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	10/12/2021

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35314 Based on observation, interview, and record review, the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for one (Resident #34) of 7 residents reviewed for accidents The facility failed to assess Resident # 34 after she was found on the floor after an unwitnessed fall. CNA B picked the resident up and placed her in bed without an assessment being completed. The resident was sent to a local emergency room and diagnosed with separated shoulder and fall. The failure placed residents at risk of injury, pain, hospitalization and a diminished quality of life. Findings include: Record review of Resident # 34's face sheet dated 10/12/21 revealed she was an [AGE] year old female admitted to the facility on [DATE]. Her diagnoses included COVID-19, Dementia and muscle weakness. Record review of Resident #34 's annual MDS assessment, dated 09/10/21, revealed Resident #34 had a BIMS score of 00 out of 15 which indicated severe cognitive impairment. She required extensive assistance from one staff for transfers and bed mobility. She was always incontinent of bowel and bladder. The resident had falls listed. Record review of Resident #34's Comprehensive Plan of Care dated 07/18/18 revealed she had short term memory loss. The resident was identified as high risk for falls. The facility would Fall-related complications, such as injury or change in cognitive function, will be promptly assessed and treated to prevent adverse outcomes dated 09/22/21. Interventions included, assess contributing factors related to fall history. Assist resident with toileting. Frequent visual checks. Observation on 10/21/21 at 12:45 pm revealed Resident # 34 in bed. The resident had discoloration to her left shoulder that was red and purple. The residents left shoulder did not align with the right shoulder, it was elevated. (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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with CNA B on 10/12/21 at 10:07 am revealed she had worked with Resident # 34 on 10/9/21 and 10/10/21 as the primary aide for the resident. On 10/10/21 she provided incontinent care on Resident # 34. She stated on the same day she entered the room of Resident # 34 and saw the resident on the floor. She stated when she saw the resident on the floor, she asked the resident if she had fallen and the resident replied yes. The resident stated did not have injures. She stated and she picked up the resident and placed the resident back into bed. She stated later during the shift she informed LVN C Resident # 34 had fallen out of bed and she helped her back into bed. She did not know Resident #34 had suffered a dislocated shoulder and was sent to the emergency room . She had not returned to work since the resident had the fall at the facility. Record review revealed CNA B last received training regarding fall management on 09/07/21 . She completed a fall prevention test on 08/05/21. She had a good knowledge of the facility's fall management. An interview with LVN C on 10/12/21 at 10:32 am revealed she worked on the evening of 10/10/21 with CNA B. During the shift she stated everything went well, there had not been any concerns regarding Resident # 34. She was not aware the resident had a fall. She stated CNA B had not informed her the resident had fallen. She stated if she was aware the resident had fallen, she would have instructed the aide to leave the resident on the floor until she was assessed for injury, she would have completed neuro checks, informed the physician, the resident family, contacted the DON. Review of the emergency room notes provided by the hospital dated 10/11/21 revealed Resident # 34 final diagnose was Left separated shoulder and fall. The x-ray revealed abnormal elevation of the clavicle relative to acromion compatible with AC joint injury . The left shoulder was raised, above the right shoulder. Review of the Incident/Accident reports for October 2021, revealed no evidence Resident # 34 had a fall on 10/10/21. Review of the nurse's notes dated 10/10/21 revealed no documentation of the resident having a fall and being assessed. Review of the nurse notes dated 10/11/21 revealed the following at 6:35 am the hospice notified the nurse of bruising to Resident #34's left shoulder. Head to toe assessment completed noted bruising/discoloration to left shoulder with minimal swelling. While attempting ROM resident unable to raise left arm c/o pain with facial grimacing noted .Completed by the nurse that work the day shift . An interview with the DON on 10/12/21 at 11:41 am revealed she was not aware Resident # 34 had a fall over the weekend, she stated nothing had been reported. She revealed CNA B had not communicated with the nursing staff regarding the fall. Her expectations were, if a resident is believed to have a fall the aides must immediately notify the nurse on the unit . From there the nurse would assess the resident, prior to removing the resident from the floor. She expected to receive a call or contacted regarding the fall. Review of the Incident/Accident Reporting policy dated 02/12/20 revealed In addition to the Incident/Accident report, for any unwitnessed incident/accident resulting in an injury, an investigation of injury of Unknown origin will be completed immediately upon facility staff becoming aware of the occurrence of the incident/accident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's Fall Management policy dated 02/12/20 If a fall occurs, the qualified staff assesses for injury from the fall, immediately investigates the reason and determines the intervention to prevent future falls-complete the Incident/Accident report in the electronic health records. The physician and family are notified.