, 11/12/24, 11/14/24, 11/15/24, 11/16/24, 11/18/24, 11/20/24, 11/21/24, 11/23/24, 11/24/24, 11/25/24, 11/26/24, 11/27/24, 11/28/24, 11/29/24, and 11/30/24. Observation on 12/09/24 at 12:00 PM of Resident #81 revealed she was sitting in a wheelchair at a table in the dining room waiting for her lunch tray to arrive. She had a person sitting next to her later identified as a family member . Resident #81 said she was doing okay today but was cautious of the food. Resident #81 was dressed in clean clothes and had her hair braided. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/10/24 at 10:05 AM with CNA A revealed she worked PRN at the facility and did not normally work on the memory care unit. CNA A said Resident #81's shower days were during the 2:00 PM-10:00 PM shift, but she was not sure what days she received showers. CNA A said normally there was supposed to be 2 aides per shift so that they could assist the nurse in monitoring the residents while showers were given. CNA A said when a CNA called in or did not show up, it meant the showers for that shift would not be completed. CNA A said for instance, yesterday (12/09/24) she was the only aide for the shift, so no residents received their showers. CNA A said normally showers would be completed at least by the next day if possible, but it depended on what the schedule was like for that day as well. CNA A said the CNA on shift was responsible for ensuring residents received their showers. Interview on 12/11/24 at 10:32 AM with ADON D revealed the CNAs document a provided shower in a resident's chart. ADON D reviewed Resident #81's Physical Functioning Instructions Report for November 2024 and said that based on the documentation, it appeared as if Resident #81 had not been receiving showers/baths. Interview on 12/11/24 at 3:32 PM with the DON revealed the memory care unit had plenty of staff, and she expected staff to complete showers during their shifts. The DON said if the staff could not get to something they should let their charge nurse and ADON know so it could be escalated and resolved. The DON said she expected residents to be offered a shower/bath at least 3 times per week. The DON said the CNA was responsible for completing the shower task for each resident. The DON said poor hygiene could result from residents not being offered a shower/bath. The DON said nurse managers looked at ADL documentation weekly. Record review of the facility's Bathing (Not Partial or Complete Bed Bath) policy, dated 02/12/20, reflected: . Assist resident with bathing .Record the procedure in the record . 43791 48236

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F 0684 Level of Harm - Minimal harm or potential for actual harm 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** 42859 Based on observation, interview, and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practices, the comprehensive care plan, and the residents' choices and based on the comprehensive assessment of a resident for 1 of 1 resident (Resident #133) reviewed for wound care. The facility failed to ensure the diabetic wound on Resident #133's left upper side second toe was covered with a dressing. This failure could place residents at risk of pain and lead to systemic infections causing harm for residents. Findings included: Review of Resident #133's face sheet dated 12/10/24 reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Review of Resident #133's quarterly MDS assessment dated [DATE], reflected Resident #133 had diagnoses which included diabetes (high blood sugar). Had a BIMS score of 03, reflecting the resident's cognition was severely impaired. He was at risk of diabetic foot ulcers. Review of Resident #133's care plan revised date 11/23/24 reflected: Problem: Wound (pressure, diabetic or stasis). Cleanse Wound Tuesday, Thursday, and Sunday every am shift (6am-2pm) 10/31/24 Goal: The resident will maintain or develop clean and intact skin by the review date. Open area will be healed over the next 90 days. Interventions: Treatments and dressings as ordered per physician. Review of Resident #133's physician orders dated 11/05/24 reflected: Cleanse Wound Tuesday, Thursday, Sunday every am shift (6am-2pm) DIABETIC WOUND TO THE LEFT DORSAL SECOND TOE: Cleanse with NS or WC, pat dry. Apply collagen sheet and calcium alginate with silver, cover with a dry dressing 3x/week. Review of Residnet#133 December medication administration record revealed wound care was last administered on 12/08/24. Observation/interview on 12/10/24 at 09:12 AM with Resident #133 revealed he had wound on his left second toe that was observed not covered and was bleeding. He stated he just removed a scab on it. He stated the last time the wound was dressed was a week ago, but he could not remember the day or the date. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation/Interview on 12/10/24 at 09:40 AM with LVN F revealed the diabetic wound on Resident #133's second left toe did not have a dressing on it. LVN F stated he was not aware Resident #133 did not have a dressing on. He stated the wound care nurse performed wound care as per the orders and they also had as needed orders in case the dressing fell off. He put supplies together, washed hands and put on gloves, cleansed the wound. He removed the gloves, and the wound care nurse came and took over. He was observed checking inside the Residnet#133 socks that he had removed, and a dressing dated 12/3/24 was found stuck inside the socks. Observation on 12/10/24 at 10:05AM with LVN T who was the wound care nurse performing wound care revealed he washed hands and put all the supplies together. He put on gloves and pat dried the diabetic wound on Resident #133's second left toe. He applied collagen, calcium alginate with silver and covered with a dry dressing dated 12/10/24. He removed the gloves and washed his hands. He put the socks back on and left the resident comfortable. Interview on 12/10/24 10:15AM with LVN T revealed Resident #133 had a physician's order to cleanse and cover the wound three days in a week: Tuesday, Thursday, and Sunday. He stated he was not made aware that Resident #133's dressing had come off until now when he was called. He stated he completed wound care (12/03/24) on Resident #133, and since then he was off duty. He stated his expectations were for the nurses to monitor the dressing every shift and if the dressing came off, they had PRN treatment orders to follow. He stated the potential risk if the dressing comes off would be a decline in the wound status and infections. He stated he had not done annual training on wound care. No C N A was interviewed that worked with Res #133 to see if they were aware the dressing fell off, and the LVN T was not asked about the wound status. Interview on 12/10/24 01:47 PM with RN V revealed she was responsible for wound care on Friday, Saturday, and Sunday. She stated she performed wound care for Resident #133 on Sunday 12/8/24 and she thought she used an old dressing that was already dated and initialed and she forgot to change the date and the initial. She stated she did not work on 12/5/24 and she did not know who signed with her initials. RN V stated she now knew better and not to use left over dressings because it looked like she did not do the dressing change and she had no proof. She said failure to change the dressing as per the physician's orders could lead to wound being infected and worsening of the wound. She stated she had not done training on wound care. Interview on 12/11/24 at 11:00 AM with the DON revealed her expectations were for her staff to follow orders and as needed orders. If the dressing, came off the nurses were to apply a new dressing. The DON stated she had done annual skill check off for nurse for wound care. She stated the risk of not having a dressing and not performing dressing change per doctor's orders could lead to infection and wound getting worse. Review of the facility's in-service training on wound care dated 4/18/24 revealed LVN T was in attendance. The policy the training covered reflected the licensed nurses were supposed to complete wound care treatments per physician orders, and they were supposed to properly and accurately document completion of wound care orders. Review of the facility's Non-Pressure Wounds: Diabetic and Neuropathic Ulcers policy, revised July 2018, reflected the following: 2. Follow physician orders.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview and record review, the facility failed to ensure a resident who is incontinent of bladder received appropriate treatment and services to prevent urinary tract infections based on the resident's comprehensive assessment for 1 of 3 residents (Residents #189) reviewed for urine incontinence/catheters. The facility failed to ensure Resident #189's catheter urine collection bag was kept off the floor. This failure placed residents at risk of urinary tract infection. Findings included: Record review of Resident #189's face Sheet, dated 12/11/24, reflected the resident was a [AGE] year-old male who was admitted on [DATE]. Record review of Resident #189's MDS dated [DATE] reflected the resident's cognition was moderately impaired with a BIMS score of 07. Active diagnosis included Indwelling catheter (including suprapubic catheter and nephrostomy tube), ostomy, cancer, hypertension, benign prostatic hyperplasia, renal insufficiency, obstructive uropathy, diabetes mellitus, fractures, and stroke. Section GG reflected resident required partial/moderate assistance with toileting hygiene and toilet transfers. Section H indicated indwelling catheter. Record review of Resident #189's care plan dated 12/11/24 reflected resident at risk for problems with elimination related to history of urinary tract infection. Goals included residents' elimination status will be maintained or improved over the next 90 days. Decrease in number of incontinent episodes by implementation of a scheduled toileting program over the next 90 days. Interventions included Monitor signs for symptoms of urinary tract infection. Observe pattern of incontinence, and initiate toileting schedule or prompted voiding if indicated. Uses brief. Resident with urinary catheter related to anatomical or functional diagnosis. Goal included resident will be free complications of indwelling catheter over the next 90 days. Interventions included care/changing of urinary catheter as ordered. Confer with physician regarding the continued need of urinary catheter, consider the risks and benefits of continuing the long-term use of an indwelling urinary catheter and remove it as soon as possible if indicated. Monitor urine appearance, amount, odor, clarity. Record review of Resident #189's order summary report dated 12/11/24 reflected the resident had an order for: 1. Foley Catheter 16 Fr (CATHETER) 1 Urethral every shift Bulb size 10cc ***PROVIDE CATHETER CARE, MONITOR FOR SECURITY STRAP AND PRIVACY BAG PLACEMENT*** 2. Catheter as Needed CLOGGED /DISLODGED Change foley catheter (change drainage bag with catheter change) CDC recommendation: Change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised (continued on next page)

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Catheter every shift Assess for bladder distention, small frequent voids, dribbling, resident complaint of bladder feeling full. Complications can include an increased risk of urinary tract infection, blockage of the catheter with associated bypassing of urine, expulsion of the catheter, pain, discomfort, and bleeding, if present notify MD. Observation and interview on 12/08/24 at 2:07 PM revealed Resident #189's catheter bag was laying on the floor on the side of the bed. Resident #189 revealed at times he can feel the catheter pulling but could not tell if it was from the bag being on the floor. Observation and interview on 12/10/24 at 2:37 PM revealed Resident #189's catheter bag was laying on flat in bed with urine in the line near the insertion cite. Resident #189's catheter bag was tangled with both his nephrostomy tubes. Resident #189 stated he felt pressure and felt like he could not urinate. LVN G observed the urine collection bag on Resident #189's bed. LVN G stated the resident catheter bag should be hung at the lowest part of the bed, not doing so placed resident at risk of urine flowing backwards causing pain or discomfort to the resident. LVN G stated it was the responsibility of all nursing staff to ensure his catheter bag was placed properly in a hanging position, not laying flat. Observation and interview on 12/11/24 at 2:07 PM revealed Resident #189's catheter bag was laying on the floor on the side of the bed. Resident #189 stated he was not aware his catheter bag was on the floor. Resident #189 stated he was not aware of whom his aide or nurse was, that it had been a while since he had last seen staff. Observation and interview on 12/11/24 at 2:15 PM with LVN K revealed it was the responsibility of all nursing staff to ensure all catheter bags were hanging on the lowest part of the resident's bed. LVN K entered Resident 189's room to reveal his catheter bag on the floor. LVN K stated having the catheter bag on the floor left resident at risk of infection and contamination. LVN K stated the aide was good about assisting residents with picking the catheter up off the floor; however, she could not do it while picking up trays from the rooms. Interview on 12/11/24 at 2:20 PM with ADON C revealed she was not aware Resident #189's urine collection bag was observed the floor several times. ADON C stated resident catheter bags should not be on the floor but hung low to allow for gravity to work, not doing so placed residents at risk of infection and bacteria. ADON C stated all nursing staff were responsible for ensuring urine collection bags were not on the floor at all times. Interview on 07/25/24 at 6:00 PM with DON revealed she was not notified by the that Resident #189's catheter was found on the floor. The DON stated her expectation was for all nursing staff to ensure catheter bags were hanging properly to allow the fluid to drain properly by flow of gravity. The DON stated if not residents were placed at risk of decline in health, possible infection and leaking. DON further stated phyician orders were expected to be followed, ADONs and floor nurses were responsible to ensure physician orders were being followed. Record review of the facility's Care and Removal of an Indwelling Catheter policy, dated 01/12/20, reflected: Staff will provide care of an indwelling catheter in accordance with standard practice guidelines. Evaluate the need for catheter care, provide privacy, and assist resident to a comfortable position.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview, and record review, the facility failed to ensure residents maintained acceptable parameters of nutritional status for 1 of five resident (Resident #81) reviewed for nutrition. The facility failed to ensure Resident #81 maintained acceptable parameters of nutritional status and provide timely interventions as demonstrated by Resident #81 experiencing a 15.51% weight loss in 30 days from October to November. Resident #81 had not continued to lose weight from November to December, however. This failure could place residents at risk for decreased nutritional status, decline in health, serious illness, or hospitalization . Findings included: Review of Resident #81's face sheet, dated 12/10/24, reflected she was an [AGE] year-old female who admitted to the facility on [DATE]. Review of Resident #81's Admission MDS Assessment, dated 10/03/24, reflected she did not have a BIMS score calculated (a term used to screen and identify a resident's cognition) Her active diagnoses included stroke (when blood flow to a part of the brain is interrupted, leading to brain cell death), Alzheimer's Disease (a type of brain disorder that causes problems with memory, thinking and behavior), and Depression (characterized by persistent feelings of sadness and loss of interest in activities once enjoyed). Her functional abilities included needing partial/moderate assistance with eating and no indication of weight loss was noted. Her MDS indicated she was on a therapeutic diet. Review of Resident #81's Consolidated Orders for December 2024 reflected the following: -as of 12/09/24, Daily Multivitamin-Minerals tablet, 1 tablet by mouth 1 time per day -as of 12/09/24, 2.0 Cal Med Pass Supplement () 60 Milliliters by mouth 4 times per day with medication pass [sic] Review of Resident #81's Care Plan, initiated 09/27/24, reflected the following: Care Area/Problem: Altered Nutritional Status, Evidenced by: Diet: Consistency- Regular .Interventions: Monitor oral intake of food and fluid . Review of Resident #81's electronic health record revealed under the weights tab of her chart was the following dates and weights: -10/03/24 149.6 pounds -11/4/24 89.6 pounds (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #81's Nurses Note from 11/26/24 reflected the following: LVN Q wrote During breakfast, resident noted to be pocketing food. 25% of meal consumed. NP notified. Interview on 12/09/24 at 11:27 AM on the phone with Resident #81's RP revealed he knew her eating habits could not be helped because she was on antipsychotics due to her dementia. Resident #81's RP said a long time ago, a doctor had explained to him that eventually she would not be able to eat on her own due to her conditions so other family members went to the facility to make sure she was assisted with her meals and encouraged to eat. Resident #81's RP said other family members who visit the resident daily have noticed her weight loss and communicated that with him. Interview on 12/10/24 at 4:28 PM on the phone with Physician P revealed he needed a few minutes to review Resident #81's chart before answering the surveyor's questions. Physician P said after reviewing Resident #81's chart her weight loss was related to sarcopenia (the loss of muscle mass specifically related to aging. It's normal to lose some muscle mass as you age) which was unavoidable but there were things the facility could put in place to slow the weight loss down. Physician P said he was not aware that Resident #81 had a decrease in appetite or was pocketing food and that he normally would be notified of those things so he could put interventions in place. Physician P said more than likely, Resident #81 was going to lose weight regardless of what interventions were put in place though. Observation and interview on 12/09/24 at 12:00 PM with Resident #81 revealed she was in the dining room sitting in a wheelchair with a family member seated next to her. Resident #81's family member had brought a protein shake with her from outside of the facility and was encouraging the resident to drink some of it. Resident #81 could be heard and seen refusing to drink the protein shake initially but eventually did accept some of it. When Resident #81 received her meal tray, the resident said she was cautious of the food and said it was terrible and that she did not want to eat any of it. Resident #81's family member was seen attempting to assist the resident with eating some of the food from the plate and once the resident had the food in her mouth, she was seen pushing it to the sides of her mouth and holding the food in her cheek. Resident #81 was seen not swallowing or attempting to chew the food. The surveyor asked Resident #81 if she wanted something different like a soup, sandwich, or salad and Resident #81 said no and that she was cautious of all the foods and that she did not believe the food was good. Interview on 12/09/24 at 1:00 PM with LVN B revealed she was new to the secured unit and to Resident #81, but she had noticed the resident pocketing food and not eating as much while she had been caring for her. LVN B said the family brought in shakes for Resident #81 to drink. LVN B said she was not sure if Resident #81 had lost weight or not and was not sure if the NP or Physician had been notified of these things. Interview on 12/10/24 at 10:05 AM with CNA A revealed she worked PRN and was newer to the secured unit. CNA A said it was normal for Resident #81 to not eat a lot, even if staff tried to assist her with eating. CNA A said Resident #81's family member was trying to help her eat yesterday (12/09/24) but she was refusing. CNA A said sometimes Resident #81 would eat and sometimes she would not; but when she did not she was offered a shake . CNA A said sometimes she would drink the shake but sometimes she did not, it depended on how she was feeling that day. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/10/24 at 2:04 PM with the Dietitian revealed she saw the 89.6 pounds weight entered into Resident #81's chart but wanted to get another weight for her because it did not seem right. The Dietitian said Resident #81 was put on her radar last month due to the weight and was not sure why a new weight was not provided to her by the ADON or DON. The Dietitian said she was not sure why the weight was not followed up on over a month ago. The Dietitian said she did not believe Resident #81 had lost that much weight and could not pull up additional information in the system at this time to provide more information. The Dietitian said she would look into it and follow-up at a later time. Interview on 12/10/24 at 2:52 PM with ADON D revealed the 89.6 pounds weight in Resident #81's chart was not right. ADON D said she only received the weights for each resident and entered the information; she was not aware that the new weight indicated such a significant weight loss. ADON D said she worked the memory care unit last week and saw that Resident #81 had a decline and decrease in appetite. ADON D said she sat at the table with Resident #81 and tried to help her to eat but she did not eat. ADON D said normally when staff noticed a resident had a decrease in appetite they would notify the doctor. ADON D said since this was only the first time she saw Resident #81 had a decrease in appetite she wanted to wait and see if it was going to be a pattern or not. ADON D said Resident #81 also had family with her at mealtimes and even the family could not get the resident to eat the meal in front of her. Interview on 12/10/24 at 3:08 PM with ADON C said she was not aware that Resident #81 had lost weight, was pocketing food, or had loss of appetite. ADON C said normally staff would share their concerns they had with her to see what interventions need to be put in place and would notify the family and doctor about their concerns. ADON C said she was not sure why nothing had been done to address Resident #81's weight loss or to see if the 89.6 pounds was an accurate weight. Observation on 12/10/24 at 3:14 PM of Resident #81 being weighed in her wheelchair with a scale revealed she weighed 166.2 pounds. Resident #81 was taken back to her room and placed in bed, while the Infection Preventionist and Staffing Coordinator brought her wheelchair back to the scale to be weighed at 3:18 PM. The wheelchair weighed 39.6 pounds. This meant that Resident #81 weighed 126.6 pounds. [This reflected a 15.51%, or 22.8 pounds, weight loss since admission, 09/27/24.] (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/10/24 at 4:38 PM with the DON revealed she had paper copies of all residents' weights for November and December 2024. The DON showed for November 2024 next to Resident #81's name was 89. 6 crossed out and 126 written next to it. The DON showed for December 2024 next to Resident #81's name was 126.4 x2 written next to it. The DON explained that Resident #81 was confused with a different resident when being weighed and that was why there was a weight discrepancy in her chart, and why the 89.6 lbs was added instead of the 126.4 lbs weight that should have been entered for her November weight. The DON said even with the 126.4 pounds, it indicated Resident #81 had weight loss from admission that had not been addressed. The DON said she knew Resident #81's appetite was going down, but she was not aware the resident was pocketing her food. The DON said Resident #81 was in the other building's secured unit and was not eating as much so she was moved to the other building's secured unit for less stimulation and seemed to be doing better. The DON said both the Physician and Dietitian could see weights in a resident's chart when they came to review care for the resident. The DON said weights were reviewed every week by the nursing department as well, but she was not sure why no one had noticed the weight discrepancy. The DON said if the nursing staff noticed Resident #81 pocketing food or having a hard time swallowing, they could put in a referral to speech therapy to see if their diet consistency needed to be changed or a swallow study needed to happen. The DON said if Resident #81 had an appetite change or was not eating the same it would be the same process, but that the Physician should be notified as well. The DON said lots of things could happen to a resident who was losing weight due to an appetite change or pocketing food; that the outcome depended on their disease process. Review of the facility's policy revised 01/12/20, and titled Weight Monitoring reflected: 2. Monthly: b) Unplanned and undesired weigh variance will be evaluated for significance utilizing the Resident Assessment Instrument Guidelines and will be reweighed according to the RAI guidelines are as followed: i. 5% in thirty (30) days, ii. 7.5% in ninety (90) days, iii. 10% in one hundred-eighty (180) days .e) If the monthly weight gain or loss shows significance as indicated in (b) above, the resident is reweighed within twenty-four (24) hours to assure accuracy of weight. f) if the reweigh identifies there is an actual weight gain or loss according to RAI guidelines outlined in (b), the resident/family, physician and Registered Dietician are notified via phone, the Registered Dietician via email. The date of such notification is documented in the nurse's notes in the HER. g) The Registered Dietitian reviews the resident's nutritional status and makes recommendations for interventions in the nutritional therapy assessment if significant weight change is noted. h) Significant, unplanned changes in weights are reviewed at the Standards of Care Committee meeting. The Committee will also identify any gradual weight loss.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation, interview, and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored securely for 2 (Resident #177 and Resident #189) of 18 residents and for 1 (100 Back Hall cart) of 8 carts reviewed for secure medication storage. 1. RN-F failed to secure his medication cart. 2. Resident #177 had 1 new box of arthritis pain cream stored at the resident's bedside table not locked in a lock box or secured in the medication cart or medication room. 3. Resident #189 had a tube of arthritis pain cream, zinc oxide cream, and eye drops inside his nightstand table not locked in a lock box or secured in the mediation cart or mediation room. These failures could place residents at risk of accessing medications not prescribed for them, and at risk of overmedicating or adverse drug reactions. Findings included: 1.Observation and interview on 12/08/24 at 11:15 AM revealed the nurse medication cart for the 100 Hall was unsecured, the locking mechanism was not depressed. RN-F was observed to be seated at the nurse's station charting on the computer, then getting up to go into the medication room and then returning to the computer at the nurse's station. All of the drawers for the cart were able to be opened. RN-F stated he did not know why the cart was unlocked. He confirmed he had the only key for the cart, and he was responsible for locking it when he stepped away from it. RN-F stated the risk of leaving the cart unlocked was residents gaining access to the medications and possibly taking medications not meant for them. 2.Record review of Resident #177's Face Sheet, dated 12/11/24, revealed the resident was a [AGE] year-old male who was admitted on [DATE]. Review of Resident #177's MDS dated [DATE] revealed the resident's cognitive was intact with a BIMS score left blank indicating score was not obtainable. Active diagnosis included fractures and other multiple traumas, cancer (abnormal cell growth with potential to spread to other parts of the body), anemia (blood disorder), coronary artery disease (heart disease), hypertension, dementia (decline in cognitive abilities), anxiety disorder (significant and uncontrollable feelings), depression (feelings of severe despondency). Section J did not indicate resident experienced any pain. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #177's care plan, dated 12/11/24, revealed the resident had care area/problem History of severe pain with Goal: Risk for negative outcomes related to black box warning will be reduced/minimized over this review period. Patient will rate pan as a 2/10 or less at the end of the shift. Interventions included ask physician to review medication for possible does reduction every three months, monitor for constipation, nausea, vomiting, sedation, lethargy, weakness confusion, dysphoria, physical and psychological dependency, hallucinations, unintended respiratory depression, report pertinent lab results to physician. Care area/problem related to chronic pain with Goal: Resident will report or demonstrate relief of pain every day over the next 90 days, Cognitively Impaired: Painaide will be used to assure resident demonstrates decreased signs of pain over the next 90 days. Resident will have pain assessed and managed for optimal comfort. Interventions included assess characteristics of pain; location, severity, on a scale 1-10, type of pain, frequency, precipitating factors, and relief factors using the pain assessment form. Give pain medications before pain becomes severe. Instruct family/resident about pain care and pain medications. Notify physician of any changes in level or frequency of pain and increase in the use of prn pain medications and any noted side effects of pan medications. Observe resident for sings of pain with care and interactions, obtain pain history, intensity, frequency. Obtain resident's pain tolerance and attempt to maintain pain tolerance level. Reassess interventions with any changes in response to pain or pain medication and with every assessment. Record review of Resident #177's order summary report dated 12/11/24 did not reveal physician's order for arthritis pain cream (over-the-counter medication used to treat symptoms caused pain). The orders further reflected: Check Pain Scale every shift indicated pain scale and location due to diagnosis Pathological fracture, left lower leg. Start date 09/23/24. Acetaminophen 300 mg-codeine 30 mg tablet. 1 tablet by mouth every 8 hours as needed for pain due to diagnosis of iron deficiency anemia. Start date 08/28/24. Observation on interview on 12/11/24 at 11:51 AM revealed Resident #177 with a new box of arthritis pain cream stored at the resident's bedside table. According to Resident #177, he used the cream for pain on his knees. Resident #177 was not able to communicate where he received the medication. Interview and observation with RN I on 12/08/24 at 11:55 AM, who was the charge nurse for Hall 100, revealed this was his first time working with Resident #177 however, the facility did not have residents who self-administered medications. RN I stated Resident #177 had complaints of constipation but no bodily pain. Observation in resident room revealed new box of pain cream at bedside table. RN I stated Resident #189 did not have an order for the cream and having the medication in his possession placed him at risk of overuse the medication or adverse reactions. RN I stated residents were not allowed to have medications in their rooms, and residents' families were educated not to leave over-the-counter medications with the residents. RN I was observed removing the pain cream from the bedside table. RN I stated it was the responsibility of all nursing staff to remove any medications from resident's bedside, he stated he did not see the mediation when rounded upon start of his shift. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/08/24 at 12:00 PM with ADON J revealed she covered this hall, ADON J stated she had spoken with family previously about bringing in over-the-counter medications and leaving them with Resident #177. ADON J stated she had educated both Resident #177 and his family that it was important to inform the nursing staff of any complaints of pain, so the nursing staff can alert the physician so interventions could be put into place. ADON J stated medications are not to be administered by residents, she expected nursing staff to remove any over the counter medications and notify her immediately. ADON J stated it was not safe for residents to have medications in their room it placed them at risk of adverse reactions. ADON J stated Resident #177 had an order to pain management however did not have an order for the over-the-counter pain cream. 3. Record review of Resident #189's face Sheet, dated 12/11/24, revealed the resident was a [AGE] year-old male who was admitted on [DATE]. Review of Resident #189's MDS dated [DATE] revealed the resident's cognition was moderately impaired with a BIMS score of 07. Active diagnosis included Indwelling catheter (including suprapubic catheter and nephrostomy tube), ostomy (a surgically created openig to the intestines), cancer, hypertension, benign prostatic hyperplasia (enlarged prostate), renal insufficiency (decreased kidney function), obstructive uropathy (structural hinderance of normal urine flow), diabetes mellitus, fractures, and stroke. Section J revealed the resident received or was offered pain medications as needed. Review of Resident #189's care plan, dated 12/11/24, revealed the resident had care area/problem History of severe pain with Goal: Risk for negative outcomes related to black box warning will be reduced/minimized over this review period. Patient will rate pan as a 2/10 or less at the end of the shift. Interventions included ask physician to review medication for possible dose reduction every three months. Monitor for constipation, nausea, vomiting, sedation, lethargy, weakness confusion, dysphoria, physical and psychological dependency, hallucinations, unintended respiratory depression. Report pertinent lab results to physician. Care area/problem related to pain with Goal: Resident will report or demonstrate relief of pain every day over the next 90 days, resident will have pain assessed and managed for optimal comfort. Interventions included administer pain medications as ordered. Assess characteristics of pain; location, severity, on a scale 1-10, type of pain, frequency, precipitating factors, and relief factors using the pain assessment form. Give pain medications before pain becomes severe. Instruct family/resident about pain care and pain medications. Notify physician of any changes in level or frequency of pain and increase in the use of prn pain medications and any noted side effects of pan medications. Observe resident for sings of pain with care and interactions, obtain pain history, intensity, frequency. Obtain resident's pain tolerance and attempt to maintain pain tolerance level. Reassess interventions with any changes in response to pain or pain medication and with every assessment. Record review of Resident #189's order summary report dated 12/11/24 revealed he had an order for: Tylenol 325mg tablet 650 milligrams by mouth every 6 hours as needed Pain/temperature for not exceed 3mg/day. Hydromorphone 4mg/m/ oral solution .5ml 2Milligram sublingually I(under the tongue) every 4 hours as needed for pain/short of breath. Hydromorphone 4mg/m/ oral solution .75ml 3Milligram sublingually every 4 hours as needed for pain/short of breath. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hydromorphone 4mg/m/ oral solution 1 Milliliter sublingually every 4 hours as needed for pain/short of breath. Interview and observations on 12/08/24 at 2:07 PM revealed Resident #189 in bed, stated he was in pain on his left torso area, Resident #189 was instructing surveyor to his bedside table to get pain aide cream out of the nightstand drawer. Observation of Resident #189 reach over into the drawer and pulled out 1 tube of over-the-counter arthritis pain cream and zinc oxide cream. Resident #189 was observed to apply the cream to this left side back area, further explaining when he was in pain, he administered the pain medication. Resident #189 was asked if nursing staff assisted him with administering the cream and he responded, they take too long to answer the call light so he would do it himself. Interview with LVN K on 12/08/24 at 2:15 PM, who was the charge nurse for Hall 200, revealed her assignment included Resident #189. LVN K stated residents were not allowed to self-administer their own medications. She stated residents were not allowed to have medications in their rooms. LVN K was observed going to Resident #189's room, and she asked the resident about the pain cream now located on top of nightstand. Resident #189 stated he used it to relieve pain and pointed toward his kidney area on the left side. LVN K was observed removing the pain cream and zinc cream from the nightstand. LVN K stated it was nursing staff's responsibility to remove any over the counter medications from resident rooms, not doing so placed residents at risk of having adverse reactions and staff not being aware of why the resident was having a reaction. Interview on 12/11/24 at 2:19 AM with the ADON C revealed residents should not have any medications in the room with them. The ADON C stated nursing staff were responsible for ensuring residents did not have any type of medications whether over the counter or prescribed in their rooms. The ADON C stated Resident #189 should not have any type of pain creams in his room because it placed him at risk of those medications negatively interacting with other medications. The ADON C stated Resident #189 frequently had visitors and they probably were bringing him over the counter medications. Interview on 12/11/24 at 3:21 PM with the DON revealed residents were not supposed to have medication of any kind in their rooms. The DON stated all medications were kept on the medication carts, not in the possession of the residents. The DON stated it was the responsibility of the nursing staff to remove any pills, prescriptions, or over-the-counter medications from resident rooms. The DON stated residents having medications in their rooms put them at risk of double medicating, staff not knowing what they are taking, or other residents could get ahold of them. Review of the facility's policy Storage of Medication, dated January 2024, reflected: Medications and biologicals are stored properly, following manufacturer's recommendations, to keep their integrity and to support safe effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. 44937

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview, and record review, the facility failed to ensure food was prepared and served according to the resident's assessment, plan of care, and in a form designed to meet the resident's needs for 1 (lunch on 12/10/24) of 3 meals reviewed for resident's needs. The facility failed to follow Resident #29's physician's order for pureed consistency food and nectar thickened liquids for the lunch meal on 12/10/24. This failure could place residents at risk of decreased food intake, weight loss and an increased risk of aspiration. Findings include: Review of Resident #29's face sheet, dated 12/11/24, reflected he was a [AGE] year-old male who originally admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #29's Quarterly MDS Assessment, dated 10/31/24, reflected he had a BIMS score of 05, indicating severe cognitive impairment. His diagnoses included pneumonia (an infection that inflames the air sacs in one or both lungs), Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA) or stroke (occurs when something blocks blood supply to part of the brain), and seizure disorder or epilepsy (a long-term brain condition where a person has repeated seizures). He also had complaints of difficulty or pain with swallowing and had a mechanically altered diet while a resident. Review of Resident #29's Consolidated Order, dated 12/11/24, reflected the following: Diet: Consistency- Puree .Diet: Liquids- Nectar/Mildly thick . Review of Resident #29's Care plan, initiated on 11/04/24, reflected the following: Care Area/Problem: Altered Nutritional Status, Evidence By: Therapeutic diet .Diet: Consistency- Puree .Diet: Liquids- Nectar/Mildly Thick . Review of Resident #29's meal ticket for Lunch- Day 10 reflected the following: Diet: Large Portion, Texture: Pureed Level 4, Liquid: Mildly Thick(2)/Nectar .Menu: Pureed Meatball Sub on Bun, Pureed Steamed Broccoli, Pureed Boston Cream Pie, Coffee or Tea- Nectar/Mild Thick (2), Water-Nectar/Mild Thick (2). Review of Resident #29's Nurses Note reflected the following: -On 12/10/24 ADON C wrote: At lunch time this resident consumed 1 potato chip and about half a glass of thin liquids. Items removed, tea replaced with thickened apple juice. No coughing noted education done with the resident and dietary manager notified to do education with there [sic] staff. The patient states I'm ok, I knew I wasn't supposed to have it, but I just ate one. [sic] No acute distress noted. [NP O] notified of the same, received new orders to do speech evaluation and treat and monitoring for any coughing and if occur obtain stat chest X-ray [sic]. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/10/24 at 12:50 PM of Resident #29 revealed he was sitting at a table in the dining room in his wheelchair. Resident #29 had a plate in front of him with food that was a pureed consistency. Resident #29 had a bowl of whole potato chips served to him by a woman passing by. Resident #29 was observed taking a whole potato chip from the bowl and eating it. (The surveyor found a staff from the nursing department and informed them that Resident #29 was eating whole potato chips but was ordered a pureed diet.) The potato chips were removed from Resident #29 by a member of the nursing department. Interview on 12/10/24 at 12:53 PM with [NAME] N revealed she was passing whole potato chips to residents in the dining room and gave Resident #29 a bowl of whole potato chips. [NAME] N said she was told to only give the whole potato chips to any resident with a sub sandwich and thought Resident #29 had one on his plate. [NAME] N said she did not see that Resident #29 had a plate of pureed food and not a whole sub sandwich in front of him. Observation on 12/10/24 at 1:00 PM of Resident #29 revealed he was telling Nutrition Aide L that he was missing his cake from his meal. Observation on 12/10/24 at 1:05 PM revealed Resident #29 had a whole piece of cake in front of him and he was attempting to take a bite of it. (The surveyor intervened and told someone from the nursing department that Resident #29 had a whole piece of cake, and they took it away from him before he could eat any of it.) The Dietitian brought Resident #29 a bowl of pureed cake to eat. Observation on 12/10/24 at 1:06 PM revealed Resident #29 had a cup of mostly drank tea in a glass in front of him; the tea was not thickened. The Dietitian took the tea away saying, It was not nectar thick and another staff member brought Resident #29 nectar thickened juice for him to drink. Interview on 12/10/24 at 2:04 PM with the DM, Dietitian, and Assistant Administrator revealed he was not sure what happened or why Resident #29 was served whole potato chips as they should not have been available to him. The DM said the person who passed the whole potato chips to Resident #29 should have recognized that he was ordered a pureed diet and not to give him whole potato chips. The DM said he was not sure why Resident #29 was served whole cake. The Dietitian said all staff should have seen the resident with pureed food and provided him with the pureed cake instead. The DM said the kitchen had thickened liquids readily available, so he was not sure why Resident #29 was given thin liquids instead today during lunch. The DM said the staff member passing liquids out should have known what the resident required. The DM said the purpose of providing residents with their ordered diet was to prevent them from aspirating (when contents such as food, drink, saliva or vomit enters the lungs) and choking which could ultimately kill someone even if it was an accident. The DM said each person in the dining room was responsible for looking at a resident's meal ticket to ensure they were provided the correct diet for food and drinks. The DM said he counted on the nursing department to catch any mistakes made by the dietary department. Review of the facility's policy, revised 02/06/24, and titled Menus reflected the following: Nutrition Services will provide a nourishing, palatable, well-balanced meal that observes the nutritional requirements, special dietary needs, preferences, and allergies of each resident.

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

41781

Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 2 of 2 kitchens (North kitchen and South kitchen) reviewed for food and nutrition services.

1. The facility failed to ensure food items were labeled and dated with name of product, date opened, and use by date.

2. Nutrition Aide M failed to wear a beard guard while prepping drinks for the lunch meal on 12/10/24.

3. Nutrition Aide L failed to wear a beard guard while putting away clean dishes on 12/10/24.

These failures could place residents at risk for food borne illness.

Findings included:

1. Observation on 12/08/24 at 9:16 AM of the facility's North Building kitchen revealed the following:

-cooked chicken and rice soup in a plastic container was not labeled and did not have a prepared date or use by date.

-cheese in a plastic container was not labeled and did not have a prepared date or use by date.

-sauteed mushrooms in a plastic container was not labeled and did not have a prepared date or use by date.

-cooked meatloaf in a plastic container was not labeled and did not have a prepared date or use by date.

-a bag of uncooked biscuit did not have an open date.

-ground meat in the fridge thawing with no pulled out or used by date.

-three component cereal container not dated or used by date.

Interview on 12/08/24 at 9:36 AM with [NAME] R revealed all items that had been open or leftover food should be labeled and dated. She stated for meats that were pulled from the freezer to thaw should be dated with the date that was removed from the freezer. She stated it was the responsibility of all kitchen staff to ensure everything was dated and labeled. She stated the potential risk would be residents getting sick.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/09/24 at 2:34 PM with DM S revealed her expectations were for her staff to label and date any open or left over items. She stated her staff and herself were responsible for ensuring all open and leftover items were labeled and dated. She stated this failure would cause food borne illness. Review of the facility policy Use of Leftovers revised 02/06/24, reflected the following: Leftovers will be properly handled and used. . 2. Leftovers should be covered, labeled, dated and stored appropriately. Record review of the Federal Food Code, 2022, reflected 3-501.17, Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking, revealed (A) .food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold or discarded when held at a temperature 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. And (B) .refrigerated, ready-to-eat time/temperature controlled for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24-hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations .and .(2) The day or date marked by the food establishment ay not exceed a manufacturer's used-by date if the manufacturer determined the use-by date based on food safety. 2. Observation on 12/10/24 at 11:20 AM of the facility's South Building's kitchen revealed Nutrition Aide M had a mustache but was not wearing a beard guard. Nutrition Aide M was prepping drinks for the lunch meal service on 12/10/24. Interview on 12/10/24 at 11:33 AM with Nutrition Aide M revealed he forgot to put on a beard guard before starting service today. Nutrition Aide M said he knew he needed one because of his facial hair. 3. Observation on 12/10/24 at 11:28 AM of the facility's South Building's kitchen revealed Nutrition Aide L was wearing a surgical mask but not a beard guard and had a full beard. Nutrition Aide L was taking clean dishes from the dishwasher and putting them on drying racks or putting them away. Interview on 12/10/24 at 11:30 AM with Nutrition Aide L revealed he knew he was supposed to have a beard guard on because he had facial hair. Nutrition Aide L said he forgot to get one when he clocked in for work earlier. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/10/24 at 2:04 PM with the DM, Dietitian, and Assistant Administrator revealed both Nutrition Aides M and L had facial hair and were not wearing beard guards while in the kitchen earlier in the day. The DM said there were not any beard guards available for them to use as he had taken the last one this morning. The DM said normally beard guards were always available to staff to use and they had been trained to make sure they were wearing one if they had facial hair. The DM said they could have used hair restraints instead as those were available. The DM said the purpose of wearing the beard guard was so that hair would not get in a resident's food and contaminate it. The DM said he was responsible for making sure that staff had beard guards available to them and were using them at all times. The DM said normally he would monitor the kitchen staff to ensure they were wearing beard guards at all times. Review of the facility's policy revised 02/06/24, and titled Employee Infection Control, reflected: .5. Anyone who enters the kitchen will have all hair restrained using bouffant caps, mesh or net, beard guard and clothing which covers body hair . Record review of the Federal Food Code 2022 reflected: 2-402.11 Effectiveness. (Hair Restraints) 1. Code of Federal Regulations, Title 21, Sections 110.10 Personnel. (b) (1) Wearing outer garments suitable to the operation (4) Removing all unsecured jewelry (6) Wearing, where appropriate, in an effective manner, hair nets, head bands, caps, beard covers, or other effective hair restraints (8) Confining .eating food, chewing gum, drinking beverages or using tobacco and (9) Taking other necessary precautions 44140

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a centralized staff work area and to ensure call light cord was accessible for 1 of 35 residents (Resident #130) reviewed for call light access. The facility did not adequately equip Resident #130's room with a call light cord to allow the resident to call for assistance. This failure could place residents at risk of not being able to call for assistance when needed. Findings included: Review of Resident #130's Face sheet, dated 12/10/24, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. Review of Resident #130's quarterly MDS assessment, dated 10/27/24, reflected he had diagnoses of hypertension (high blood pressure) and hemiplegia (paralysis on one side of the body) and hemiparesis (one-side muscle weakness). His brief interview for mental status assessment was unable to be completed due to the resident was rarely/never understood. The MDS further indicated Resident #130 was partial/moderate assistance from staff. Review of Resident #130's care plan, updated on 09/17/24, reflected Problem: Fall Risk: [Resident #130] has the potential for falls related to cognitive status. Goal: [Resident #130] Resident at Risk for Falls resident safety will be maintained over the next 90 days. Interventions: Keep call light and most frequently used personal items within reach. Observation and interview on 12/08/24 at 11:08 AM revealed Residents #130 lying in bed. Observation further revealed no call light cord for Bed A (Resident #130). Interview with Resident #130's revealed he had no call light cord and could not explain for how long he did not have a call light. Resident #130 stated he pushed his call light at times for help, but he was able to ambulate to the nurse's station. Observation and interview on 12/09/24 at 8:18 AM with CNA H revealed Resident#130 did not have a call light cord. She stated she was the CNA assigned to Resident #130. She stated every resident should have a call light cord in their room and within reach. CNA H stated she was not aware Resident #130 did not have a call light cord and she had not noticed during the rounds. She stated in case of a missing call light staff was supposed to document on the maintenance logbook and report to the Maintenance Director. She stated it was all staff's responsibility to check for call rights while performing the 2 hourly rounds. She stated the potential risk of not having a call light would be residents not being able to ask for help. She stated she had done training on call lights checking and answering.She was not asked on type of assitance she offered to resident #130. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/09/24 at 8:24 AM with LVN F revealed he was the nurse assigned to Resident #130. LVN F stated he had not noticed Resident #130 did not had a call light cord until it was pointed out today (12/09/24). He stated the potential risk would be residents would be unable to call for assistance. He stated staff was supposed to document on maintenance logbook and notify the maintenance director in case of missing call light or call that are not functioning. Interview on 12/09/24 at 8:28 AM with the ADON revealed each resident should have a call light cord in their room and within reach. It was all staff's responsibility to check and ensure residents have the call light within reach and they have call light in their rooms. She stated she was unaware Resident #130 did not have a call light. She stated the risk of not having a call light would be not getting help and needs not being met. Observed the ADON review the maintenance logbook and stated there had not been any requests for call lights documented. Interview on 12/10/24 at 2:08 PM with the Maintenance Director revealed each resident should have a call light in their room. He stated he was unaware Resident #130 did not have a call light until on12/09/24. The Maintenance Director stated he had a maintenance logbook on each nurse's station, and they were checked daily by the maintenance department and there was no documentation of call light missing and those that were reported were already replaced. He stated he had not had any requests for call lights. Interview on 12/11/24 11:12 AM with the DON revealed each resident should have a call light in their room and within reach and functioning. She stated she was unaware Resident #130 did not have a call light. She stated she expected the staff to document on maintenance logbook so that the call light was replaced if not functioning. She stated the risk of not having a call light in place and functioning would be safety. Review of the facility's Call Lights Answering policy, dated 01/19/23, reflected: The staff will provide an environment that helps meet the needs of the resident by answering call lights appropriately. .7. When leaving the room, be sure the call light is placed within the resident's reach. The policy did not address room being equipped with a functioning call light.