

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455994	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Desoto Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on observation, interview and record review, the facility failed to ensure one (Resident #1) of five residents was properly supervised when Resident #1 eloped from the facility on 1/17/2026 at approximately 4:30 a.m. The facility failed on 1/17/26 to ensure Resident #1 received adequate supervision to ensure that residents were not exposed to possible hazards or injury when Resident #1 eloped from the facility and wandered toward a bridge over an active creek, which could have led to possible injuries. An immediate jeopardy existed from 1/17/26 4:30 a.m. to 1/17/26 5:00 a.m. The IJ was determined to be at past noncompliance as the facility had implemented actions that corrected the noncompliance prior to the beginning of the investigation. This deficient practice placed residents at risk for falls, injuries, hospitalization, and death. Findings included: Review of Resident #1's undated face sheet revealed she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnosis that included: Unspecified Dementia (a decline in cognitive function), unspecified Severity without Behavioral Disturbance, Generalized Anxiety Disorder and Major Depressive Disorder. Review of Resident #1's Quarterly MDS dated [DATE] reflected a BIMS score of 09, indicating moderate cognitive impairment of noticeable memory problems, disorientation or confusion. Section E of MDS (Behavior) reflected that Resident #1 did not exhibit wandering behavior. Section G (Functional Abilities) reflected no impairment with range of motion, the resident used a walker to assist in ambulation, could walk 150 feet with minimal assistance, and did not use a wheelchair. Review of Resident #1's Care Plan dated 2/11/26 reflected that the Care plan had been updated on 1/17/2026 that Resident #1 was at risk for wandering History of attempts to leave facility unattended, with an intervention that reflected that Resident #1 would reside in the secure unit. The care Plan further reflected that Resident #1 was at risk for elopement as evidenced by exit seeking (1/19/26) with a goal of Resident #1 will remain safe within the facility unless accompanied by staff or other authorized person through review date, and interventions of Assess/record/report to MD risk factors for potential elopement such as: Wandering. Repeated requests to leave facility, statements such as I'm leaving, I'm going home, attempts to leave the facility, elopement attempts from previous facility, home or hospital. Record Review of an Elopement Risk assessment dated [DATE] and signed by ADON, revealed that Resident #1 had no history of attempts to leave own residence/facility. No restlessness or anxiety and was found to be at moderate risk for elopement due to cognitive impairment. Record Review of an Elopement Risk assessment dated [DATE] and signed by LVN J, revealed that Resident #1 had no history of attempts to leave own residence/facility. No restlessness or anxiety and was found to be at moderate risk for elopement due to cognitive impairment. Record Review of an Elopement Risk assessment dated [DATE] and signed by ADON, revealed that Resident #1 had an attempt to leave own residence/facility. No restlessness or anxiety and was found to be at high risk for elopement due to cognitive impairment. Record Review of the facility census revealed that Resident #1 moved from room [ROOM NUMBER]-A (Semi-Private) to room [ROOM NUMBER]-B (Secured unit) on 1/17/26. Record Review of Resident #1's progress notes revealed: A note written by LVN D on 1/17/2026 at 08:44:00 the note text read Resident eloped through 200 hall exit door, event (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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She stated that she had volunteered to move into the secure unit, and she felt safer in the secure unit because she had not meant to leave the facility. In an interview on 2/10/26 at 1:20 p.m. LVN G revealed that she had received in-services related to the elopement of Resident #1, she stated that the facility had changed all door codes, and the Maintenance Director had checked alarms for all exit doors everyday since the elopement incident. She correctly described the procedures/protocol of what to do in case of a resident elopement. In an interview on 2/10/26 at 1:32 p.m. LVN D revealed that she had been one of the nurses on duty the morning that Resident #1 had eloped from the facility. She stated that she had been charting when an alarm sounded on the panel located behind the nursing station where she had been charting. She stated that LVN L had been closer to the panel and identified that an exit alarm had sounded on the 200-hall, and CNA K started to check the rooms on the 200-hall to identify if all residents were present and discovered that Resident #1 was not in her room. She stated that she looked outside the 200-hall exit and did not see Resident #1. She then returned to the nursing station to notify the ADM and DON and that LVN L went outside the building to do a perimeter search and CNA K got into his car to search for Resident #1. She stated she was still in the process of notifying the appropriate staff when LVN L and CNA K returned with Resident #1 after approximately 20-30 minutes of being outside the facility unsupervised. She stated she and LVN L did assessments on Resident #1 and found no injuries, and that Resident #1 volunteered later to move to the 300-hall Secure Unit. She stated that the facility conducted elopement drills, conducted in-services, and had placed new alarms on each exit door in the facility. In an interview on 2/10/26 at 1:44 p.m. with CNA K revealed that he had been in the break room on the 100-hall near the nursing station when he heard the central alarm panel sounding around 4:30 a.m. in the morning. He stated that LVN L was already at the panel and told him that the alarm door for the 200-hall had been set off. He stated that he then checked all the rooms on the 200-hall and found that Resident #1 was not in her room. He stated that LVN D looked outside the exit from the 200-hall and did not see Resident #1. He stated that LVN L then went outside to do a perimeter check of the facility and that he went out to his car to search for Resident #1 on the street. He stated that as he approached the driveway to the street, he saw Resident #1 on the sidewalk about 25 feet south of the driveway he was at. He stated that he pulled up next to Resident #1. He tried to get Resident #1 to get into the vehicle, but Resident #1 refused because she would not get into a vehicle with a strange man she did not know. CNA K then discovered he did not have his phone with him to contact the facility and then proceeded to go back to the facility to get help from one of the nurses. He stated that he was able to call out to LVN L in the parking lot and then proceeded back to Resident #1 with LVN L. He stated that Resident #1 had walked further south to a small bridge when LVN L. was able to stop Resident #1 and convince her to get into the vehicle [approximately 500 ft from entrance to facility]. He stated that he participated in in-services related to the elopement incident, had participated in elopement drills and was able to describe the correct procedures/protocols in case of elopement. In an interview on 2/11/26 at 5:23 a.m. CNA M revealed that she had participated in in-services related to the elopement incident. She stated that she had participated in an elopement drill and was able to describe the correct procedures/protocols in case of an elopement. She stated that the facility had changed all of the door codes and had put new alarms at each exit. In an interview on 2/11/26 at 5:36 a.m. LVN L revealed that she had been one of the nurses on duty the morning that Resident #1 had eloped from the facility. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	She stated that she was next to the alarm panel when the exit alarm sounded. She stated that after CNA K discovered it was Resident #1 that was missing she left the front of the facility and did a perimeter search around the facility. She stated that she was just coming back around to the front of the facility and in the parking lot when she saw CNA K in his car calling out to her. She then got into CNA K's car and they went around 500 ft down to the start of the bridge and she was able to get Resident #1 into CNA K's car and then she and LVN D assessed Resident #1 and found no injuries. She then stated that Resident #1 agreed to transfer into the secure unit for her own safety. She stated participated in the in-services related to the elopement incident and in the elopement drills subsequent to the incident. She stated that the facility had also installed new alarms at each exit door and that she had observed the Maintenance Director do alarm checks on the door since the elopement incident occurred. In an interview on 2/11/26 at 5:36 a.m. with CNA M, she revealed that she had been working in the 300-hall Secure unit the morning of the elopement of Resident #1. She stated that she had become aware of the elopement when Resident #1 had been brought back to the facility that morning. She stated that Resident #1 appeared to have no injuries and had gone immediately to sleep after a room was made ready for her on the secure unit. She stated that she and the oncoming staff had started 1:1 monitoring of Resident #1 and they had continued that for 3 days, she stated that Resident #1 had not attempted to leave the secure unit. She stated that she had completed all of the in-services related to the elopement incident, and he participated in two of the elopement drills. She was able to correctly describe the procedures and protocols of how to respond to an elopement. She stated that the facility had changed the door codes and had installed new alarms on the exit doors around the facility. In an interview on 2/11/26 at 5:47 a.m. with CNA N she revealed that she had been working the morning of Resident #1's elopement incident. She stated that she had been working on the 400-hall and that she had started to check all of those rooms to make sure all of her residents had been accounted for. She stated that Resident #1 had come back with LVN L and CNA K not too long after the alarm had gone off. She stated that she had participated in both the in-services and elopement drills related to the elopement incident. She was able to describe the protocols and procedures associated with resident elopements and she stated that the facility had changed all of the door codes and had installed new alarms on each exit door. In an interview on 2/11/26 at 6:00 a.m. CNA O revealed she had been working on the 300 hall the morning Resident #1 had eloped from the facility, she stated that she had been at the end of the 300-hall engaged in resident care at the time the alarm and had not heard it immediately. She stated that when she found out about the alarm she started to check all of her resident rooms on the 300 and 100 halls. She stated that Resident #1 was back at the facility pretty quick, but she was unsure about the time. She stated that she had participated in both the in-services and elopement drills related to the elopement incident. She was able to describe the protocols and procedures associated with resident elopements and she stated that the facility had changed all of the door codes and had installed new alarms on each exit door. She stated that she had heard the new alarms go off when the maintenance manager was testing them and that the new alarms are very loud. In an interview on 2/11/26 at 11:22 a.m. the Maintenance Director stated that he had installed new alarms at each door, he stated that he had also conducted training for the staff on how to read/use the alarm panel. He stated that he had changed the door codes and had also been checking he doors and alarms since the day of the elopement and he was still checking the doors/alarms everyday. In an interview on 2/12/26 at 9:50 a.m. the ADM stated that Resident #1 had almost made it to a small bridge close to the facility. He stated that had Resident #1 fallen into the creek or had gone off the sidewalk she could have been exposed to multiple hazards, injuries or worse. He stated that the facility had conducted in-services as soon as possible, they had procured and installed new alarms on the exit doors and that there had been no other incidents with Resident #1 or any other resident at the facility since the incident occurred. Incident was reported to state authority, police, Medical Director and Resident #1 family member. PNC IJ Template presented to ADM on 2/12/26 at 2:35 p.m. The facility implemented the following (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	interventions: Record review of a document titled [Resident #1] 1:1 monitoring schedule dated 01/17/2026 to 01/20/2026 found that 1:1 monitoring had been conducted with Resident #1 by LVN B, CNA M, CNA N, CNA A, CNA I and LVN H. Record review of a set of documents titled Door Alarm Monitoring dated 01/17/2026 to 2/12/2026 found that door alarms had been tested each day at all exits. Record review of a set of documents titled In-Service and dated 01/18/2026 and 01/19/2026 found that In-Service training had been conducted in the subjects of Elopement, Alarm Panel Policy, Missing Resident Policy, Resident Abuse and neglect and Resident Rights had been conducted with all staff at the facility. Record review of the Facility Policy entitled Wandering and Elopements reflected that, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Record review of the facility Missing Resident / Elopement Policy, revealed, Purpose: To ensure the immediate safety and rapid recovery of any resident who leaves the facility without authorization. Prevention: Residents must sign in / out when leaving, Staff monitor return times, At-risk residents identified in service plans, Annual elopement training and drills. When a resident is Missing: 1. Search entire facility (rooms, bathrooms, outside), 2. Notify Manager, 3. Check sign-in/out log; ask staff/residents for info, 4. Search surrounding areas (sidewalks, stores, bus stop), 5. If not found within 15 minutes, call 911, 6. Notify healthcare provider and responsible party. 7. Document all actions. When Resident is Found: Assess for injuries or changes in condition, Notify Manager and healthcare provider. Update care plan and incident report. Documentation: Incident report, progress note, follow-up assessment same day. Record review of a facility policy entitled Memory Care Alarm Policy reflected that .If resident is not by the door and alarm has been triggered, notify the nurse and co-workers of possible elopement. Check all stairwells and each floor for possible elopement, once resident is found turn alarm off. An immediate jeopardy existed from 1/17/26 4:30 a.m. to 1/17/26 5:00 a.m. The IJ was determined to be at past noncompliance as the facility had implemented actions that corrected the noncompliance prior to the beginning of the investigation.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled for one (Resident #39) of five residents, reviewed for pharmacy services. The facility failed to ensure LVN C and LVN H documented administration of morphine at the time of administration to Resident #39 on the MAR and the narcotic record. The facility failed to ensure LVN D, LVN E, RN F, and LVN G documented administration of morphine at the time of administration on the medication administration record for Resident #39. These failures could place residents at risk of being over medicated or under medicated if the doses are not documented on the medication administration record. Findings included: Review of Resident #39's Quarterly MDS Assessment, dated 01/09/26, reflected the resident was an [AGE] year-old female admitted to the facility on [DATE]. The BIMS was 15. The resident was cognitively intact. Her diagnoses included cancer. Over the past five days, the resident's activities were limited occasionally. Review of Resident #39's Care Plans, dated 07/07/25, reflected: Resident was on pain medication therapy related to diagnosis of lung cancer with metastasis. Facility interventions: Administer medication as ordered. Review of Resident #39's Order Summary Report, dated 01/25/25, reflected: Morphine Sulfate oral tablet 15 milligrams. Give 15 milligrams by mouth every 4 hours as needed for pain. Review of Resident #39's Medication Administration Records for February 2026 reflected Resident #39 received one dose of Morphine Sulfate 15 milligrams on 02/06/26. Review of Resident #39's Narcotic Count Record, dated February 2026, reflected Resident #39 received a dose of Morphine Sulfate 15 milligrams on the following dates: 02/07/26 1:00 AM by LVN D 02/07/26 7:00 AM by LVN E 02/07/26 3:35 PM by RN F 02/07/26 7:20 PM by RN F 02/08/26 12:30 AM by LVN D 02/08/26 6:00 AM by LVN D 02/09/26 1:30 AM by LVN G 02/09/26 5:30 AM by LVN G 02/09/26 4:00 PM by unknown nurse 02/10/26 3:00 AM by LVN D 02/10/26 9:40 AM by LVN C 02/10/26 7:00 PM by LVN C 02/11/26 8:00 AM by LVN H 02/11/26 12:30 PM by LVN C. An interview on 02/10/26 at 10:30 AM with Resident #39 revealed she was grimacing and crying out in pain. The resident said she had breast cancer and said, I think I'm dying, I am having a lot of pain. The resident said her pain level on a scale of 1-10 was 15. LVN C entered the resident's room and said she gave the resident a dose of Morphine at 9:40 AM. LVN C left the resident's room and returned with medication. LVN C said she was going to give the resident a dose of Tramadol. An interview on 02/11/26 at 11:25 AM with LVN C revealed she did not document the morphine dose on the MAR. She said she documented it on the narcotic record and the 24-hour report. She said she knew she was supposed to document on the MAR but said state was in the building, and she was moving too fast. LVN C said there was a risk to the resident if the dose was not documented on the MAR, because the resident could be double-dosed or not medicated at all. An observation of medication pass on 02/11/26 at 12:20 PM revealed Resident #39 was crying out and said her pain level was 12. CNA I was in the hall and said she was going to get LVN C. LVN C grabbed the medication cart and went to Resident #39's room. LVN C said she was going to give the resident morphine. LVN C signed out the medication on the narcotic count record. The narcotic count record reflected the resident received a dose at 7:00 PM on 02/10/26. The dose was not documented in the MAR. An interview on 02/11/26 at 12:55 PM with LVN H revealed she medicated Resident #39 with Morphine the morning of 02/11/26. She said she did not document the dose on the narcotic record or the MAR. She said she was going to document the dose but got busy. An interview on 02/12/26 at 11:55 AM with LVN H revealed she medicated Resident #39 with Morphine at 7:30 AM on 02/11/26. An observation on 02/12/26 at 12:28 PM revealed Resident #39 was on Hospice and resting comfortably. An interview on 02/12/26 at 1:50 PM with LVN D revealed she said she administered doses of (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Morphine to Resident #39 and thought she documented the doses on the MAR but might have gotten busy and did not document. She said she had been trained to document medication on the MAR. LVN D said failure to document could cause the nurse to not know when Resident #39 last received a dose. An interview on 02/12/26 at 1:55 PM with LVN G revealed she administered doses of Morphine to Resident #39 and she forgot to document the doses on the MAR. LVN G said she was trained to document on the MAR. LVN G said failure to document on the MAR could place the nurse at risk of not being able to read the narcotic record and not know what dose the resident received. A phone interview was attempted with LVN E on 02/12/26 at 1:58 PM. LVN E did not return the call of the Surveyor. An interview on 02/12/26 at 2:00 PM with RN F revealed she administered doses of Morphine to Resident #39 and did not know why she did not document the doses on the MAR. RN F said she was trained to document on the MAR. RN F said the resident was at risk of not having her pain assessed if the doses were not documented. An interview on 02/12/26 at 1:00 PM with the Corporate Nurse revealed staff were supposed to document Resident #39's dose of Morphine on the narcotic record and the MAR. She said failure to document placed the resident at risk of not receiving a dose or receiving an extra dose. Record review of the facility policy, Medication Administration and General Guidelines, not dated, reflected: .The resident's MAR is initialed by the person administering the medication.if utilizing the electronic medical record, the initials of the nurse are automatically stamped into the record.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 that temperatures for food items stored in a reach-in freezer had been logged twice daily and that there was an additional thermometer in the freezer to ensure accurate readings.2. The facility failed to ensure ice scoops were stored in a manner that protected against dust contamination and/or mold/mildew build up for the facilities only ice-machine. These failures could place residents at risk for food borne illness.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 that temperatures for food items stored in a reach-in freezer had been logged twice daily and that there was an additional thermometer in the freezer to ensure accurate readings.2. The facility failed to ensure ice scoops were stored in a manner that protected against dust contamination and/or mold/mildew build up for the facilities only ice-machine. These failures could place residents at risk for food borne illness.Findings included:In an observation on 2/10/26 at 9:15 a.m. Temperature logs for two reach in refrigerators and the walk-in refrigerator were found to be missing entries for morning temperature checks for 2/3, 2/6, 2/7, 2/8 and 2/9. Further observations of the reach-in freezer closest to the steam tables found that the freezer had no secondary thermometer inside the freezer. In an interview on 2/10/26 at 9:19 a.m. [NAME] revealed that he knew that every refrigerated unit had to have a separate thermometer but he could not locate the thermometer at that time. He stated it was important to have a separate thermometer to verify that the built-in unit thermometer was accurate. He stated that it was important to check the freezer and refrigerator temperatures at least twice a day to make sure that foods in them do not refreeze or go above 41 degrees Fahrenheit which could cause foods to spoil and expose residents to possible food borne illnesses.In an observation and interview on 2/10/26 at 9:27 a.m. the DM revealed that 2 ice-scoops were observed stored bowl-side up on a tray on top of the only ice machine in the facility. The tray was found to have wet areas directly under the ice-scoops that were continually exposed to dust contamination on top of the ice-machine. The DM stated that they had previously had a self-drying container but the lid had broken off and the container had come loose from the wall several months ago. She stated that ice-scoops should be protected from dust and not stored in standing water because it could contaminate the ice and expose resident to possible illness. She also stated that it was important to check refrigerator and freezer temperatures daily as foods outside of safe temperatures could expose residents to food-borne illnesses.Record review of the facility policy titled Policy: Food Holding, And Service, Policy Number: 03.005, Date Revised: June 1, 2019, review in the following documentation, Policy: To ensure that all food served by the facility is a good quality and safe for consumption, all food will be held and served according to the state and US Food Codes and HACCP guidelines. Procedure:2. Refrigerators . d. Refrigerators and freezers must have separate, free-standing thermometers to ensure proper functioning of internal/built in freezer/refrigerator unit thermometers.f. Temperatures logs must be kept for all refrigerator/freezer units that contain potentially hazardous foods (PHF's), to ensure that PHF's stay at or below 32 degrees Fahrenheit for freezers and at or below 41 degrees Fahrenheit for refrigerators.		

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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** Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for one (Resident #29) of three residents reviewed for care plans. The facility failed to ensure Resident #29 had a comprehensive care plan for pain. This failure could place residents at risk of staff not knowing how to care for their pain. Findings included: Review of Resident #29's admission MDS Assessment, dated 02/02/26, reflected the resident was a [AGE] year-old male. He admitted to the facility on [DATE]. He had a BIMS score of 13. The resident's cognition was moderately impaired. The Resident had diagnoses which included heart failure, kidney failure, and non-Alzheimer's dementia. The assessment did not reflect the resident had pain. Review of Resident #29's Comprehensive Care Plan, not dated, reflected the resident did not have a care plan for pain. Review of Resident #29's Order Summary Report, dated February 2026, reflected: 01/20/26 Tylenol with Codeine #3 Tablet 300-30 MG (Acetaminophen-Codeine), orally, every 6 hours as needed for pain. Review of Resident #29's Medication Administration Record, dated February 2026, reflected the resident received a dose of Tylenol with Codeine #3 on 02/03/26 and 02/07/26. An interview and observation with Resident #29 on 02/10/26 at 11:45 AM revealed he required pain medication because of pain in his right hip. He said he was having pain and told a CNA (unknown). He said he fell at another facility and had suffered with hip pain since then. An interview on 02/11/26 at 4:50 pm with the DON revealed she did not know why Resident #29 did not have a care plan for pain. She said care plans were developed by the [NAME] President of Clinical Services based on assessments and the comprehensive assessment. The DON said care plans were necessary so that nursing staff would know interventions in place for the resident's pain. Review of the facility policy, Comprehensive Care Planning, not dated, reflected: The facility will develop and implement a comprehensive person-centered care plan for each resident.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455994	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Desoto Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 observations, interviews, and record reviews 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 two (Resident #41 and Resident #8) of five residents, reviewed for infection control. The facility failed to ensure CNA A performed hand hygiene during incontinence care for Resident #41. The facility failed to ensure LVN B performed hand hygiene during wound care for Resident #8. These failures could place residents at risk for healthcare associated cross contamination and infections. Findings included: Review of Resident #41's Annual MDS Assessment, dated 01/06/26, reflected the resident was an [AGE] year-old female admitted to the facility on [DATE]. The resident did not understand others and was not able to make herself understood. Her diagnoses included non-Alzheimer's dementia and seizure disorder. The resident was always incontinent of urine and bowel movement. Review of Resident #41's care plan dated 02/18/22 reflected: Resident had an activities of daily living deficit. Facility interventions: Resident required one staff assist for toilet use. An observation on 02/10/26 at 10:35 AM of incontinence care for Resident #41 revealed she was lying in bed. The resident was positioned onto her left side. CNA A cleaned the resident's buttocks. CNA A did not change gloves or perform hand hygiene. CNA A applied barrier cream to the resident's buttocks with her soiled gloves. CNA A did not change her gloves or perform hand hygiene. CNA A placed a new brief on the resident with the soiled gloves. An interview on 02/10/26 at 1:20 PM with CNA A revealed she did not change her gloves or perform hand hygiene because she was nervous. She said she was trained to change gloves and perform hand hygiene during incontinence care. CNA A said it was important to perform hand hygiene and change gloves during incontinence care to prevent the spread of infection. 2. Review of Resident #8's admission MDS Assessment, dated 12/22/25, reflected the resident was an [AGE] year-old male admitted to the facility on [DATE]. His cognitive skills for daily decision making were severely impaired. His BIMS score was 2. His diagnoses included seizure disorder. The resident was at risk for developing pressure ulcers. Review of Resident #8's Care Plans, dated 12/22/25, reflected: The resident has a pressure ulcer or potential for pressure ulcer development: trauma injury to sacrum. Facility interventions included: The resident needs assistance to turn/reposition at least every 2 hours. Review of Resident #8's Order Summary Report, dated 02/11/26, reflected: Cleanse wound to sacrum with wound cleanser, pat dry, apply hydrogel and cover with a dry dressing daily and as needed. An observation on 02/12/26 at 10:11 AM of wound care for Resident #8 revealed LVN B removed the dressing on the sacrum. LVN B changed her gloves but did not perform hand hygiene. LVN B cleaned the wound and changed her gloves. LVN B did not perform hand hygiene. LVN B patted the wound dry, changed her gloves, but did not perform hand hygiene. LVN B applied the treatment to the wound. LVN B changed her gloves but did not perform hand hygiene. LVN B applied the dressing. An interview on 02/12/26 at 10:20 AM with LVN B revealed she forgot to perform hand hygiene during wound care. LVN B said she had been trained to perform hand hygiene after changing her gloves. LVN B said hand hygiene was important to prevent the spread of germs. An interview on 02/11/26 at 4:45 PM with the Corporate Nurse revealed staff were supposed to perform hand hygiene and change gloves while performing incontinence care. She said failure to do so could cause infection. An interview on 02/12/26 at 10:22 AM with the Corporate Nurse revealed staff were supposed to perform hand hygiene when changing gloves their gloves. The Corporate Nurse said staff needed to perform hand hygiene after changing gloves, because there could be something on the staff's hands. Record review of the facility policy, Hand Hygiene, not dated, reflected: You may use alcohol-based hand cleaner or soap/water for the following: After removing gloves. You must use soap/water for the following. when hands are visibly soiled, before and after assisting resident with toileting.		