STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455994	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desoto Nursing & Rehabilitation Center	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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide or obtain laboratory services as ordered by the physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State Law, including scope of practice laws and promptly notify the ordering physician of the results for one (Resident #7) of two residents reviewed for labs. The facility failed to obtain urinalysis (UA) for Resident #7 as ordered by physician on 02/25/2026. This failure could place residents at risk of a delay in receiving the necessary treatments to treat their medical condition.Findings included: Record review on 04/30/2026 at 10:00 a.m. of Resident #7's MDS, dated [DATE], reflected a [AGE] year-old male admitted [DATE] and readmitted on [DATE]. His BIM score of 00 indicated severe problems with thinking or memory. His diagnoses include Acute Respiratory Failure with Hypoxia (lungs cannot adequately oxygenate the blood), Dysarthria (speech disorder) following Cerebral Infraction (stroke), and Alzheimer's Disease (brain condition that damages memory). Record review of Resident #1's electronic physician orders for June 2025 revealed an order dated 10/17/24 for CBC (measures varies components of your blood), CMP (blood test that measures fourteen different substances in the blood), lipid (broad group of organic compounds which include fats, waxes, sterols, fat-soluble vitamins, monoglycerides, diglycerides, phospholipids, and others), and Valproic acid a blood test to measure the concentration of valproic acid (medication used to treat certain types of seizures) in the bloodstream) every six months and Hgb (a protein in red blood cells) and A1C (is a blood test that provides an average of blood sugar levels over the past 2-3 months) every three months. Record review of Resident #7's change of condition form, dated 02/25/2026, revealed physician ordered a UA to be completed. Record review of Resident #7's electronic clinic record from 02/25/2026 to 04/30/2026 revealed there were no UA labs results. During an interview on 04/30/2026 at 3:49 p.m., the ADON revealed she was unsuccessful in locating the UA results for Resident #7 for 02/26/2026 as requested by the physician. She stated it had to be done because the physician ordered antibiotics. She stated she would contact the laboratory to see if they were able to locate them. She stated that if they were not successful in obtaining a sample that would have been documented. Requested facility policy on labs on 04/30/2026 at 4:04 p.m., via email to facility ADM but did not receive prior to exit. Attempted an interview on 04/302026 at 4:06 p.m., with the facility's Medical Director at the contact number provided by the facility with no call back prior to exit. During an interview on 04/30/2026 at 4:11 p.m., the DON revealed that she was unable to find the UA results in EHR and stated the physician ordered the UA so the staff should have gotten the UA lab from Resident #7. The DON stated the staff was aware of change of condition, documented, reached out to the physician and the physician ordered Resident #7 antibiotics so the facility was treating Resident #7 for infection and Resident #7's vitals were in normal range so would not have caused concern by the nursing staff. The DON stated the risk when UA were not done would not be able to determine what type of infection Resident #7 had. During an interview on 04/30/2026 at 4:45 p.m., the ADM revealed her expectation of her clinical staff was to follow physician orders. She stated if they could not obtain a sample they were to document that in EHR. The ADM stated the risk to the residents was that could lead to potential health issues that the physician would not be able to address.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 maintain medical records on each resident that were accurately documented for 1 of 7 residents (Residents #2) reviewed for medical records. The facility failed to document at least once per shift that the task turn/reposition for Resident #2 was completed. This failure could place residents at risk of developing skin breakdowns.Findings included: During a record review on 04/29/2026 at 8:45 a.m. of Resident #2's MDS Nursing Home PPS Item Set assessment, dated 03/24/2026, reflected a [AGE] year-old female admitted [DATE]. Her BIMS score was a 10 which indicated moderate problems with thinking and memory were moderately impaired. Her diagnoses included Atherosclerotic Heart Disease (coronary artery disease), Dementia (symptoms affecting memory, thinking and social abilities), and Rheumatoid Arthritis (chronic inflammation disorder). The resident required substantial/maximal assistance on staff for repositioning to her back, left, and right side. The resident had two stage three pressure ulcers and one stage four pressure ulcer listed on admission. During a record review on 04/29/2026 at 8:47 a.m. of Resident #2's task Turn/Reposition located in Resident #2's EHR for April 2026 reflected missing documentation of the task being completed on the following:04/17/2026 - third shift04/19/2026 - third shift04/20/2026 - third shift04/28/2026 - second and third shift Record review on 04/29/2026 at 8:53 a.m. of Resident #2's care plan, dated 04/06/2026, reflected:Resident #2 had pressure ulcer development or potential for pressure ulcer development.Goal:The resident's pressure ulcer will show signs of healing and remain free from infection.Interventions/TaskFollow facility police/protocols for the prevention of skin breakdownThe resident needs assistance to turn/reposition at least every two hours. During an observation on 04/29/2026 at 2:59 Resident #2 in activities. During an interview on 04/29/2026 at 1:09 p.m., CNA A revealed that residents were required to be checked and changed every two hours and, during that time they were turned and repositioned. CNA A stated that they have to chart once per shift in EHR. CNA A stated that if staff did not chart at least once per shift that they had did turn/reposition that would mean the staff member forgot to document the task or that they had not completed the task. She stated the risk to the resident if task was not documented would potentially lead to skin break downs. During an observation and interview on 04/30/2026 at 12:40 p.m., Resident #2 located in the common area revealed that staff do check and change her and reposition her. During an interview on 04/30/2026 at 12:59 p.m., LVN B revealed the facility policy was to check/change and turn/reposition residents every two hours. She stated that the aides were required to chart in the EHR system at least once per shift. LVN B stated that if it was not charted it did not happen. LVN B stated the risk of staff not documenting residents being checked/changed and turned/repositioned at least once per shift meant that the task wasn't completed and that could cause skin to break down. During an interview on 04/30/2026 at 3:49 p.m., the DON stated that it was expectation for staff to check/change and turn/reposition every two hours. She stated that staff are required to chart once per shift. She stated if EHR did not show they charted it meant it meant the task was not performed. The DON stated that if the care provided was not documented the risk to the resident was skin breakdowns. During an interview on 04/30/2026 at 4:45 p.m., the ADM stated that her expectations to document for check and change/repositioning and turning was once per shift. She stated if it was not documented it did not happen. The ADM stated that if it is not documented the risk to the resident would be skin breakdowns. Requested facility policy on charting incontinence care and turning and repositioning on 04/30/2026 at 4:04 p.m., via email to facility ADM but did not receive prior to exit.