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	05/14/2022

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28691 Based on observation, interview and record review the facility failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 2 of 6 residents (Resident #1 and Resident #2) reviewed for pressure ulcers/wounds. The facility failed to ensure Resident #1's wound treatments and wound assessments was completed daily to prevent the worsening of her pressure ulcer on her sacrum. The facility failed to promptly intervene when Resident #1's wound increased in size within six days: 03/16/22 the wound measured 1.7 CM x 0.3 CM X 0.1 CM and on 03/22/22 the measurements increased to 6.2 CM X 5.1 CM X 0.1 CM, which progressed to a Stage IV pressure ulcer with osteomyelitis and required hospitalization . The facility failed to ensure Resident #2 received interventions to prevent him from developing a pressure ulcer on his sacrum, that was already a Stage 3 when it was discovered. An Immediate Jeopardy (IJ) was identified on 05/13/22 at 12:19 PM. While the IJ was removed on 05/14/22 at 4:00 PM the facility remained out of compliance at scope of a pattern and a severity level of actual harm that is not Immediate Jeopardy, due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk of developing or worsening of wounds and placing them at risk of infection, a decline in health, pain, hospitalization , or death. Findings include: Review of Resident #1's face sheet dated 05/10/22 revealed she was an [AGE] year-old female readmitted to the facility on [DATE] and discharged to the hospital on 04/12/22. Resident #1's diagnoses included unspecified dementia without behavior disturbances, cerebral infarction (ischemic stroke), non-pressure chronic ulcer of skin of other sites with unspecified severity and aphasia (loss of ability to understand or express speech caused by brain damage). (continued on next page)

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

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's quarterly MDS dated [DATE], revealed she was rarely or never understood and rarely or never understands and her cognitive skills for daily decision making was severely impaired and she had no behaviors. Resident #1 was a total assist of two plus persons for bed mobility, transfer, and toilet use. Resident #1 required total assistance from one person for locomotion on unit, dressing, eating, personal hygiene and bathing. Resident #1 had impairment to one side of her upper extremity, both sides of her lower extremities and was always incontinent of bowel and bladder. The MDS also revealed she received 51% or more of her nutrition through a G-Tube (feeding tube) and was at risk for but had no pressure ulcers. Review of Resident #1's care plan dated 02/23/22 revealed she was at risk for problems with elimination of bowel and bladder, with a goal of residents elimination status will be maintained or improved over the next 90 days. Review of Resident #1's Care Plan dated 02/23/22 revealed she was resistant to care. Interventions included: Cue resident prior to delivery, use on-step directions and a slow pace. Respect resident's right to refuse, and show respect for resident's decisions. Discuss with resident her objections, reasons, fears, ideas. Give positive feedback and reinforcement for resident's compliance. Inform resident about risks of non-compliance. Offer as many alternatives as possible for resident to choose from. Psychiatric consult if indicated. Assess residents understanding of the situation, coping skills and support system. Emphasize positive aspects of compliance. Review of Resident #1's care plan updated 04/06/22 revealed she was at risk for/actual skin breakdown related to stage 3 pressure ulcer, incontinent of bowel. The goal was to have Resident #1 maintain clean and intact skin over the next 90 days, take measures to prevent skin breakdown over the next 90 days and the open area would be healed over the next 90 days. Interventions included to apply a protective or barrier lotion after incontinent episodes, assist her to turn and reposition frequently, inspect skin complete body head to toe every week and document results, and inspect skin daily with care and bathing, and report any changes to charge nurse. Keep skin clean, dry, and free of irritants. Position resident properly, use pressure reducing or pressure-relieving devices (e.g., pillows, positioning wedges, and alternating pressure mattress if indicated. Treatments and dressings as ordered per physician. Review of Resident #1's eTAR dated 02/24/22-02/28/22 reveled an order, Cleanse wound every AM PM shift (6am-2pm-10pm) SHEAR WOUND OF LEFT BUTTOCKS: Apply house barrier cream with collagen (to attract fibroblasts and encourage new collagen to the wound bed) twice a day & LOTA (Leave Open to Air). Dx (Diagnosis): Non-pressure chronic ulcer of skin of other sites with unspecified severity. Start Date: 02/25/2022 End Date: 03/24/2022 There were Xs or Os in the areas for each day. Per the Key, O indicated she received the treatment and X indicated she did not receive the treatment. Per the February 2022 eTAR Resident #1 received the treatment both shifts for 4 days but the dates 29-31 were cut off so do not know it the treatment was received. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's March 2022 eTAR revealed she received treatment to her left buttocks on both shifts as ordered on 3/01/22, 03/02/22, 03/08/22, 03/09/22, 03/10/22, 03/15/22, 03/16/22, 03/17/22, 03/19/22 and03/20/22. She received the ordered treatments on the evening shift only for 03/03/22, 03/05/22, and 03/12/22. She received the ordered treatment on the day shift only on 03/07/22, 03/23/22 and 03/24/22. Resident #3 did not receive the treatment for any shifts on 03/04, 03/06, 03/11, 03/13/22, 03/14/22, 03/18/22, 03/21/22 and 03/22/22. Review of Resident #1's e-Tar dated for March 2022 revealed an order dated 03/24/22 which read, CLEANSE SITE every am shift (6am-2pm) 23 Days SHEAR WOUND OF LEFT BUTTOCK: Cleanse area with NS (Normal Saline) or wound cleanser apply anasept (skin/wound cleanser solution) w/ (with) Collagen (to attract fibroblasts and encourage new collagen to the wound bed) with dry dressing and PRN if soiled or dislodged. DX: Other Skin Changes. Start Date: 03/24/2022 End Date: 04/06/2022 Review of Resident #1's eTAR for March 2022 revealed she received the ordered treatment on 03/25/22, 03/26/22, 03/27/22, 03/30/22 and 03/31/22 and did not receive the new treatment on 03/28/22 and 03/29/22. Review of Resident #1's eTAR for April 2022 revealed she received the ordered treatment on 04/03/22 and did not receive the treatment on 04/01/22, 04/02/22, 04/04/22, 04/05/22 and 04/06/22. Review of Resident #1's eTAR for April 2022 revealed an order, CLEANSE SITE every am shift (6am-2pm) STAGE 3 PRESSURE WOUND TO THE LEFT BUTTOCKS: Cleanse area with NS or wound cleanser apply Santyl (Chemical debridement ointment) and calcium alginate cover with dry dressing daily and prn (as needed) if soiled/dislodged DX: Other skin changes START DATE: 04/06/2022 END DATE: 04/16/2022 Review of Resident #1's April 2022 eTAR she received the ordered treatment on 04/07/22 and 04/11/22 and did not receive it on 04/08/22, 04/09/22 and 04/10/22. She went to the hospital per her family request in 04/11/22. Review of Resident #1's April 2022 eTAR revealed an order, MAY HAVE PRESSURE ALTERNATING LOW AIR LOSS MATTRESS FOR WOUND 1 time per day DX: Pressure ulcer of sacral region, unstageable Review of Resident #1's eTAR for April 2022 also revealed an order, Santyl 250 units/g (gram) Ointment 1 time per day DX: Pressure ulcer of sacral region, unstageable Start Date: 04/11/2022 End Date: 04/11/2022 Review of Resident #1's Wound Evaluation and Management Summary note written by Wound Physician dated 12/29/21 revealed, .Wound Sacrum (Resolved on 12/29/21) Review of Resident #1's nursing note dated and signed by LVN DD on 02/15/22 at 7:40 PM revealed, opening observed on right buttocks cheek, skin on left buttocks cheek observed as thin. No opening to left cheek yet, opening cleaned with NS, dressing applied to entire buttocks, rp (responsible party) made aware Review of Resident #1's nursing notes from 03/16/22 to 04/12/22 revealed no documentation regarding the resident's refusal of care. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's Wound Evaluation and Management Summary note written by Wound Physician dated 02/23/22 revealed, SHEAR WOUND OF LEFT BUTTOCK FULL THICKNESS .Wound Size (L x W x D) 3.7 x 4.1 x 0.1 cm .Cluster Wound .Exudate .Light Sero-sanguinous It further reflected: Granulation tissue . 20% Skin .80%. Review of Resident #1's Wound Evaluation and Management Summary note written by Wound Physician dated 03/16/22 revealed, SHEAR WOUND OF LEFT BUTTOCK FULL THICKNESS .Wound Size (L x W x D) 1.7 x 2 x 0.1 cm .Cluster Wound .Exudate .Light sero-sanguinous It further reflected, Granulation tissue . 25% Other viable tissue .25% (Dermis) Skin .50% Wound Progress: Deteriorated. Review of Resident #1's Wound Evaluation and Management Summary note written by Wound Physician dated 03/23/22 revealed, STAGE 3 PRESSURE WOUND OF THE LEFT BUTTOCK FULL THICKNESS . Wound Size (L x W x D) 6.2 x 5.1 x 0.1 cm .Cluster Wound . Exudate .Light sero-sanguinous It further reflected, Thick adherent devitalized necrotic tissue .10% Granulation tissue .30% Skin: 60% Wound progress: Deteriorated Review of Resident #1's Wound Evaluation and Management Summary note written by Wound Physician dated 03/30/22 revealed, STAGE 3 PRESSURE WOUND OF THE LEFT BUTTOCK FULL THICKNESS . Wound Size (L x W x D) 8 x 7.5 x 0.1 cm .Cluster Wound . Exudate .Light sero-sanguinous It further reflected, Thick adherent devitalized necrotic tissue .30% Granulation tissue .30% Skin: 40% Wound progress: Deteriorated Review of Resident #1's Wound Evaluation and Management Summary note written by Wound Physician dated 04/06/22 revealed, STAGE 3 PRESSURE WOUND OF THE LEFT BUTTOCK FULL THICKNESS . Wound Size (L x W x D) 8.2 x 7.3 x 0.1 cm .Cluster Wound Exudate .Moderate Sero-sanguinous It further reflected, Thick adherent devitalized necrotic tissue .50% Granulation tissue .10% Skin: 40% Wound progress: Deteriorated Review of Resident #1's nurse's note dated 04/06/22 and signed by the DON revealed, Resident daughter, _____, in the facility and requested to speak with this nurse. This nurse updated family about the wound orders and nutritional supplements being given. Also was informed that resident will be switched from a regular mattress to low air loss mattress for comfort and healing. Dr. ____was in facility and aware of resident's treatment changes and my communication with family. No other concern at this time. Review of Resident #1's nurse's note dated 04/06/22 at 12:04 PM and signed by the Wound Nurse revealed, Spoke with daughter about wound during family visit with resident post (Wound Physician) visit. Family understood treatment and is [sic] providing wound bandages. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's nurse's note dated 04/12/22 at 12:15 AM written by RN EE revealed, 0015: Resident's [family member]continuing to wait on _____ (ambulance company) to transport resident to Baylor. Per family, nurse during prior shift was suppose [sic] to have called _____ (ambulance company), family states they never call. Per report, family called for transport. RN called (ambulance company) for transportation, spoke with rep. (Ambulance company representative), required info given. Confirmation # 1354127, per staff, transportation would be here within 45mins (minutes). Update provided to resident's daughters who appear upset with the situation. RN reassured [family members] that _____ (ambulance company) had been called and was [sic] now on their way. No other issues voiced at this time, daughter's calm, resident resting w(with)/no noted distress. Review of Resident #1's nurse's note dated 04/12/22 at 12:15 AM written by RN EE revealed, ____ (ambulance company) arrived, resident to be transported to _____(Hospital) . Review of Resident #1's weekly skin assessments indicated the following: There were assessments for March 2022-03/03/22, 03/10/22, 03/17/22, 03/24/22, 03/31/22 but no weekly skin assessments for April 2022. In an interview with the DON on 05/12/22 at 2:46 PM, revealed he had done a skin assessment on Resident #1 but must have not gotten it into the computer, he stated he did have a nurse's note from that day 04/06/22, where he had spoken to Resident #1's family member regarding the wound. The DON said he did not know where the skin assessment went but felt he was probably interrupted while doing it and did not complete it. He said Resident #1's wound had not looked that bad when he assessed it. It was like the first layer of skin had been sheared off. The surveyor went over the Wound Evaluation and Management Summary's and the DON agreed the wound was not stageable because of the necrotic tissue, which would require debridement. In an interview with Resident #1's family member on 05/09/22 at 12:01 PM, revealed the family member requested Resident #1 be sent to the hospital again. The hospital told her the resident could not go back to the facility. The hospital said Resident #1 should be on antibiotics. After being in the hospital for 8 days on IV antibiotics she had been sent to a long-term acute care (LTAC) center. The LTAC had informed her caring for the wound would be a long process and Resident #1 would be sent to another long-term care (LTC) facility after. She stated they had to insist she be sent out to the hospital in April 2022 as the facility was not going to send her out. It had taken all day to get the ambulance to come. Resident #1 was finally sent out around 2 AM on 04/12/22. Review of Resident #1's hospital records dated 04/12/22 with discharge 04/20/22 revealed the reason for the visit was a sacral wound. The visit diagnoses included sacral osteomyelitis (infection of the bone), sacral decubitus stage IV and debility. Review of the hospital's emergency room physician's provider note dated 04/12/22 at 5:03 AM revealed, Skin: .8 cm x 4 cm sacral decubitus ulcer with overlying purulence (containing or forming pus), [sic] poor wound margins. It further reflected, Critical care time was necessary to treat or prevent imminent or life-threatening deterioration of the following conditions: Severe skin infection, osteomyelitis. Review of a picture from the hospital of Resident #1's wound dated 04/12/22 revealed a large necrotic slough filled wound that appears to be very moist and had jagged edges. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with the DON on 05/10/22 at 3:36 PM, revealed they had two treatment nurses, one for each building and had just hired a treatment nurse for the weekends. The weekend charge nurses did the wounds on the weekends before the new treatment nurse was hired. They also had a wound physician that would come every Wednesday and make rounds on the residents with wounds. He also stated Wound Care Nurse B came in to do rounds with the wound physician weekly on Wednesday, early in the morning. An interview with LVN C on 05/11/22 at 10:54 AM, revealed she had worked with Resident #1 but was not here when she was sent out to the hospital. She stated she had not known until she came back and in report the outgoing nurse did not know why Resident #1 had been sent out. LVN C said Resident #1 could move herself in bed a little bit, and she needed moderate assist. She did not think Resident #1 could turn back on her back if she was on her side but said she would push back and may take a swing at staff. LVN C said Resident #1 was feisty but had no real behaviors, she would grab your lanyard. She also said Resident #1 had some contractures of her hands, they would get her up in a wheelchair but could not stay up for long because of her sacral wound. LVN C felt Resident #1 did not refuse care and she was not able to speak so would not refuse care but would let you know she was unhappy. When informed of the large increase in size of her sacral wound from 1.7 cm x 2 cm x 0.1 cm to 6.2 cm x 5.1 cm x 0.1 cm one week later, LVN C said, that was a huge [NAME] in the size. She also said she was not sure if it was her nutrition and that she was not very familiar with her. She said one of her CNAs had given her a stop and watch (a monitoring task) that said there was an odor to Resident #1's wound. She said she went to go assess it and called her physician to let him know about the change so the wound physician could come back by and look at it to make sure the treatment was ok. She had looked at the wound but could not remember what day it was or what it looked like but felt she needed to make a note and had the wound care physician come and check it. Review of Resident #1's nurses note dated and signed by LVN C on 04/05/22 at 14:43 (2:43 p.m.) revealed, Performed dressing change to resident wound to sacral area applied skin protectant underneath R buttock area skin break. (This was the only nurses note about Resident #1's wound by LVN C found and there was no mention of an odor or contacting the physician.) An interview with NCNA E on 05/11/22 at 11:27 AM, revealed she had taken care of Resident #1. She said Resident #1 could not move herself in bed, she did not have any behaviors and sometimes she wound pinch you. NCNA E said she had a place on her bottom that would get small, dry up and heal then it would get moist and open again. She said they would clean her and put moisture cream on her, and they would get her up in a wheelchair. She said when Resident #1 was up in a WC she would check her every hour for incontinence. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with LVN D on 05/11/22 at 12:07 PM, revealed Resident #1used to be in room [ROOM NUMBER] A. She could minimally move herself in bed but most of the time she was total care. They used to get her up in a wheelchair every day but could not propel herself. If she was in bed she would be in bed. She had a G-tube, and we stopped the feeding at 7AM and put it back up at 7 PM. She ate by mouth a little during the day and would be taken to the dining room. LVN D said sometimes she would be combative but not always and sometimes when trying to feed or change her she would resist. LVN D said they would need help of two as she would try to pull out her G-tube so they would need two to work with her. LVN D said Resident #1 had a wound on her bottom. The wound nurse would change it and sometimes when she was soiled, we would change the dressing. Surveyor explained that it went from 1.7 X2 X 0.1 on 03/16/22 to 6.2 X 5.1 X 0.1 on 03/22/22. LVN D stated, Oh my God, that is a big increase. She already had the wound when I started, and the wound nurse would change it. I was PRN and when I came here Resident #1 had left to go to the hospital, she did not know why and had since heard she was transferred somewhere else. An interview with Wound Nurse A on 05/11/22 at 2:39 PM, revealed most of the time they had two CNAs back there, not often that only one CNA was back there on the secure unit. She said there were usually 2 CNAs and 2 nurses. She stated they had just hired a weekend nurse to do wounds on the weekends. Wound Nurse A said when they didn't have a weekend wound nurse the staff nurses were supposed to do the wounds, but they were not done at times. Wound Nurse A said the weekend nurses had a hard time getting the wounds done on weekends prior to getting the wound nurse for the weekends. She said she had worked with Resident #1 and she could not move herself in bed but could move her arms well. Wound Nurse A said Resident #1 was mainly total care and had not liked to be changed or liked her to change her dressings. She said Resident #1 would try to hit my hands, pinch, grab my badge. She also said she not like people pulling up her gown or getting into her personal space. Wound Nurse A said she had found the dressing soiled and even Resident #1 soiled at times. An interview with CNA F on 05/12/22 at 1:25 PM, revealed she had taken care of Resident #1 and she was totally dependent on staff for bed mobility, transfers, and locomotion in the wheelchair. She also said Resident #1 would fight them when they tried to clean her up. She felt one person could take care of her by themselves and she would talk to her about where they both had come from and she would calm down. CNA F said when Resident #1's wound had first started she told the nurse (LVN D) the wound had opened back up at the scaring on her bottom. CNA F said she had been off for three- four days and when she came back Resident #1 had gone to the hospital. She said Resident #1's wound had developed a black and squishy wound bed with an odor, and she told the nurse that it had developed an odor. CNA F said Resident #1 also had 6 bowel movements that day before she had notified the nurse because of the odor. She stated she thought the odor was from the bowel movement, so she told the nurse Resident #1's dressing was dirty, and the nurse went and changed it. CNA F said Resident #1's family member was by the bedside at that time and saw the wound as well. CNA F said her responsibility when caring for wounds and preventing them from worsening was if the dressing was dirty, she would get the nurse to change it and if the dressing had come off, she would go let the nurse know so she could replace it. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with LVN D on 05/12/22 at 1:58 PM, revealed she had not taken care of Resident #1 every day because the wound nurse took care of it every day. The wound nurse was there every day and did the dressings. She stated she had changed Resident #1's dressing one time when it had become soiled, and the CNA (CNA F) came and told her it was soiled. LVN D stated the time she had changed the dressing the wound was not that bad. LVN D said when Resident #1 was sent to the hospital she had not known how big it was. LVN D again stated she had worked PRN (as needed). LVN D said red flags they should watch for that indicate a wound is deteriorating wase if it changed in size, color, or smelled different and if was not improving but staying the same. LVN D said to help prevent a wound from deteriorating if they were bed bound, they must reposition them and try not to lay them on their side with the wound, incontinent care should be done frequently, they needed to make sure they were eating good, getting supplements and change the dressing if it got soiled. LVN D also said Resident #1 stayed in bed most of the time the last few weeks and was total care, she also had a G-tube. She said she would do rounds every two hours and if Resident #1 was in the same position, she would help them change it if needed. An interview with the DON on 05/12/22 at 2:46 PM, revealed he did not think Resident #1 could move herself in bed as she was a total assist. He stated her family wanted her up for breakfast so they would get her up in her wheelchair. The DON also said Resident #1 did not eat well and could not swallow very well so she had nocturnal feeds and bolus feeds if she ate less than 50%. Yes, she had behaviors, she would try to hit you even when the daughter was there, she was fighting but her daughter was talking to her and calmed her down. The DON said she had a scar on her sacrum, and she had a decubitus previously, so she was prone to break down. He again said Resident #1 wound just the top skin, there was no depth, so it was just the first layer, so it was a shear. He also said if they suspected a wound was getting infected or if it was getting worse, they would change the treatments and if they were not able to get it to improve, they would send them to a LTAC. He said if a wound was infected and needed antibiotic therapy, they would send them to the hospital. The DON said Resident #1's pressure ulcer did not appear infected when he saw it on 04/06/22. He stated they had started an air mattress on that day. When asked why he had not ordered her an air mattress prior especially since she was prone to developing a pressure ulcer the DON said her family had a special mattress they wanted on her bed, so I told them maybe we need to change out the mattresses and we did. Resident #1 had a problem with weight loss previously, but we had it stable. He said at one time the doctor had been concerned with Resident #1's nutrition, so it had already been addressed. The DON said he did not do the skin assessments on residents but would help if they needed help and he was standing in as the unit manager at that time. He said the nurses were to do the skin assessments weekly. When asked what they could do to prevent pressure ulcers from developing or deteriorating the DON said turning and repositioning them timely, getting an air mattress, making sure they have proper nutrition, and they are receiving incontinent care timely. The DON revealed nurses were in charge of completing skin assessments and stated skin assessments were not conducted because he had forgotten to complete them. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with MA G on 05/12/22/at 3:11 PM, revealed she would check her residents every 2 hours for incontinence care and /or to change their position if they were bed bound. If a resident called and was wet or dirty, she would answer the call light and if the supplies were in the room, she would change them if not she would go get the supplies and come back and change them. MA G said her role in preventing pressure ulcers was if they are incontinent, we changed them every 2 hours, make sure they are clean and use cream after wiping, turning them every 1 or 2 hours and if they had a wound, after cleaning them up, she would use a pillow to pad them to help keep pressure off. MA G said if she finds a new bruise or wound the first thing, she would do was tell the nurse in charge. MA G said there was supposed to be two CNAs, a MA and two nurses on the north secure unit. She also said if they were short. A CNA from another hall would help them care for the residents. She said she had worked with Resident #1 before she moved out and she did have a wound, could not move herself in the bed and she was generally up in a wheelchair when she came on at 2:00 PM. She said they would get Resident #1 up in the morning and when she came on at 2:00 they would put her in bed and had to change her, clean her, and get her back up because that was what the family wanted. She said she would get another CNA to help as Resident #1 would scratch staff so the other CNA kept would help by protecting the CNA that was doing the actual changing. (continued on next page)

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	05/14/2022

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with Wound Nurse A on 05/12/22 at 3:31 PM revealed she had worked there officially almost a year. She started as the wound nurse a couple months ago, not too long, she thought she started as wound nurse in March. Wound Nurse A said before she was the wound nurse she had worked on the floor, was PRN but had worked full time hours. She said regarding the residents with wounds, she expected staff to turn them every two hours but felt they should turn them every 1-2 hours, as well as change them and clean them up in the same time frame. Wound Nurse A also stated to prevent pressure ulcers they should keep bedbound residents off bony prominences, rotate them every 2-4 hours, keep them clean and dry, and if not bedbound then up ambulating or up sitting check them for incontinence, adequate diet nutrition, being bathed and changed properly. Wound Nurse A said usually, the CNAs or the nurse would tell her if they found a new bruise or open area on a resident. She said she felt they usually had enough help as the unit had 2 aides and two nurses there most of the time, she said she had not seen only 1 CNA on the unit very often. Wound Nurse A said the weekend nurses were to do the wound care on the weekends prior to the new weekend treatment nurse. They are supposed to do the wounds when wound nurses were not on call, they just changed it. On another shift/on floor (when on call not as wound nurse) the nurses are supposed to do the treatments. She said resident wounds were not done at times as the nurses had a hard time getting treatments done. She also said the nurses were supposed to do skin assessment every day during their assessments and it was documented in the electric medical record under routine data. Wound Nurse A said she had worked with Resident #1 and she could not move herself in the bed as she was total care even though she could move her arms. As far as behaviors Resident #1 did not like to be changed and did not like Wound Nurse A to do her wound care as she would try to hit your hand or pinch you. She was sweet unless you were invading her personal space, Resident #1 did not like people trying to pull up her gown or change her. She said she had found her wet and dirty a couple of times but had never found her with her dressing removed. It may be soiled but never completely removed. She said she was not the treatment nurse when the wound physician healed Resident #1's sacral wound in December 2021 but in March around the same time as the wound physician began to see her again was when she first cared for Resident #1 as wound nurse. When asked Wound Nurse A about what may have caused Resident #1's wound going from 1.7 cm x 2 cm x 0.1 cm to 6.2 cm x 5.2 cm x 0.1cm in a week she said could be the aides weren't changing her, were not careful when they moved her around or put her in the chair and left her. Wound Care Nurse said Resident #1 went out on 4/12, and she just remembered reading the note about why, but had not been there when Resident #1 went out to the hospital. She stated she had not been there a couple days prior to her being sent out because she had been working the floor as a charge nurse and there was a week in there when she had the flu and had not seen her. Wound Nurse A said her part in preventing a wound from getting worse was to let the nurses know that she would not be there so they could do the residents wounds and that she could see the bandage when she came back meaning if the bandages had not been changed her initials would still be on them. Showed her the picture of Resident #1's wound from the hospital and she said she had seen Resident #1's wound on 04/06/22 because when the wound physician came, she always removed the dressings and would not re-dress them, so she had redressed Resident #1's that day. She said the edges of the wound were not like that. The edges were more defined, not raggedy and the wound bed was not mostly slough (a yellow-tannish viscous fribrinous tissue). An interview with Wound Nurse A on 05/13/22 at 10:47 AM, revealed if she came back to work after being off for the weekend or working someplace else in the facility what she would do if the same dressing she had put on was still there she said she would change them. She also said she would tell the nurse and sometimes tell the DON that they had not been changed. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with LVN I on 05/13/22 at 10:54 AM, revealed she knew Resident #1 but had never taken care of her because she worked on the other side of the secure unit. She said some of her residents had skin issues she cared for and if the wound nurse was not there a notice usually pops up in the electronic chart that the wound needs to be done on the eTAR. She did not know what the X meant on a day and time slot and said that meant it needed to be done right? LVN I said usually it would pop up so they would initial it on the mar, on the day it was to be done, and if the wound nurse was not there, they would know to do the treatments. LVN I also said when you signed off, it would show7 up on the MAR that you completed it. She again said she did not know what the X meant. An interview with LVN C on 05/13/22 at 10:59 AM, revealed when she does a wound treatment on any resident, it should be charted on the eTAR. When shown Resident #1's eTAR she said that was not what the eTAR looked like. She said when they did them it did not come out like that, when they looked at it in their view, they were typing yes, no and answering questions. Surveyor showed her a resident's eTAR on the computer [TRUNCATED]