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	01/12/2023

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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** 45507 Based on observation, interview, and record review the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for 4 of 5 (Resident # 4 , # 5, #21 and #22) residents reviewed for ADL care. 1. The facility failed to ensure Resident #21 was provided showers as scheduled and personal hygiene based on the resident's preference. 2. The facility failed to ensure Resident #22 was provided showers as scheduled. 3. The facility failed to ensure Resident # 4, and Resident # 5 had their ADL needs met in a timely manner. These failures could place residents at risk of not receiving personal care services and a decreased quality of life. Findings included: Resident #21 Record review of Resident #21's face sheet revealed a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included pneumonia, end stage renal disease, metabolic encephalopathy, and muscle wasting and atrophy. Record review of Resident #21's admission MDS dated [DATE], revealed a BIMS of 9, indicating moderate cognitive impairment. Further review of the MDS revealed Resident #21 required extensive assistance of one staff for bed mobility, dressing, personal hygiene, extensive assistance of two staff for transfers, and was total dependence on one staff for bathing. Record review of Resident #21's care plan, dated 10/15/2022, revealed Self care deficit with goal of resident will maintain or improve self-care area of dressing, grooming hygiene and bathing over the next 90 days with interventions that included Encourage resident to complete as much self care as possible independently or with minimal assist, Prefers bath in AM, Provide assistance with self care as needed. Review of the care plan did not indicate Resident #21 had refused any care. (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	01/12/2023

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #21's ADL sheet dated 10/17/2022 to 12/20/2022, revealed the last shower that was documented was on 11/11/2022. Observation and interview on 12/21/2022 at 9:52 am revealed Resident #21 was lying in bed eating breakfast. When asked if he received his showers or bed baths, Resident #21 stated if he had one complaint that would be it. Resident #21 stated he liked to be clean and dress nice, and once or twice he has gone 2-3 days without water touching him. Resident #21 stated he was told by staff he could ask for a shower or bath but he would not receive one. Resident #21 stated he told the nurse or the tech on an unknown date that he would like to bathe or shower and stay clean. Resident #21 stated he did not know when his shower days were scheduled. Resident #21 stated staff told him he could request a shower but when he did, staff would not provide him with a shower. Interview on 12/21/2022 at 11:03 am with CNA P revealed she has worked at the facility for 3 years and normally worked 700 hall. She stated CNA's are responsible to give showers to residents. She stated the shower schedule was even numbered rooms on Monday, Wednesday, and Friday and the odd numbered rooms were Tuesday, Thursday, and Saturday. She stated the 6 am to 2 pm shift showered the A beds and the 2 pm to 10 pm shift showered the B beds. She stated if a resident refused their shower, she would try again later and if they still refused, she would tell the nurse and document the refusal. She stated when CNA's completed showers they were documented as given. She stated she was about to shower Resident #21 when surveyor requested to speak with her. She stated Resident #21's shower was actually B bed shower (2 pm to 10 pm shift) but she was going to do everybody's shower. She stated she just asked him today because she had extra time. Observation and interview on 12/22/2022 at 4:43 pm, revealed Resident #21 lying in bed wearing a blue t shirt which appeared to have crumbs or flakes on the chest/chin area. Resident #21 was observed to have stubble on chin, cheeks and above the lip. When asked if he received his shower, Resident #21 stated he got the first one yesterday (12/21/2022) in a long time but he felt so good. Resident #21 stated he was going to get another one tomorrow. Resident #21 stated the last time he had a shower before 12/21/22 was 4-5 days before that. Resident #21 stated he wanted his face to be shaved and said it had been about a week since the aides had last shaved him. Observation and interview on 12/23/2022 at 4:15 pm, revealed Resident #21 was lying in bed and was observed to be wearing the same blue t shirt as yesterday (12/22/2022). There appeared to be crumbs or flakes on the shirt on the chest area. Resident #21 was observed to have stubble on his face the same as the previous day. Resident #21 stated he did not get a shower today and stated whenever the staff came back into the room, he was going to ask for a soapy towel to wash himself. Resident #21 stated he had no skin breakdown. Resident #21 stated he liked to be shaved every 3-4 days. Resident #22 Record review of Resident #22's face sheet revealed he was a [AGE] year-old male who admitted to the facility on [DATE] and discharged on [DATE]. Resident #22's diagnoses included encephalopathy, unspecified intracranial injury without loss of consciousness, displaced comminuted fracture of shaft of right femur, and heart failure. (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	01/12/2023

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident#22's of the 5-day MDS revealed a BIMS of 13, which indicated the resident's cognition was intact. Record review of Resident#22's discharge MDS dated [DATE], revealed Resident #22 required limited assistance with transfer and dressing, extensive assistance with toilet use and personal hygiene, and physical help in part of bathing activity. Record review of Resident #22's care plan, dated 09/05/2022, revealed Self care deficit with goal that resident will maintain or improve self care area of dressing, grooming hygiene and bathing over the next 90 days with interventions that included Prefer Bath in PM and Provide assistance with self care as needed. Review of the care plan did not indicate Resident #22 had refused any care. Record review on 12/21/2022 of Resident #22's ADL sheet dated, 08/03/2022 to 10/01/2022, revealed no entries for bathing. Record review of the provider investigation report dated 10/07/2022 revealed Resident #22 reported that he was not receiving his showers as requested and that was neglect. Record review of the investigation summary revealed the ADON had interviewed staff about Resident #22's showers and the staff had reported that showers were given, and at times the resident would request showers on nonscheduled days or would refuse. Interview on 12/23/2022 at 3:37 pm, the ADON stated CNA's are responsible for giving residents showers. She stated the schedule is per room per shift and even rooms are Monday, Wednesday, Friday and odd are Tuesday, Thursday, Saturday with A bed 6 am to 2 pm shift and B Bed 2 pm to 10 pm shift. She stated the facility has ongoing education with CNA's but have not had any issues with showers or bed baths. She stated the risk to residents if they do not get showers/ADL care was skin integrity and infection control. When asked how it would make the resident feel to not get a shower, she stated she could not say how they feel or not feel. She stated Resident #21's shower schedule was Monday, Wednesday, Friday 6 am to 2 pm and the resident wanted a shower everyday and only the times he wanted, he never complained on his shower days that he was not getting a shower, he complained that he was not getting a shower on his off days. Interview on 12/23/2022 at 5:33 pm, the ADON stated she had just got off the phone with IT and said that the bathing task was unassigned and that was why it was not showing but they would be showing now. She stated with agency aides sometimes they cannot document so they are looking at doing a soft file where the aide can chart it on paper and staff can later put it in the system. She stated she was going to in-service the nurses about assigning the aides in the system. The ADON provided ADL sheets for Residents #21 and #22. Review of ADL sheets dated 12/23/2022 for Resident #21 reflected Resident #21 had no entry for the following dates on his scheduled shower days: 11/07/2022, 11/09/2022, 11/25/2022, 12/02/2022, 12/09/2022, 12/14/2022, 12/12/2022, and 12/19/2022. Review of ADL sheets dated 12/23/2022 for Resident #22 reflected Resident #22 had no entry on his scheduled shower days for 09/12/2022 and 09/16/2022. (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	01/12/2023

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy titled, Bathing (not partial or complete Bed bath) effective 01/12/2018, revised 02/12/2020 reflected the procedure for showers and included, in part: Residents have the right to choose if they want to be bathed at certain times and with certain methods in accordance to the care plan .tasks commonly completed during the bathing process: inspect skin, especially those what are showing redness or signs of breakdown .record the procedure in the record .If the resident refuses to independently or allow staff to assist with bathing, document the refusal in the record. Resident # 4 Record review of Resident # 4's face sheet, dated 11/29/22, revealed she was a [AGE] year-old who admitted to the facility on [DATE]. Resident # 4's diagnoses included long term (current) use of antibiotics, edema, overactive bladder, osteoarthritis, non-pressure chronic ulcer of right heel and ankle. Record review of Resident # 4's MDS, dated [DATE], revealed a BIMS of 14, which indicated the resident's cognition was intact. Record review of Resident # 4's care plan, dated 11/29/22, revealed resident was incontinent, was an extensive assist for transfers, used a wheelchair and staff was to provide assistance with self-care as needed. Resident # 5 Record review of Resident # 5's face sheet dated 12/28/22 revealed a 70-yr-old male who admitted to the facility on [DATE]. Resident # 5's diagnoses included other specified metabolic disorders, acute kidney failure, personal history of transient ischemic attack, cerebral infarction and hypertension. Observation on 12/20/22 at 7:49 AM revealed call light for Resident # 5 was triggered and CNA AE walked past his room without responding to the call light. Interview on 12/20/22 at 7:50 AM with Resident # 5 revealed he triggered his call light six hours ago and no one came to answer it. Interview on 12/20/22 at 7:53 AM with LVN AA who was on the hall passing meds revealed he was unsure if call light for Resident # 5 was triggered when he started his shift at 6AM that morning. When asked if he attempted to answer Resident # 5's call light when he saw that it was on, LVN AA stated he had not really noticed the light was on until he observed the surveyors enter the room. Observation on 12/20/22 at 7:53 AM revealed call light for Resident # 4 was triggered. A member of the housekeeping staff was at the entrance of Resident # 4's Rm cleaning that area. Observation on 12/20/22 at 7:58 AM revealed a male Janitor walked past still triggered call light for Resident # 5 without entering the room to see what Resident # 5 needed. Observation on 12/20/22 at 8:00 AM revealed ICN AC walked down the hallway and passed the rooms of Resident # 4 and Resident # 5 without responding to the call lights. (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	01/12/2023

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 12/20/22 at 8:04 AM revealed Resident # 4 was not wearing pants, was covered in a purple blanket with her legs exposed and bent over leaning off the bed. Resident #4 stated she pressed her call light a while ago because she wanted to get changed and dressed. As Resident # 4 was speaking urine began falling from resident onto the floor. Interview on 12/20/22 at 8:07 AM with LVN AA revealed CNA AE was working with him, he was not sure exactly which room she was in at the moment, and he was unsure how many rooms CNA AE had to cover but he could find out. Interview on 12/20/22 at 12:53 AM with ICN AC revealed that all staff were to answer call lights including house keeping staff. ICN AC stated if a staff member was not able to render the requested service, they were to leave he call light on and go report to an aide or a nurse. When asked why she did not answer two call lights that were triggered this morning when she passed by surveyors interviewing LVN AA, she stated she did not notice the call lights were triggered. This interview was witnessed by the Assistant Administrator. Interview on 12/22/22 at 9:05 AM with Resident # 5 revealed it was typical for staff to ignore his call light from 10:30 PM to 7:30 AM. He stated there were 2 occasions when his urinal fell , and no one came. Interview on 12/22/22 at 9:24 AM with Resident # 4 revealed that on 12/20/22 after surveyor visit it took about fifteen minutes for staff to come get her cleaned up. Resident # 4 sated the facility was shorthanded and could not keep enough staff. Review of the facility's policy titled, Call lights - Answering, revised 02/12/20, indicated Respond to patients/resident's call lights and emergency lights in a timely manner.

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	01/12/2023

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 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 44197 Based on observation, interview and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices to meet each resident's physical mental and psychosocial needs for one (Resident #6) of seven residents reviewed for quality of care. The facility failed to ensure Resident # 6 received medications according to physician orders for pain management when the resident experienced a fall with injury that resulted in a fracture to the left hip. Resident # 6 was in pain for three days before being sent to the hospital. This failure placed residents at risk of unrelieved pain and discomfort. An Immediate Jeopardy was determined to have existed from 11/04/22 through 11/07/22. The IJ was removed on 11/08/22 because the facility implemented actions that corrected the non-compliance prior to the beginning of the survey. The facility Administrator was provided the IJ Template on 01/12/23 at 9:52 AM. Findings included: Review of Resident # 6's Face Sheet dated 12/23/2022 revealed a 79-yr-old female who admitted to the facility on [DATE] and discharged on [DATE]. Resident # 6's diagnoses included cerebral infarction, unspecified injury of head, diabetes mellitus, and central pain syndrome. Review of Resident # 6's Progress Note dated 11/04/22 written by LVN S reflected, Resident was in her room and was pushed down by another resident, resident fell on her left hip and exhibited signs of pain called dr to report change of condition, ordered x- ray to have left hip examined. Review of Resident # 6's NP Note dated 11/4/22 reflected, The patient is seen for a periodic follow-up visit. She is seen sleeping in her bed recently, easily awoke with verbal stimuli. She is very confused secondary to dementia but denies any acute problem at the present time. Later on I was notified over the phone while I am driving that the patient is complaint pain on the left hip area. She was pushed by another confused patient and the patient fell . Ordered left hip x ray and instructed to treat the pain with the pain medication. Nurse will notify provider if symptoms get worst. She is generally agreeable to care routine and easily redirected. Review of the Incident Report dated 11/04/22 reflected Resident # 6 was involved in a witnessed altercation with a fall and had pain upon movement at a level four on a scale of 1-10. Review of Resident #6's Physician's Orders reflected the only pain ordered for Resident # 6 was 500 mg of Naproxen. One tablet was to be given twice per day as needed for Mild pain on a scale of 1-3. This Naproxen medication was to be given with food and the diagnosis for this medication was central pain syndrome. (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	01/12/2023

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Medication Administration Record (MAR) in the electronic medical record on 01/12/23 for Resident #6 revealed she had pain at a level six to her left hip on 11/06/22 in the evening. The MAR also revealed Naproxen was not administered to Resident # 6 from 11/4/22 through 11/7/22. The MAR reflected that no pain medication was given to Resident #6 during that time frame. Review of Resident # 6's Progress Note dated 11/06/22 at 2:13 PM written by LVN S reflected, resident having difficultly standing on left hip has mild edema of left leg, notified NP, ordered x ray STAT per NP if not completed in 3-4hr span was advised to send resident out. Review of Resident # 6's Progress Note dated 11/07/22 at 1:55 PM written by LVNS on reflected, resident having difficultly standing on left hip has mild edema of left leg, notified Dr ordered x ray STAT per NP if not completed in 3-4hr span was advised to send resident out , x- ray not done notified [agency name] ambulance to transport resident to hospital for x- ray and further care, notified family/ unit manager of change of condition, ambulance scheduled for 3:30pm to transport. Review of the Witness Statement dated 11/08/22 reflected LVN S was notified on 11/04/22 that Resident # 6 was pushed by another resident and fell . LVN S found resident on her left side and completed an assessment. The written statement indicated, Assessment noted pain to left hip with no visible injuries. New orders received and inputted for x-ray to left hip. On 11/6/22 x-ray had not been performed, I was notified by aide that resident continued with decrease in mobility and signs of pain upon assessment left hip noted with minimal edema, I notified NP and was given orders to reorder Xray as STAT, I inputted the orders. Upon arrival on 11/7/22 X-rays had not been performed I notified the NP and received orders to send to ER for further evaluation, resident was sent via non-emergency transportation. Review of the Witness Statement dated 11/08/22 reflected CNA AF witnessed the incident with Resident # 6 and notified LVN S immediately. CNA AF's written statement indicated, Resident #6, continued to have symptoms of pain to her left hip and decreased mobility on 11/5/22 and 11/6/22, I notified the charge nurse and resident remained in bed on those dates. Interview on 12/22/22 at 10:20 AM with LVN S revealed the general procedure if a resident had a witnessed fall, the nurse was to complete a full assessment to include skin and pain evaluations, vital signs, then inform the unit manager, the Administrator, the family and the doctor. In a later interview on 01/12/23 at 10:09 AM LVN S stated she gave Resident #6 pain medication after she fell on [DATE]. LVN S stated Resident # 6 typically wanted to stay in bed, but once staff got her up, she would get up and walk around. LVN S said she would personally walk the halls with Resident # 6 but would keep a wheelchair close by in case the resident got weak and needed to sit down. A later phone Interview on 01/12/23 at 3:01 PM with LVN S revealed she attributed not documenting the administration of the Naproxen to the adrenaline of the whole issue. Interview on 01/12/23 at 11:27 AM with CNA AF stated Resident # 6 was able to walk to the dining room on 11/4/22 after the fall with no problem after LVN S did all the assessments. CNA AF stated that on 11/5/22 Resident # 6 was no longer getting up, could not walk and was screaming of pain. CNA AF stated that Resident #6 was able to walk before the fall, although if the staff would let her, she would lay in bed all day. (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	01/12/2023

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 01/12/23 at 12:45 PM the ADON stated she checked their system and did not find any documentation of pain medication given to Resident #6, however she spoke with LVN S who stated she gave Resident # 6 Naproxen. Interview on 12/22/22 at 3:38 PM with Resident # 6's Primary Contact listed on Face Sheet stated Resident #6 was diagnosed with left hip fracture and had surgery where her socket was removed. The primary contact stated the resident was still in pain and was at another (different) facility and had to go on hospice after the surgery. The Primary contact stated Resident #6 used to walk and now she stayed in a fetal position in bed because she was in too much pain. Interview on 01/12/23 at 5:30 PM DON stated if a Resident has had a fall, their pain should be treated. DON stated that if pain medication was not adequate, the staff should contact the doctor to get something stronger so that the resident is not in distress. DON stated If the stronger medication does not help, the resident should be sent to the hospital. DON also stated that in the nursing world if it was not documented, it was not done. Review of the facility's Pain Management and Basic Comfort Measures policy, revised 01/12/20, revealed, . Provide pain medication as prescribed by an authorized prescriber . Consult with family members, other health care providers for assistance with pain management techniques . Observe for unresolved pain and address per physician's orders . Record pain management techniques in the record. The Plan of Removal process was not needed at this time because the facility implemented actions that corrected the non-compliance prior to the beginning of the survey on 12/20/2023. The facility implemented the following interventions to address non-compliance: Review of the facility's one on one in-service (training) titled Fall prevention, Xray ordering process, family communication, dated 11/07/22 with LVN included: pain management, Xray process, review of adverse events that occurred as a purpose for the training or identified gaps during facility assessment (these must be part of the in-service and discussed), all steps in the fall management process and the credentials to login to the online portal for the x-ray company. Review of the facility's In-Service for all nursing staff on falls with injury dated 11/8/22, included pain management. Review of additional in-services dated and completed on 11/29/22, 12/19/22, 12/22/22, 12/23/22 and 1/5/23 revealed staff were trained on all aspects of the fall management process especially when the resident was injured. In an interview on 01/12/23 at 10:09 AM LVN S stated she was in-serviced (one on one) by the Unit Manager (LVN U) after the incident where Resident #6 was sent to the hospital. In a later interview on 1/13/23 at 3:01 PM LVN S stated the Unit Manager discussed with her about the fall process and stressed the importance of documenting administration of medication because if it is documented it means it was not done. The Unit Manager pointed out to her that she needed to call the doctor for a stronger medication since the Naproxen was only for pain on a scale of 1-3. LVN S stated she has since had to call the doctor for stronger pain meds for a different patient with a similar issue. (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	01/12/2023

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews beginning on 12/20/22 at 7:53 AM through 01/12/23 at 4:30 PM with the nursing staff included: LVN E, LVN V, LVN W, LVN AA, LVN AB, LVN AG, LVN AH, LVN AI, RN AJ, and LVN AK. Interviews revealed nurses knew the procedure for pain management, communicated via the 24 hr report and gave a verbal report at shift change to each other, the nursing staff knew the steps to follow if a resident had a fall with suspected injury, and the nursing staff had been in-serviced on these topics. The nurses also were aware that if there was not a medication to cover the pain level indicated, that they should call the doctor to get another order. Observations from 12/20/22 at 7:40 PM to 01/12/23 at 3:30 PM revealed fall protocols were in place for residents who required such protocols (Resident #'s 4, 7, 8, 10, 11 and 13). Interviews with Residents with PRN pain management on 01/12/23 revealed they got medication when requested and they were not in any pain (Resident #'s 11, 12 and 13). Review of the MAR for Residents with PRN pain management revealed pain assessments were completed and pain medications administered as ordered for Resident #'s 11, 12, 13, 15, 16, 17 and 18. Review of a facility Monitoring Tool dated from 11/7/2022 to 01/12/23 titled Incident/Accident Report and Diagnostic Review was used daily from 11/7/22 to 01/12/23 by the ADON. In an interview on 01/12/23 at 5:45 PM DON revealed signing off on the monitoring tool meant the incident reports were reviewed daily by the ADON and the DON. The ADON and DON were following up to check what was done to address the pain scale on the incident reports. The ADON and DON were monitoring pain meds and ensuring they had meds ordered that covered all numbers on the pain scale. The DON stated for example that if a Resident only had pain medication coverage for pain level of 1-3, the facility would call the doctor to get a medication to cover a higher level of pain. DON stated the IDT team met daily to review each fall and to ensure follow up from each department as needed.

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	01/12/2023

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 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44197 Based on observation, interview, and record review the facility failed to promptly notify the ordering physician of results that fell outside of clinical procedures for notification of the ordering physician for one (Resident #6) of five residents reviewed for diagnostic services. The facility did not ensure diagnostic services were provided for Resident #6 as ordered when the resident experienced a fall with injury that resulted in a fracture to the left hip. Resident # 6 remained at the facility for three days before being sent to the hospital where the x-rays were obtained. These failures could place residents at risk for delayed identification and treatment of undiagnosed illnesses, hospitalization , pain, and suffering. An Immediate Jeopardy was determined to have existed from 11/04/22 through 11/07/22. The IJ was removed on 11/08/22 because the facility implemented actions that corrected the non-compliance prior to the beginning of the survey. The facility Administrator was provided the IJ Template on 01/12/23 at 9:52 AM. Findings included: Review of Resident # 6's Face Sheet dated 12/23/2022 revealed a 79-yr-old female who admitted to the facility on [DATE] and discharged on [DATE]. Resident # 6's diagnoses included cerebral infarction, unspecified injury of head, diabetes mellitus, and central pain syndrome. Review of Resident # 6's Care Plan dated 12/23/22 revealed a 'fall care plan was in place with the following intervention added on 11/04/22, Assess for potential fall-related injury prevention, looking at circumstances, location, medication, new or worsening medical problems, etc. Review of 24-hour report dated 11/4/22 reflected a comment written by LVN S, resident was pushed down by another resident, exhibited pain in left hip call Dr and ordered x-ray. Review of Resident # 6's Progress Note dated 11/04/22 written by LVN S reflected, Resident was in her room and was pushed down by another resident, resident fell on her left hip and exhibited signs of pain called dr to report change of condition, ordered x- ray to have left hip examined. Review of Resident # 6's Progress Note dated 11/06/22 at 2:13 PM written by LVN S reflected, resident having difficultly standing on left hip has mild edema of left leg, notified NP, ordered x ray STAT per NP if not completed in 3-4hr span was advised to send resident out. Review of Resident # 6's Progress Note dated 11/07/22 at 1:55 PM written by LVNS on reflected, resident having difficultly standing on left hip has mild edema of left leg, notified Dr ordered x ray STAT per NP if not completed in 3-4hr span was advised to send resident out , x- ray not done notified [agency name] ambulance to transport resident to hospital for x- ray and further care, notified family/ unit manager of change of condition, ambulance scheduled for 3:30pm to transport. (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	01/12/2023

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 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident # 6's NP Note dated 11/4/22 reflected, The patient is seen for a periodic follow-up visit. She is seen sleeping in her bed recently, easily awoke with verbal stimuli. She is very confused secondary to dementia but denies any acute problem at the present time. Later on I was notified over the phone while I am driving that the patient is complaint pain on the left hip area. She was pushed by another confused patient and the patient fell . Ordered left hip x ray and instructed to treat the pain with the pain medication. Nurse will notify provider if symptoms get worst. She is generally agreeable to care routine and easily redirected. Review of facility's Provider Investigation Report dated 11/15/22 revealed Resident # 6 was pushed by another resident on 11/08/22 which resulted in a witnessed fall. Resident # 6 was assessed and complained of pain to left lower leg. Further review of the report indicated the resident was sent to ER for further evaluation where x-rays revealed a fracture to the left hip. This report reflected the incident occurred on 11/8/22 even though it occurred on 11/4/22. The facility was informed of Resident # 6's x-ray results on 11/8/22 after sending her to the hospital on 11/7/22. The facility in-serviced (trained) staff on abuse, neglect, resident to resident behaviors, fall with injury and x-ray ordering on 11/8/22. Review of the Witness Statement dated 11/08/22 reflected LVN S was notified on 11/04/22 that Resident # 6 was pushed by another resident and fell . LVN S found resident on her left side and completed an assessment. The written statement indicated, Assessment noted pain to left hip with no visible injuries. New orders received and inputted for x-ray to left hip. On 11/6/22 x-ray had not been performed, I was notified by aide that resident continued with decrease in mobility and signs of pain upon assessment left hip noted with minimal edema, I notified NP and was given orders to reorder Xray as STAT, I inputted the orders. Upon arrival on 11/7/22 X-rays had not been performed I notified the NP and received orders to send to ER for further evaluation, resident was sent via non-emergency transportation. Interview and record review on 12/20/22 beginning at 7:53 AM with LVN AA revealed a one-time left hip x-ray (2 views) was ordered for Resident # 6 on Friday 11/04/22. A Stat x-ray with the same views was ordered for Resident # 6 on Sunday 11/06/22. LVN AA stated he did not know why the x-rays were not done. LVN AA stated after reviewing the record that it was LVN S that entered the x-ray orders. LVN AA stated that it was the doctor and not the LVN that determined the type of x-ray that was ordered, whether stat or regular. LVN AA stated that normal practice was if someone had a fall and was in pain, to get an order from the doctor, enter the order into the system and then call it into the x-ray company. Interview on 12/22/22 at 10:20 AM with LVN S stated she entered an x-ray order after Resident # 6 fell on [DATE]. LVN S stated she had some time off in between the two x-ray orders on 11/04/22 and 11/06/22. LVN S stated the general procedure if a resident had a witnessed fall, the nurse was to complete a full assessment to include skin and pain evaluations, vital signs, then inform the unit manager, the Administrator, the family and the doctor. Interview on 01/12/23 at 10:09 AM with LVN S revealed at the time of the fall LVN S did not know she had to call the x-ray company after entering the order in the facility's electronic medical record. LVN S stated she did not call the company on 11/4/22, however she stated she called them on 11/06/22. LVN S stated Resident # 6 typically wanted to stay in bed, but once staff got her up, she would get up and walk around. LVN S said she would personally walk the halls with Resident # 6 but would keep a wheelchair close by in case the resident got weak and needed to sit down. (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	01/12/2023

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 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview via telephone on 12/22/22 at 11:22 AM with NP AD revealed the x-ray company typically obtained the x-ray the same day it was ordered whether he ordered a stat x-ray or not. He stated that when x-ray orders came in, the facility was supposed to informed him right away. NP AD stated if an x-ray revealed a fracture, it would be an immediate transfer to the ER. NP AD stated with a fall on 11/4/22, if the staff called him on 11/6/22 he would have told them if an x-ray was not done within the hour, that the Resident should be sent out to the hospital. When informed Resident # 6 was not sent out until 11/7/22 after falling on 11/4/22, NP AD was surprised at the length of time that had elapsed, NP AD stated he did not know what happened, and stated that he always answered his phone. Interview on 12/22/22 at 3:38 PM with Resident # 6's primary contact listed on Resident # 6's Face Sheet on revealed Resident was diagnosed with left hip fracture and had surgery where her socket was removed. She stated the resident was still in pain and was at another facility and had to go on hospice after the surgery. She stated Resident #6 used to walk and now she stayed in the fetal position in bed because she was in too much pain. Interview on 12/22/22 beginning at 5:02 PM with the Assistant Administrator and DON revealed LVN S should have called the x-ray company to find out the estimated time of arrival of the x-ray company. They stated LVN S thought that when she entered the order in the facility's electronic medical record platform, that it automatically went to the x-ray company, but there was actually an additional step. DON stated The facility needed to fax the company and then the company would call to confirm. The Assistant Administrator stated that after the incident she told LVN U, the Unit Manager to educate LVN S on the process of x-ray ordering. The Assistant Administrator stated x-ray ordering should have been part of LVN S's new hire training process. The DON stated the LVN that worked 2-10 PM shift on 11/06/22 should have sent Resident # 6 out to the hospital when it was realized that the x-ray was not obtained in the time frame (3-4 hr span of time) provided by the nurse practitioner. The DON stated she understood the danger of having a long-time lapse before being sent to the hospital after a fall. She stated if a person was normally ambulatory and then that changes, they should have an x-ray and often those patients need to be sent out to the hospital for further evaluation. In a later interview on 01/12/23 at 12:01 PM with the DON and ADON, it was clarified that staff could either enter the x-ray order in the online portal of the x-ray company or call them on the phone to communicate the x-ray order. The Plan of Removal process was not needed at this time because the facility implemented actions that corrected the non-compliance prior to the beginning of the survey on 12/20/2023. The facility implemented the following interventions to address non-compliance: Review of the facility's In-Service (training) dated 11/07/22 reflected LVN U, the Unit Manager provided one on one training to LVNS S titled Fall prevention, Xray ordering process, family communication, included pain management, Xray process, review of adverse events that occurred as a purpose for the training or identified gaps during facility assessment (these must be part of the in-service and discussed), all steps in the fall management process and the credentials to login to the online portal for the x-ray company. Review of the facility's in-service dated 11/8/22 reflected training for all nursing staff on Falls with Injury, included instructions on ordering x-rays from the x-ray company. (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	01/12/2023

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 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of additional in-services dated and completed on 11/29/22, 12/19/22, 12/22/22, 12/23/22 and 1/5/23 revealed staff were trained on all aspects of the fall management process especially when the resident was injured. In an interview on 01/12/23 at 10:09 AM LVN S stated she was in-serviced (one on one) by the Unit Manager (LVN U) after the incident where Resident #6 was sent to the hospital. LVN S stated she was given instructions on the entering the x-ray orders on the online portal of the x-ray company and on calling the company on the phone to get confirmation that the order was received. Interviews beginning on 12/20/22 at 7:53 AM through 01/12/23 at 4:30 PM with the nursing staff included: LVN E, LVN V, LVN W, LVN AA, LVN AB, LVN AG, LVN AH, LVN AI, RN AJ, and LVN AK. Interviews revealed nurses knew the procedure for ensuring x-ray orders were carried out, communicated via the 24 hr report and gave a verbal report at shift change to each other, the nursing staff knew the steps to follow if a resident had a fall with suspected injury, and the nursing staff stated they had been in-serviced on these topics. Observations from 12/20/22 at 7:40 AM to 01/12/23 at 3:30 PM revealed fall protocols were in place for residents who required such protocols (Resident #'s 4, 7, 8, 10, 11 and 13). Review of facility Fall Incidents between November 2022 and December 2022, aside from Resident # 6, reflected facility residents with a fall were sent out to the hospital in a timely manner when a change of condition was identified for Resident #'s 4, 8, 9 and 10. Review of a facility Monitoring Tool dated from 11/7/2022 to 01/12/23 titled Incident/Accident Report and Diagnostic Review was used daily from 11/7/22 to 01/12/23 by the ADON. In an interview on 01/12/23 at 5:45 PM DON revealed signing off on the monitoring tool meant the incident reports were reviewed daily by the ADON and the DON. The ADON and the DON were following up to check that x-rays were completed if ordered. DON stated the IDT Team met daily to review each fall and to ensure follow up from each department as needed.

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	01/12/2023

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44197 Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of COVID-19 for 1 of 2 (Resident # 2) residents and 3 of 5 (CNA B, CNA C, and Med Aide D) staff reviewed for infection control. The facility failed to ensure CNA B, CNA C, and Med Aide D were wearing appropriate PPE and following infection control practices during care of residents positive with COVID-19. The staff subsequently entered rooms of residents who were negative for COVID-19 and did not perform hand hygiene during meal service. An Immediate Jeopardy (IJ) was identified on 12/21/22 at 12:03 PM. While the IJ was removed on 12/23/22 at 4:40 PM, the facility remained out of compliance at a level of no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope of pattern as the facility was continuing to monitor the implementation and effectiveness of their corrective systems. The IJ template was provided to the Assistant Administrator on 12/21/22 at 2:43 PM. These failures could place residents at risk of exposure of Covid-19 virus which could result in serious illness, hospitalization , and/or death. Findings included: Record review of Resident # 2's face sheet, dated 12/23/22, revealed an [AGE] year-old female admitted to the facility on [DATE]. Record review Resident # 2's consolidated orders, dated 12/23/22, revealed she had a diagnosis of COVID-19. Review of the Resident Census Roster dated 12/20/22 revealed as of 12/20/22 two residents (including Resident # 2) were positive for COVID-19 and Resident # 2 was assigned to Rm 124. Review of Admission/Discharge log revealed Resident # 2 went to the hospital on 12/17/22 and returned to the facility on [DATE]. Review of Isolation list revealed Resident # 2 was placed on isolation upon return to the facility on [DATE] because she tested positive for COVID-19 while at the hospital. Interview with Resident # 2's family representative on 12/20/22 at 8:54 AM revealed there was a camera in Resident # 2's room. Review of video footage on 12/20/22 at 9:15 AM revealed CNA A and an unknown agency staff were at bedside of Resident # 2 to perform incontinent care at 4:40 AM that morning. Both staff wore a N95 mask and gloves. No eye protection or gowns were noted. CNA A wore two N95 masks with the top strap of both masks behind her head, while the bottom straps of both masks hung underneath her chin. (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	01/12/2023

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the staff schedule dated 12/19/22 revealed CNA A was assigned to 23 residents on 12/19/22 10PM-6AM shift, including Residents #2 and #3. The schedule also revealed 2 agency aides had worked on that shift as well. Interview via telephone with CNA A on 12/21/22 at 7:07 AM revealed she did not know the name of the aide that helped her change Resident # 2 in the morning on 12/20/22. When asked what the appropriate PPE was for entering a covid-19 positive room, CNA A stated gown, gloves, face shield and mask. Interview with Staffing Coordinator on 12/20/22 at 3:30 PM revealed she did not have access to the phone numbers of the staff sent to her from the agency company with whom the facility had a contract. Observation on 12/20/22 at 5:56 PM revealed CNA B entered Resident # 2's room to answer the call light. CNA B was wearing an N95 and a face shield. He did not wear a gown. Review of video footage of Resident # 2's room from 12/20/22 at 5:56 PM when CNA B answered the call light revealed CNA B reached over without gloves, grabbed the resident with both hands and pulled her over so that she was positioned in the center of the bed. The video footage revealed hand hygiene was not performed while CNA B was in the room. Observation on 12/20/22 at 5:58 PM revealed CNA B exited Resident # 2's room pushed his face shield up to his forehead leaving the face shield at an angle and pulled his N95 down below his chin and turned around to speak with the resident from the doorway. No hand hygiene was performed. Observation on 12/20/22 at 6:02 PM to 6:14 PM revealed CNA B in a COVID-19 negative room delivering dinner meals. CNA B exited the COVID-19 negative room and proceeded to the beverage cart on the hallway. CNA B picked up drinking cups by the rim and lined them up on the cart, grabbed pitchers of water and iced tea and poured drinks into the respective cups. CNA C then grabbed those same beverage pitchers to pour drinks that were delivered to other residents as well. CNA B delivered resident meals and beverages, and helped residents get set up to eat in four covid negative resident rooms. Each room housed two residents each (8 residents total). CNA B used hand sanitizer only once upon exit of one of the four rooms. Observation on 12/20/22 at 6:15 PM revealed CNA C and the kitchen server pushed the beverage and hot food cart down to the other side of the 100 hall to continue serving meals to covid negative residents (the same cart CNA B had touched to deliver food to residents after entering Resident #2's room). Interview via telephone on 12/21/22 at 12:36 PM with CNA B revealed he recalled entering Resident # 2's room without a gown during the evening shift on 12/20/22. CNA B stated there were gowns available in the gray container outside the resident's room and stated he could not explain why he did not wear a gown before entering the room. He stated he had been in-serviced recently on the need to wear N95, face shield and gown to enter a covid positive room. He stated handwashing was covered in the recent in-services. CNA B stated entering a covid positive room without proper PPE and then entering a covid negative room could increase the chances of getting other residents sick or contamination of other things. (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	01/12/2023

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of video footage revealed on 12/20/22 at 7:13 PM Med aide D entered Resident # 2's room with medications and a cup. Med aide D wore gloves, N95 mask and goggles. He was not wearing a gown. Observation on 12/20/22 at 7:30 PM revealed Med aide D entered a covid negative room to administer medications to both residents in that room. In an interview on 12/21/22 at 4:10 PM Med aide D revealed he gave Resident # 2 her medications first for the 7PM medication pass on 12/20/22. Med aide D stated after Resident # 2, he gave meds to two residents on the same side of the hall as Resident # 2, and then gave meds to the residents on the A side of 100 hall as most of the residents on that hall had 7PM meds ordered. Med aide D stated it escaped his mind to use the gown when he administered meds to Resident # 2 on 12/20/22. He stated the risk for entering covid negative rooms after not wearing appropriate PPE in a covid positive room was transmission of covid-19. Record review of the Coronavirus Management Plan Texas Phase 2 & 3, which the facility was using as their policy, dated 11/03/22, revealed COVID Positive Unit .Personnel who enter the room will wear N95 respirators. In addition, staff should wear a gown, gloves, and face shield or goggles. Review of the CDC Guidance titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-10) Pandemic, dated 09/23/22, reflected HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved particulate respirator with N95 filters or higher , gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). On 12/21/22 at 1:11 PM the Assistant Administrator, DON and Regional Director of Operations were notified an Immediate Jeopardy (IJ) situation was identified due to the above failures. The IJ template was provided to the Assistant Administrator on 12/21/22 at 2:43 PM. The facility's Plan of Removal was accepted on 12/22/22 at 12:14 PM and reflected the following: [name of the facility] PLAN OF REMOVAL FOR IMMEDIATE JEOPARDY on 12/21/22 To Whom it May Concern, Infection Control F880- The facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Identify residents who could be affected (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	01/12/2023

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	All residents have the potential to be affected by this alleged proficient practice Problem Staff members were seen providing care for a COVID positive resident without wearing appropriate PPE and/or wearing PPE in an inappropriate manner. Staff members were seen not performing hand hygiene after entering a COVID positive resident's room and when passing meal trays to residents. Action Taken Infection Control c ICP will re-educate Director of Nursing and Assistant Director of Nursing on company's infection control policy related to Covid 19 by end of day on 12/22/2022. c Use of alcohol-based hand sanitizer and hand washing with soap and water with emphasis on when to use soap and water versus alcohol-based hand sanitizer c Donning/Doffing of proper PPE for N95, gowns, gloves, face-shields/goggles before entering and exiting Covid positive rooms c ICP is responsible for monitoring the education of the Director of Nursing and the Assistant Director of Nursing on company's infection control policy related to Covid 19 Hand Hygiene and Competency c Staff in-servicing on alcohol-based hand sanitizer and hand washing with soap and water with emphasis on when to use soap and water versus alcohol-based hand sanitizer with competency conducted by ICP, Director of Nursing, Assistant Director of Nursing, and/or Designee include staff handwashing and when to use hand sanitizer. c Competencies consist of review of necessary steps and 100 % accuracy on return demonstration. c Inservicing was implemented on 12/21/2022. All staff to be included in training. Training to be completed by 12/23/22. Staff not physically in community to receive their education in person prior to their next shift by ICP, Director of Nursing or Assistant Director of Nursing and/or Designee and will be able to perform a return demonstration. c This training will be part of new hire orientation checklist starting 12/22/2022 to include any new agency staff prior to working their next shift. (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	01/12/2023

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	c Monitoring will begin 12/22/2022 and will be conducted by ICP, Director of Nursing, Assistant Director of Nursing, and/or designee to observe and document hand hygiene compliance twice daily throughout the outbreak then three times a week for four weeks, then two times a week for two weeks, then weekly for one month then as needed thereafter to ensure continued compliance. If the Director of Nursing or designee sees that a staff member is not following the company's infection policy, immediate on the spot re-education and redirection will be given. PPE and Competency c ICP, Director of Nursing, Assistant Director of Nursing, and Designee in-serviced all staff on what PPE to wear to include type of mask i.e. N95, gowns, gloves, face-shields/goggles before entering and exiting Covid positive rooms c All staff will be in-serviced in person prior to working their shift. Training to be completed by 12/23/22 Those not physically in community will receive their education in-service in person prior to working their shift by ICP, Director of Nursing or Assistant Director of Nursing and/or Designee and will be able to perform a return demonstration prior to working their next shift. c This training will be part of new hire orientation checklist starting 12/22/2022 to include any new agency staff prior to working their first shift. c Monitoring began 12/22/2022 and will be done by ICP, Director of Nursing, Assistant Director of Nursing, or designee through random questioning on PPE and hand hygiene to ensure knowledge has been retained on various eight hour shifts to begin 12/22/2022. c Director of Nursing or designee is rounding twice daily throughout the outbreak then three times a week for four weeks, then two times a week for two weeks, then weekly for one month then as needed thereafter to ensure continued compliance ensuring proper infection control practices are in place through observation and questioning. If the Director of Nursing or designee sees that a staff member is not following the company's infection policy, immediate on the spot re-education and redirection will be given. On 12/22/22 to 12/23/22 the surveyor confirmed the facility implemented their Plan of Removal sufficiently to remove the IJ by: Review of the facility's in-service and competency testing records revealed: 1.The DON's name was listed as the facilitator of the in-services. The in-service topic was Infection Control, Covid-19 with an emphasis on hand hygiene and donning/doffing PPE. 2.As of 12/23/22 at 4:40 PM a total of 132 staff employed at the facility had been in-serviced and passed the hand hygiene and PPE competency. Observations conducted from 12/22/22 at 10:55 AM to 5:00 PM on 12/23/22 revealed staff were donning and doffing PPE appropriately upon entrance and exit of covid-19 positive rooms. (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	01/12/2023

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interviews conducted on 12/23/22 from 9:48 AM to 5:30 PM with staff from all three shifts(LVN E, Med aide F, CNA G, CNA H, CNA I, CNA J, COTA, ST Assistant Director, LVN K, Housekeeper L, Environmental Director, Laundry aide, Dietary cook M, Dietary cook N, PT O, CNA P, RN Q, CNA R, LVN S, CNA T, LVN U, LVN V, Housekeeper Z, LVN W, RN X, CNA Y, and Rehab tech), revealed staff were knowledgeable about what PPE was required to enter a COVID-19 positive room and why hand hygiene was important after doffing to prevent the spread of infection. The staff stated they had to watch videos on hand hygiene and PPE and had to perform a skills test. In an interview with the ADON on 12/23/22 at 4:56 PM it was revealed that utilizing PPE and performing hand hygiene was the way to ensure COVID-19 was not being spread when going from a positive room to a negative room. The ADON stated charge nurses, direct supervisors and everyone was in charge of going behind staff to ensure they followed infection control protocols. They could make rounds and address any issues at that time. The ADON stated an IJ was identified because the staff were not following the proper PPE and hand hygiene protocols, thereby placing residents at risk. The ADON stated the facility was going to implement ongoing monitoring, monitoring tools and schedules to ensure proper infection control measures were followed. In an interview with the DON on 12/22/22 at 8:39 AM she stated an IJ was identified because staff was caring for sick residents and then entered rooms of residents who were not sick without proper PPE or hand hygiene, thereby spreading germs to others. In an interview with the DON on 12/22/22 at 8:39 AM she stated she understood why this was identified as an IJ because staff was caring for sick residents and then entered rooms of residents who were not sick without proper PPE or hand hygiene, thereby spreading germs to others. In an interview on 12/23/22 at 5:48 PM, the Assistant Administrator stated an IJ was identified because of the failure of staff to wear the proper PPE, going in and out of resident rooms that were covid positive and negative in addition to concerns with handwashing and sanitizing. She stated all this could lead to potential harm or spread of infections and diseases. An Immediate Jeopardy (IJ) was identified on 12/21/22 at 12:03 PM. While the IJ was removed on 12/23/22 at 4:40 PM, the facility remained out of compliance at a level of no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope of pattern as the facility was continuing to monitor the implementation and effectiveness of their corrective systems.