STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255296	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desoto Healthcare Center	7805 Southcrest Parkway Southaven, MS 38671

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 44804 Based on observation, staff interview, record review and facility policy review, the facility failed to ensure there was a physicians order for a bolster sheet that was being used to prevent a resident from getting out of bed for one (1) of 27 residents on sample. Resident #81 Findings Include Review of the facility policy titled, Restraints with a revision date of 11/28/17 revealed . Restraint Order . orders for restraint should specify: the rationale (medical necessity) for the use of restraint, the type of restraint . An observation on 07/15/24 at 10:50 AM, revealed there was a concave mattress on Resident #81's bed and the resident was gone to dialysis. An interview on 7/16/24 at 9:00 AM, with Registered Nurse (RN) #1 revealed Resident #81 had several falls and the facility had implemented several different measures to prevent them. She stated that the residents' mind has worsened, and she thinks she can still walk sometimes, especially if she wakes up at night. She revealed they had put her bed in the lowest position and used the concave mattress, because she would forget to use her call light. An interview on 7/16/24 at 3:00 PM, with the Director of Nurses (DON) confirmed Resident #81 had several falls and they have ended up using the concave mattress and it has helped. Record review of Resident #81's physicians orders revealed there was no order for a Concave mattress or Bolster sheet. Record review of the Resident #81 care plans revealed a care plan that was initiated on 12/11/23 for Risk for Falls with interventions that included Bolster sheet to air mattress. An observation, interview and record review on 7/17/24 at 9:40 AM, with RN #1 and Licensed Practical/Quality Assurance Nurse (LPN/QA) #2 confirmed Resident #81 had a Bolster sheet on top of her air mattress and did not have an order. She stated that it appeared that it may have been implemented with the fall that occurred 6/8/24. LPN/QA #2 confirmed Resident #81 should have an order for the bolster sheet on her air mattress and that it does prevent her from getting out of bed. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255296	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desoto Healthcare Center	7805 Southcrest Parkway Southaven, MS 38671

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 7/17/24 at 10:12 AM, the DON confirmed Resident #81 did not have an order for the bolster sheet on her air mattress. She stated she was not aware they needed an order since they were using it to define the parameters of the bed. She stated the purpose of the bolster sheet is to prevent resident's from getting out of the bed. Record review of Resident #81's Admission Record revealed the resident was admitted to the facility initially on 7/12/23 with medical diagnoses that included Osteomyelitis of Vertebra.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255296	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desoto Healthcare Center	7805 Southcrest Parkway Southaven, MS 38671

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 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	Assure that each resident’s assessment is updated at least once every 3 months. 47874 Based on record review, staff interview, and facility policy review, the facility failed to complete a Quarterly Minimum Data Set (MDS) resident assessment within the fourteen-day time frame for two (2) of 27 sampled residents. Resident #54 and #59 Findings Include: Record review of the facility policy titled MDS Assessments with a revision date of 6/9/2023 revealed Policy Explanation and Compliance Guidelines: 1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate, and standardized assessment of each resident's functional capacity using the RAI (Resident Assessment Instrument) manual. Record review of the facility's MDS 3.0 NH (Nursing Home) Final Validation Report dated 7/11/2024 revealed a warning message for Resident #54 and Resident #59's Quarterly MDS with an Assessment Reference Date (ARD) of 5/29/24 indicated, Assessment Completed Late: Z0500B (assessment completion date) is more than 14 days after A2300 (assessment reference date). Record review of Resident #54 and Resident #59's Quarterly MDS with an ARD of 5/29/2024 revealed under section Z0500, Date RN (Registered Nurse) Assessment Coordinator signed assessment as complete indicated 07/11/2024. An interview with the MDS nurse on 7/17/2024 at 11:10 AM, confirmed Resident #54 and Resident #59's Quarterly MDS assessments were completed late. She revealed that she had made corrections to both assessments which caused some delay. The MDS nurse confirmed that both assessments should have been closed by 6/12/2024. She explained they follow the RAI procedure manual for guidance in completing the MDS. An interview with the Director of Nursing (DON) on 7/17/2024 at 11:21 AM, revealed her expectations were for the MDS Nurse to complete the MDS assessments within the designated time frame set forth by CMS (Centers for Medicare and Medicaid Services). Record review of the Admission Record revealed the facility admitted Resident #54 on 12/16/2022 with medical diagnosis of Alzheimer's disease. Record review of the Admission Record revealed the facility admitted Resident #59 on 8/29/2023 with medical diagnosis of Alcohol dependence with alcohol-induced persisting dementia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255296	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desoto Healthcare Center	7805 Southcrest Parkway Southaven, MS 38671

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 - Few	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** 45598 Based on observation, resident and staff interview, record review and facility policy review, the facility failed to implement an Activities of Daily Living (ADL) care plan for one (1) of 26 residents care plans reviewed. Resident #93 Findings Included: Record review of the facility policy titled, Comprehensive Plan of Care revised 10/10/22 revealed Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment . Record review of Resident #93's care plan, date initiated 4/11/24 revealed Focus: The resident has an ADL self-care performance deficit .Interventions . Resident is usually extensive assistance x (times) 1 with bed mobility, toilet use, personal hygiene, and dressing . During an interview on 7/15/24 at 10:55 AM, an interview with Resident #93 revealed she had been at this facility about three (3) months. She revealed the Certified Nursing Assistants (CNAs) gave her good baths but she was concerned about her teeth. Resident #93 revealed that the staff had brushed her teeth a few times since she had been here, but they had not brushed her teeth since 1 day last week. She stated, If I ask, they will sometimes do it, but if I don't ask, it doesn't get done. Resident #93 revealed that she knew that not brushing her teeth could lead to tooth decay and bad breath and she liked her teeth brushed every day. On 07/16/24 at 9:00 AM, an observation and interview with Resident #93 revealed she was sitting up in her wheelchair in her room drinking her coffee. She revealed that if someone would get her a toothbrush and toothpaste and set them up for her, she could brush her own teeth. She revealed that she had her own teeth and stated, I have good teeth but at this rate, they won't last much longer. On 07/16/24 at 9:05 AM, an observation revealed resident's poor oral hygiene with a yellow substance between her upper and lower teeth and gum line. On 07/16/24 at 1:30 PM an interview with Licensed Practical Nurse (LPN) #1, confirmed the yellow substance on Resident #93's upper and lower teeth and gum line and confirmed that her teeth had not been cleaned. She stated, Her mouth looks pretty rough. LPN #1 revealed that mouth care should be done every day and she would get it taken care of now. LPN #1 revealed that failure to complete daily oral care could lead to gingivitis, loss of appetite, and other issues. She also revealed that mouth care was included in daily personal hygiene and documented by the CNAs. On 07/16/24 at 1:35 PM, an interview with CNA #1 revealed that personal hygiene included mouth care and was supposed to be done every day. She revealed the CNAs helped residents brush their teeth, they rinsed their mouth and provided mouthwash for the residents. CNA #1 revealed she didn't get there until 8:00 AM today and that Resident #93's mouth care had not been done. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255296	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desoto Healthcare Center	7805 Southcrest Parkway Southaven, MS 38671

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 - Few	On 07/17/24 at 9:20 AM, an interview with Director of Nursing (DON) revealed the CNAs were responsible for resident oral care. She revealed that personal hygiene included oral care and was included in Resident #93's care plan. The DON revealed the purpose of the comprehensive care plans was to ensure the staff knew how to take care of each resident to meet their individualized needs. She agreed Resident #93's ADL Care Plan was not implemented when the CNAs failed to ensure that she received daily oral care. Record review of Resident #93's Admission Record revealed an admitted [DATE] with diagnoses that included Parkinson's Disease without Dyskinesia and Need for Assistance with Personal Care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255296	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desoto Healthcare Center	7805 Southcrest Parkway Southaven, MS 38671

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 - Few	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** 45598 Based on observation, resident and staff interviews, record review and facility policy review, the facility failed to ensure Activities of Daily Living (ADL) care was provided daily as evidenced by a resident did not receive daily oral care for one (1) of 26 residents reviewed. Resident #93. Findings Include: Record review of the facility policy Activities of Daily Living (ADL) revised 09/15/22 revealed Policy Explanation and Compliance Guidelines . 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene . On 07/15/24 at 10:55 AM, an interview with Resident #93 revealed she was admitted to the facility about three (3) months ago. She revealed the Certified Nursing Assistants (CNAs) gave her good baths, but she had a concern about her teeth not getting brushed. She revealed the CNAs had helped her brush her teeth a few times since she had been there and wasn't sure if they were supposed to help her with this. She stated, If I ask, they will sometimes do it, but if I don't ask, it doesn't get done. Resident #93 revealed that she brushed her teeth once or twice a day when she was at home. She revealed that she had used a wet washcloth and paper towels to clean her teeth a few times in the facility, but they didn't get her teeth clean. She revealed that she knew that poor oral care could cause tooth decay and bad breath and she would like her teeth to be brushed every day. On 7/16/24 at 9:00 AM an observation and interview with Resident #93 revealed she was sitting up in her wheelchair in her room drinking coffee. She revealed that the CNAs had not helped her brush her teeth since one day last week. She revealed that if they would get her a toothbrush and toothpaste and set up for her, she could brush her own teeth. Resident #93 revealed that she had asked staff several times to get her a toothbrush and toothpaste so she could brush her teeth and they told her that they would get someone to do it or they gave other excuses and never returned. Resident #93 stated, I guess they got busy or forgot about it. She also revealed that she had her own teeth and stated, I have good teeth but at this rate, they won't last much longer. On 7/16/24 at 9:05 AM, an observation revealed Resident #93 had poor oral hygiene as evidenced by a yellow substance between her upper and lower teeth and gum line. During an interview on 7/16/24 at 1:30 PM, with Licensed Practical Nurse (LPN) #1 in Resident #93's room confirmed the yellow substance on Resident # 93's upper and lower teeth and gum line. LPN #1 stated Her mouth looks pretty rough. LPN #1 revealed that mouth care should be done every day, she confirmed that Resident #93's teeth had not been cleaned and that she would get it taken care of now. LPN #1 revealed that failure to provide daily oral care to this resident could lead to gingivitis, loss of appetite, tooth decay, and other issues. She revealed that CNAs were responsible for completing daily personal hygiene and it included oral 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
	255296	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desoto Healthcare Center	7805 Southcrest Parkway Southaven, MS 38671

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 - Few	On 7/16/24 at 1:35 PM, an interview with CNA #1 revealed personal hygiene included mouth care and was supposed to be provided every day. She revealed the CNAs helped residents brush their teeth, rinsed their mouth and provided mouthwash for the residents. CNA #1 revealed she didn't get here until 8:00 AM today and assumed the night shift CNA had taken care of Resident #93. CNA #1 looked at Resident #93's teeth and confirmed that her mouth care had not been done. She revealed that failure to provide mouth care could lead to gingivitis and other problems. On 07/17/24 at 9:20 AM, an interview with the Director of Nursing (DON) revealed the CNAs were responsible for providing personal hygiene for all residents. She confirmed personal hygiene included oral care. She revealed that failing to provide oral care for Resident #93 was not healthy and agreed that it could lead to tooth decay, bad breath, and other health problems. She revealed mouth care was supposed to be done every day and as needed. The DON revealed the CNAs on night shift got some of the residents up before the day shift came in and the day shift CNAs got the rest up and stated, I hate she's fallen through the cracks. She revealed they would resolve this issue now and that she wanted all their residents taken care of. Record review of Resident #93's Admission Record revealed an admitted [DATE] with diagnoses that included Parkinson's Disease without Dyskinesia and Need for Assistance with Personal Care. Record review of Resident #93's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/09/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated that she was cognitively intact. Section GG revealed she required partial to moderate assistance with oral hygiene.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255296	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desoto Healthcare Center	7805 Southcrest Parkway Southaven, MS 38671

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44804 Based on observation, Resident Representative (RR) and staff interview, record review and facility policy review the facility failed to prevent the possibility of an accident as evidenced by a physician ordered medication being found in a resident's bed for one (1) of 27 sampled residents. Resident #52 Findings Include: Review of the facility policy titled, Medication Administration with a revision date of 6/8/23 revealed under Policy Explanation and Compliance Guidelines .#16. Observe the resident consumption of medication. An interview and observation on 07/15/24 at 11:22 AM, with the RR for Resident #52 revealed she was making her mother's bed and found a blue pill in the sheets. This observation revealed she was holding the blue pill. She stated she had called for the nurse. She stated this is not the first time she has found medicine in her mother's bed, but it has been a while. An observation and interview on 7/15/24 at 11:25 AM, with Licensed Practical Nurse (LPN) #3 confirmed the blue pill found in Resident #52's bed was Levothyroxine150 micrograms (mcg). An observation at this time of the resident's medication cards confirmed this pill was Levothyroxine 150 mcg. She stated that it was supposed to have been given between 5-6 AM this morning. She stated the nurse should always stay with the resident to make sure the resident has swallowed all the medications. She stated she would make the Registered Nurse (RN) supervisor aware. An interview on 7/15/24 at 11:30 AM, with RN #1 confirmed the nurse giving the medications should always stay with the resident and make sure the resident has swallowed all medications. An interview on 07/16/24 03:11 PM, with the Director of Nurses (DON) confirmed the medication nurses should always stay with the resident until they had swallowed all medications. She stated the purpose was to make sure the resident took all of their medication, and that no other resident would have access to it. An interview on 7/16/24 at 8:50 PM, with LPN #5 revealed she was Resident #52's nurse on Sunday night 7/14/24 going into Monday morning 7/15/24 and confirmed she gave the resident her medicine while she was in her wheelchair. She stated she has only worked with this resident twice but was warned by other staff members that she tends to not swallow all her medications. She stated the purpose of staying with the resident to make sure they swallow the pills is to make sure they do not get choked on the medications, or that there are no medications left that other residents could find and take. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255296	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desoto Healthcare Center	7805 Southcrest Parkway Southaven, MS 38671

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 7/16/24 at 9:04 PM, with LPN #6 revealed she was Resident #52's nurse on Saturday night 7/13/24 going into Sunday morning 7/14/24 and she gave the resident her medication while she was sitting in her wheelchair. She revealed she always stays with her resident while they take their medicines to make sure they swallow it all. She stated she had been warned about this resident not always wanting to swallow her medicines, so she was aware of that possibility, but she stayed with her. She stated that the purpose of staying with the resident while they take their medicines is because its physicians orders, they get the medicines they need and to make sure no other resident gets them. Review of Resident #52's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Alzheimer's disease. Review of the Care Profile for Resident #52 revealed a physician order dated 10/11/23 for Levothyroxine TAB (tablet) 150 mcg Give 1 tablet by mouth one time a day. Record review of Resident #52's July 2024, Medication Administration Record (MAR) revealed Levothyroxine 150 mcg was documented as given daily through 7/16/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255296	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desoto Healthcare Center	7805 Southcrest Parkway Southaven, MS 38671

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 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. 47874 Based on observation, staff interview, and facility policy review, the facility failed to prevent the possibility of cross contamination to food, as evidenced by failure to perform hand hygiene after picking up a soiled item off the floor during steam table temperature checks for one (1) of three (3) kitchen observations. Findings Include: Review of the facility policy titled Infection Prevention and Control with a revision date of 6/8/2023 revealed Policy: This facility has established and maintains 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 as per accepted national standards and guidelines . During an observation of the lunch meal steam table temperature checks on 7/17/2024 at 11:58 AM, Dietary Staff #1 dropped a pen on the floor. She retrieved the pen from the floor and continued to check and record the food temperatures without washing her hands. An interview with Dietary Staff #1, on 7/17/2024 at 12:08 PM, revealed she was nervous and should have stopped and washed her hands to prevent the spread of bacteria to the food. An interview with the Administrator, on 7/17/2024 at 12:36 PM, revealed Dietary Staff #1 should have got a new pen or washed her hands after retrieving the pen from the floor to continue temperature checks. He acknowledged bacteria could cross contaminate the food.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255296	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desoto Healthcare Center	7805 Southcrest Parkway Southaven, MS 38671

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 45598 Based on staff interview, record review and facility policy review, the facility failed to accurately submit staffing data into the Payroll-Based Journal (PBJ) system for two (2) of 2 quarters reviewed. First and Second Quarters of 2024. Findings Include: Record review of the facility policy, Nursing Services and Sufficient Staff revised 10/12/22 revealed . Policy Explanation and Compliance Guidelines . 7. The facility is responsible for submitting timely and accurate staffing data through the CMS (Centers for Medicaid/Medicare Services) Payroll-Based Journal (PBJ) system . Record review of the PBJ (Payroll Based Journal) Staffing Data Report CASPER Report 1705D FY (Fiscal Year) Quarter 2 2024 (January 1-March 31) revealed Excessively Low Weekend Staffing Triggered. Triggered =Submitted Weekend Staffing data is excessively low. Record review of the PBJ Staffing Data Report CASPER Report 1705D FY Quarter 1 (October 1 - December 31) revealed Excessively Low Weekend Staffing Triggered. Triggered = Submitted Weekend Staffing data is excessively low. On 07/16/24 at 9:20 AM, an interview with the Administrator (ADM) revealed he was aware they triggered excessively low weekend staffing for January through March 31, 2024, and for the last quarter, October 1 through December 31, 2023. He revealed that he was unsure why they triggered low staffing because they had more than adequate staffing. He revealed their staff ratio was usually above 3.0. The ADM revealed the Payroll Coordinator was responsible for gathering the information and putting in the data for the PBJ and submitting it. He revealed they had been trying to figure out why they triggered low weekend staffing so they could get it fixed but they couldn't find the problem. He revealed the Payroll Coordinator had contacted CMS (Centers for Medicare and Medicaid Services) and they were looking into it. The ADM revealed there seemed to be glitches in the system because they had trouble printing out the PBJ Staffing Data Report after submitting their information. On 07/16/24 at 9:30 AM, an interview with the Payroll Coordinator revealed when she realized they triggered for excessively low weekend staffing, she contacted CMS by phone, and she hadn't heard back. She revealed after she submitted the payroll information, she was not able to run the PBJ Staffing Data Report for January 1 through March 31 due to glitches in the system. The Payroll Coordinator stated she double checked everything and confirmed that the information was submitted correctly but she was afraid it would trigger again because they didn't know how to fix it or why it triggered low staffing. She stated, We have more than enough staff. She revealed she enters agency staff hours manually, but all other direct care staff hours roll over to her directly from their payroll system. The Payroll Coordinator revealed she always compares the date in their payroll system and makes sure it is correct before she submits it. Record review of the Staffing Grid for the quarters that triggered for low weekend staffing revealed staffing in the facility was sufficient.