STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455994	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DESOTO LTC PARTNERS, INC	**1101 N HAMPTON RD 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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for three (Residents #6, #9, and #2) of ten residents reviewed for care plans. 1. The facility failed to revise Resident #6's care plan to update their current code status. 2. The facility failed to revise Resident #9's care plan to update their current code status. 3. The facility failed to develop an accurate individual comprehensive care plan which identified Resident #2's [MEDICAL CONDITION]. Findings included: 1. Record review of Resident #6's face sheet, dated [DATE], revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #6's care plan, dated [DATE], revealed the resident had a code status of Full Code CPR order in place. Further review revealed the goal was Request for CPR to be initiated will be followed and the intervention reflected Review medical record to ensure that proper documents are signed. Record review of Resident #6's physician's orders [REDACTED].#6's Out of Hospital Do Not Resuscitate (OOH-DNR), undated, revealed the resident's POA (Power of Attorney) and the physician signed on [DATE] . An interview on [DATE] at 2:59 PM with the MDS Coordinator revealed it was an oversight that the code status for Resident #6 did not match what was reflected in the care plan . An interview on [DATE] at 9:14 AM with the ADON revealed it was important that the care plan reflected the resident's wishes in terms of advance directives and did not know that Resident #6's care plan did not match her advance directives or doctor's orders. 2. Record review of Resident #9's face sheet, dated [DATE], revealed she was an [AGE] year-old female admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #9's physician orders, dated [DATE], revealed the resident was ordered to have been a full code with an active date of [DATE]. Record review of Resident #9's care plan, dated [DATE], revealed the care plan did not address the code status for the resident. An interview on [DATE] at 2:59 PM with the MDS Coordinator revealed it was an oversight that the code status for Resident #9 was not reflected in the care plan. During an interview on [DATE] at 9:14 AM with the ADON revealed it was important that the care plan reflected the resident's wishes in terms of advance directives and did not know that Resident #9's care plan did not address her advance directive. Record review of facility's policy, dated [DATE], and titled Advance Directives, reflected .7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record . 10. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive. 3. Review of Resident #2's quarterly MDS assessment, dated [DATE], reflected Resident #2 had an ostomy. Resident #2's bowel incontinence was not rated because the resident had an ostomy or did not have a bowel movement for the entire 7 days. Review of Resident #2's [DATE] Order Summary Report reflected monitor [MEDICAL CONDITION] to LUQ qshift every shift for [MEDICAL CONDITION] care with a start date of [DATE]. Review of Resident #2's care plan, revised [DATE] and provided by the MDS Coordinator on [DATE] at 9:09 a.m., did not reflect the resident's [MEDICAL CONDITION]. Interview on [DATE] at 2:59 p.m. with the MDS Coordinator Resident #2's [MEDICAL CONDITION] was not on his care plan. She stated this was an oversight on her part. She stated she noticed today, [DATE], that the [MEDICAL CONDITION] was not on the care plan and would be added. Review of Resident #2's care plan, revised [DATE], reflected Resident #2 required the use of an Ostomy as evidenced by: [MEDICAL CONDITION] to LUQ of abdomen. An interview on [DATE] at 2:59 PM with the MDS Coordinator revealed that she was responsible for ensuring that the care plan was completed and matched the MDS (Minimum Data Set). She said that the care plan's purpose was to let the staff know how to care for the resident and what their direct care needs were. She said that the advance directives care area should have been on the care plan and addressed. She said that the resident's code status should reflect either full code or DNR based on their wishes. She said that the purpose was so that the nurse knew what to do when the resident was unresponsive. An interview on [DATE] at 9:14 AM with the ADON revealed that the care plan included everything that a resident needed to be taken care of. She said that it reflected how to take care of the resident and advance directives were included on the care plans. During an interview on [DATE] at 9:22 AM with the DON revealed that the care plans included everything related to the resident's care. He said that the advance directive in terms of full code or DNR status should have been on the care plan. He said that the MDS Coordinator was responsible for ensuring the code status matched the resident's wishes. During an interview on [DATE] at 10:23 AM with the Administrator revealed that the care plans included a complete picture of the resident and their needs. She said that the care plan was completed by the MDS Coordinator and that advance directives should have been on the care plans. She also said that she did not think that the advance directive had to be included on the care plan because the nurse would not look there in an emergency situation when deciding to provide CPR or not.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food safety in the facility's only kitchen. 1. The facility failed to ensure food items in the dry storage and freezer were labeled and dated. 2. Dietary Aide E failed to wear an effective hair restraint. 3. Dietary Aide E failed to follow proper hand washing procedures. These failures could affect residents by placing them at risk for food-borne illness. Findings included: 1.Observation on 03/02/20 at 8:53 a.m. of the dry storage revealed four clear, plastic bags of shredded coconuts, as identified by the Dietary Manager, that were not labeled with identifying information of the content. Interview on 03/02/20 at 8:53 a.m. with the Dietary Manager revealed the bags of coconut had been taken out of the original box. She stated items were labeled once they were taken out of the box and opened. Observation of the freezer and interview with the Dietary Manager on [DATE] at 10:29 a.m. revealed the following: - two resealable bags of zucchini, as identified by the Dietary Manager, were not labeled -one bag of omelets, as identified by the Dietary Manager, was not labeled or dated -one resealable bag of okra, as identified by the Dietary Manager, was not labeled or dated -a second resealable bag of okra, as identified by the Dietary Manager, was not labeled Interview with the Dietary Manager revealed the food items were supposed to be dated and labeled. She did not know why they were not labeled or dated. She stated staff usually labeled and dated the food items, but sometimes if the bags got wet, the writing would come off. Review of the facility's Food Receiving and Storage policy, revised July 2014, reflected .8. All foods stored in

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) the refrigerator or freezer will be covered, labeled and dated (use by date) . Review of the U.S. Public Health Service Food Code, dated 2017, reflected: .3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A food specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; P (2) Is in a container or package that does not bear a date or day; P or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A). .(D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: .(2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section; (3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section. 2.Observation on [DATE] at 10:09 a.m. revealed Dietary Aide E's mustache was not covered. Dietary Aide E was in the dish room operating the dish machine. Interview on [DATE] at 10:12 a.m. with Dietary Aide E revealed he had to wear a hair net around his head and face area so hair would not fall in food or juice. He stated his mustache was supposed to be covered but he could not walk around with that thing covering his mouth. Review of the facility's Preventing Foodborne Illness -- Employee Hygiene and Sanitary Practices policy, revised October 2017, reflected, .12. Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens. The US Food and Drug Administration's Food Code 2017 reflected, .Hair Restraints 2-402.11 Effectiveness .Food employees shall wear hair restraints such as hats, hair covering or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single service and single-use articles . 3. Observation on [DATE] at 10:03 a.m. revealed Dietary Aide E washed his hands, turned off the faucet with clean hands, and grabbed a paper towel to dry his hands. Interview on [DATE] at 10:12 a.m. with Dietary Aide E revealed the procedure for washing hands was to put soap on his hands, wash and rinse, dry his hands, and then turn the faucet off. He stated sometimes he forgot. Review of the U.S. Public Health Service Food Code, dated 2017, reflected: (C) TO avoid recontaminating their hands or surrogate prosthetic devices, FOOD EMPLOYEES may use disposable paper towels or similar clean barriers when touching surfaces such as manually operated faucet handles on a HANDWASHING SINK or the handle of a restroom door.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have complete and accurate documented medical records for one (Resident #14) of four residents reviewed for medical records. The facility failed to have physician's orders [REDACTED]. This failure could place residents at risk for inadequate care and a decline in health status. Findings included: Review of Resident #14's Admission record, dated 03/04/20, revealed he was a [AGE] year-old male admitted to the facility on [DATE], then readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #14's care plan, revised on 03/04/20, reflected the resident had impaired [MED]gen exchange related to [MEDICAL CONDITION]/SOB. Review of Resident #14's March 2020 Order Summary Report, provided by the MDS Coordinator on [DATE] at 9:09 a.m., reflected there was no order for Resident #14's [MED]gen. Observation on 03/02/20 at 10:07 a.m. revealed Resident #14 lying in bed with [MED]gen tubing in his nose. Resident #14's [MED]gen concentrator was on and set at 3 LPM. Observation on [DATE] at 8:42 a.m. revealed Resident #14 lying in bed with [MED]gen tubing in his nose. Resident #14's [MED]gen concentrator was on and set at 3 LPM. Interview on [DATE] at 8:49 a.m. with LVN D revealed Resident #14's [MED]gen concentrator was supposed to be set at 2 LPM. LVN D confirmed Resident #14's [MED]gen concentrator was set at 3 LPM. She stated she did not know why Resident #14's [MED]gen was set at 3 LPM but would check his physician's orders [REDACTED].#14's physician's orders [REDACTED].#14's physician's orders [REDACTED].#14's [MED]gen on hold and confirm with the doctor. She stated Resident #14 required [MED]gen for shortness of breath and pneumonia. She stated when Resident #14 returned from the hospital, someone must have forgotten to put the order in the system. Review of Resident #14's March 2020 Order Summary Report, provided by the ADON on 03/04/20 at 10:54 a.m., reflected the following: -check O2 sat Q shift and PRN every shift, with a start date of [DATE] -change respiratory tubing mask, bottled water, clean filter q7d every night every Sun, with an order date of 03/04/20 and start date of [DATE] -[MED]gen at 3L via NC as needed for SOB/decreased O2 sats, with a start date of [DATE] Interview on 03/04/20 at 9:01 a.m. with the DON revealed the expectation was for Resident #14's admitting nurse to transcribe his physician's orders [REDACTED].
F 0908 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Keep all essential equipment working safely.** Based on observations, interviews, and record review, the facility failed to ensure all patient care equipment was in safe operating condition for nine (Residents #28, #43, #51, #16, #29, #40, #34, #11, and #8) of 46 residents reviewed for wheelchair and bedside table maintenance. 1. The facility failed to properly maintain wheelchairs for Residents #28, #43, #11, and #8. 2. The facility failed to properly maintain overbed tables for Residents #28, #51, #16, #29, #40, #34, and #8. These failures could place residents at risk for skin issues and discomfort. Findings included: 1. Observation on [DATE] at 10:20 a.m. revealed Resident #28's wheelchair had numerous cracks in the back of his wheelchair. The edges of the overbed table was cracked with splintered and exposed wood. Observation on [DATE] at 10:22 a.m. revealed Resident #43's right and left armrest of her wheelchair was ripped with foam exposed, and with sharp edges on the hard plastic. Observation on 03/04/20 at 9:15 a.m. revealed Resident #11's left, and right armrest of her wheelchair had numerous cracks with the foam exposed, leaving an open, porous and unsanitary surface on the wheelchair. Observation on 03/04/20 at 9:45 a.m. revealed Resident #8's left, and right armrest of his wheelchair had numerous cracks with the foam exposed, leaving an open, porous and unsanitary surface on the wheelchair. 2. Observation on [DATE] at 10:20 a.m. of Resident #28's overbed table revealed the edges were cracked with splintered and exposed wood. Observation on [DATE] at 12:23 p.m. revealed the overbed table in Resident #51's room had edges that had splintered and exposed wood. Interview on [DATE] at 12:23 p.m. with Resident #51 revealed her overbed table was falling apart and the wood was rough, and she needed a new one. Observation on [DATE] at 12:24 p.m. revealed the overbed table in Resident #16's room had broken edges with the wood falling off. Interview on 03/04/20 at 12:24 p.m. with Resident #16 revealed she was aware that her overbed table had broken wood on the edges and she was wondering when they were going to replace it. Observation on 03/04/20 at 8:20 a.m. revealed the overbed table in Resident #29's room had broken splintered wood with rough edges. Observation on 03/04/20 at 8:45 a.m. revealed the overbed table in Resident #40's room had broken splintered wood on the edges. Observation on 03/04/20 at 9:00 a.m. revealed the overbed table in Resident #34's had broken splintered exposed wood on the edges. Interview on 03/04/20 at 9:30 a.m. with CNA A revealed if equipment was broken she would tell the maintenance man. Interview on 03/04/20 at 9:35 a.m. with MA B revealed if equipment was broken she would fill out a form and put it in the book at the nurse's station. Interview on 03/04/20 at 2:15 p.m. with LVN C revealed if any equipment needed repair, staff would inform the maintenance department. Interview on [DATE] at 11:15 a.m. with the Maintenance Director reflected if equipment needed repair, staff would notify the maintenance department by filling out the communication form and placing in the box on the door. He stated no one had informed him of the wheelchair armrests or overbed tables needing to be repaired. Review of the maintenance communication forms book revealed there were no requests for residents' wheelchairs armrests to be repaired. Interview on 03/04/20 at 10:13 a.m. with the Administrator revealed the staff was supposed to fill out the communication form and place it in the box on the maintenance door. The Administrator said the entire staff had been in-serviced on the process for reporting broken equipment. When the equipment that needed repair was identified, the Administrator said the corporation revealed the facility would get all new equipment. The Administrator said that she was surprised by some of the wheelchairs that had been identified since the facility just did a full sweep of the wheelchairs. Review of the Procedure for Reporting Broken Wheelchairs, Resident Equipment, and Maintenance Work Order dated 03/15/19 reflected .Do not place a resident in any broken wheelchair that needs tires, brakes, chair arms, etc. (fill out the communication form) . Do not allow broken furniture to remain in any resident's room (Fill out the communication form) All staff will monitor needed for work orders along with the maintenance staff.