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	05/20/2026

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 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** Based on observation, interview and review record the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 6 residents (Resident #7) reviewed for ADL Care. The facility failed to provide Resident #7 with scheduled showers between 05/07/2026 - 05/20/2026. This failure could place residents at risk of not receiving care and services contributing to overall poor hygiene, risk of experiencing a diminished quality of life, and possible skin infections.The findings include: Record review of Resident #7's Nursing Home PPS MDS assessment, dated 05/14/2026 reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His BIMS was a 09, which indicated moderate cognitive impairment. His diagnoses included Metabolic encephalopathy (a broad term for brain dysfunction caused by chemical imbalances in the blood, organ failure, or systemic illness, rather than direct physical injury), Atelectasis (partial or complete collapse of a lung or a specific section [lobe] of a lung) and Idiopathic gout (a painful inflammatory arthritis caused by an excess of uric acid in the blood). Resident #7 was dependent on staff for showering/bathing, upper body dressing and lower body dressing. Record review of Resident #7's Comprehensive Person-Centered Care Plan, dated 05/07/2026, reflected Resident #7 had an ADL performance deficit. Goal to maintain or improve current level of education in personal hygiene with the intervention that Resident #7 was totally dependent on staff to provide bed bath/shower as necessary. Record review of the facility's shower sheet log for the month of May reflected staff had only provided Resident #7 with a shower/bed bath on 05/15/2026. Observation of photos provided by Resident #7's family member revealed a blue air mattress with a dried brown substance. Resident #7 was not observed in the photo. During an interview on 05/18/2026 at 5:46 p.m., Resident #7's family member stated Resident #7 had concerns with the facility. She stated Resident #7 had only received one shower/bath since he was admitted to the facility, and she said she had to bring it to the facility attention. Resident #7's family member stated on 05/13/2026 upon arrival, Resident #7 was dirty with dried feces on the bed that she had pictures of. Resident #7's family member stated his shower days were supposed to be Monday, Wednesday and Friday's. During an interview and observation on 05/19/2026 at 9:47 a.m. of Resident #7 revealed he gets his showers as scheduled now, but when he first got here arrived at the facility he was not provided with a shower for the first few days. Observation of Resident #9 in bed revealed the resident had no odors and did not look dirty and the mattress was clean. An attempt to contact the DON on 05/19/2026 at 2:20 p.m., was unsuccessful. A voicemail was left. Did not receive a return call prior to exit. During an interview on 05/19/2026 at 2:41 p.m., the Director of Rehabilitation (DOR) revealed on05/13/2026 Resident #7's family member stated to the DON that Resident #7 was dirty. The DOR stated the DON had gotten staff to get him up and showered and Resident #7's family sat with him and fed him. During an interview on 05/19/2026 at 3:00 p.m., CNA F stated they were assigned to Resident #7's hallway, and Resident #7's shower days were Monday, Wednesday and Friday. CNA F stated he had provided Resident #7 his showers on his scheduled shower days. CNA F stated he could not tell me why Resident #7 would state he did not receive showers. He stated if a resident received a shower or bed bath they documented it on a (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shower sheet and turned the shower sheet into the nurse. She stated even if a resident refused a shower or bed bath, they documented the resident refused. CNA F stated showers/bed baths were documented in the resident electronic health record. CNA F stated if a sheet was not provided either the aide had forgotten to document on the sheet, may have forgotten to turn the shower sheet in or did not provide a shower to the resident. She stated if a resident was not provided with a shower, they would become dirty and they had the right to be clean. During an interview on 05/20/2026 at 3:38 p.m., LVN A stated residents stated they had not received their showers. LVN A stated she would inform the aide of the residents request or she would provide the resident a shower if an aide was not available. LVN A stated aides were required to document on shower sheets and in the electronic health record that showed it was completed. LVN A stated if it was not documented, it did not happen. During an interview on 05/13/2026 at 4:49 p.m., the Administrator stated her expectation was for residents to receive their scheduled shower on Monday, Wednesday, Friday or Tuesday, Thursday, Saturday which was established at admission. The Administrator stated her expectation was for showers to have occurred on the scheduled days, and the risk to residents who had not received a shower would be skin breakdown and dignity issues. The Administrator stated the DON never reported any complaints from family members who stated a resident had not received a shower. During record review of the printed shower documentation, from 05/07/2026 through 05/20/2026, reflected Resident #7 was only provided a PRN shower on 05/15/2026. Record review of the facility's, undated, policy, titled, Bath, Shower/Tub, reflected bathing by tub bath or shower is done to remove soil, dead epithelial cells, microorganisms from the skin, and body odor to promote comfort, cleanliness, circulation and relaxation.Goals:The resident will experience improved comfort and cleanliness be bathing.2. The resident will maintain intact skin integrity.The resident will be free from soil, odor, dryness, and pruritus following bathing

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review 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 for 1 of 5 residents (Residents #9) reviewed for infection control. LVN A failed to put on a gown and mask prior to assisting Resident #9 who vomited. This failure could place residents at risk of exposure and/or possible transmission of communicable diseases and infections.Findings include: A record review of Resident #9's nursing home and swing bed tracking item set MDS Assessment, dated 05/06/2026, reflected Resident #9 was a [AGE] year old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #9 had active diagnoses which included Chronic respiratory failure with hypoxia (a long-term condition where the respiratory system cannot adequately oxygenate the blood) and Obstructive uropathy and reflux uropathy (closely related conditions affecting the urinary tract, both capable of causing kidney damage). A record review of Resident #9's admission MDS assessment, dated 05/27/2025, noted Resident #9 had a BIMS of 3, which indicated her cognition was severely impaired. Resident #9 had a feeding tube. A record review of Resident #9's care plan, dated 04/29/2026, indicated contact precautions were to be used when providing resident care. A record review of the facility EBP sign stated all providers and staff must wear gloves and a gown for high-contact activities. Resident #9 had discharged to the hospital and was not observed during through the duration of the survey. During an observation on 05/20/2026 at 10:55 a.m., of a video Resident #9's family member provided from 05/18/2026 at 5:41 a.m. revealed LVN A walked in Resident #9's room without gloves or gown and assisted the resident who vomited. LVN A held a rubber bin near Resident #9's face as he continued to vomit. During an interview on 05/20/2026 at 10:27 a.m. Resident #9's family member stated staff had not followed infection control procedures when they cared for Resident #9. Resident #9's family member stated Resident #9 had been diagnosed with C-Diff (a bacterium that causes severe inflammation of the colon [colitis] and watery diarrhea) and had been placed on isolation. Resident #9's family member stated they had video of a staff member who had not followed EBP. During an interview on 05/20/2026 at 1:03 p.m., the ADON stated Resident #9 had a diagnosis of C-Diff which had the side effects of diarrhea and vomiting. The ADON stated Resident #9 was placed on contact isolation and if staff provided care they were required to put on PPE. The ADON stated gloves and gowns were placed outside the room and staff were required to place gown and gloves outside the room. She said she expected the nurses to adhere to Enhanced Barrier Precautions when providing direct care to residents. She said EBP required staff wore gloves and gowns when providing direct care to residents with exposure to bodily fluids. She said the purpose was to reduce the risk of spreading infections and diseases. The ADON stated that no other residents in the facility had C-Diff. During an interview on 05/20/2026 at 3:38 p.m., LVN A said she should have put on a gown prior to entering Resident #9's room because Resident #9 had C-Diff which required EBP. LVN A said EBP was important for preventing the spread of infection. LVN A said she forgot to put on a gown because she believed it was more important to ensure Resident #9 did not choke on his vomit. A record review of the facility's, undated, policy titled Standard Precautions indicated Standard precautions are based upon the principle that all blood, body fluids, secretions, excretions (except sweat), non-intact skin, and mucous membranes may contain transmissible infectious agents. Standard precautions are intended to be applied to the care of all persons in all healthcare settings, regardless of the suspected or confirmed presence of an infectious agent. Implementation of standard precautions constitutes the primary strategy for preventing healthcare associated transmission of infectious agents among residents and healthcare personnel. Appropriate infection control measures should be used in each resident interaction.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interviews, the facility failed to provide a safe, functional, sanitary environment and comfortable environment for residents, staff and the public for 1 of 3 unoccupied resident room air condition unit reviewed for environment. The unoccupied resident room air conditioning was detached from the wall and exposed outside. This deficient practice could place residents at risk of pests, exposure to the outside elements, pest and an unpleasant environment.The findings were: During an observation on 05/20/2025 at 10:37 a.m., an unoccupied resident room had air conditioner that was not attached to the wall properly. The air conditioner allowed exposure to outside. During an interview on 05/20/2026 at 11:52 a.m., the Maintenance Director stated he was responsible for fixing any broken items within his expertise. The Maintenance Director stated the facility used maintenance care to report any maintenance issues or concerns. The Maintenance Director stated he checked maintenance care every hour to see if there were any maintenance requests. The Maintenance Director stated he did not have a maintenance request for any air conditioning units. The Maintenance Director observed the unoccupied room air conditioner unit and stated it looked like someone either kicked the unit or pushed it out, because it was broken away from the wooden frame it sat in to prevent outside from being exposed. He stated he would have it fixed today. He stated the risk to the facility would be leaks or an access point to pets. The Maintenance Director stated that staff checked room daily for any items broken. He stated that he also made rounds at least once per week but was unable to state why that air conditioning unit had been missed. During an interview on 05/20/2026 at 4:49 p.m. the ADM stated it was her expectation that staff observed and reported any maintenance concerns to the maintenance department immediately. She stated all air conditioner units were sealed properly and free of any air space or outside view, to prevent inclement weather or pest from access to the facility. A record review of the facility's, undated, policy, Maintaining a Safe, Functional Environment, revealed, It is the policy of the facility to develop and implement plans, programs and process to promote and maintain safe functional, controlled and comfortable environment suitable to the care, treatment and services provided.The facility keep furnishings and equipment safe and in good repair.