

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676492	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/17/2024
NAME OF PROVIDER OR SUPPLIER  Methodist Transitional Care Center-Desoto LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  109 Methodist Way 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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50445</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation.</p> <p>1. The facility failed to properly store, date, and label food items in the walk-in freezer.</p> <p>These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness.</p> <p>The findings included:</p> <p>Observation on 05/15/2024 at 09:45 AM in the walk-in freezer revealed, two open cases of food: one case of frozen cookies and one case of hamburger patties. Both open cases had interior plastic bags that were open, exposing the food to the ambient air in the freezer and subjecting the food to potential contaminants, freezer burn and a decrease in quality. In the walk-freezer was also a coil of sausage with no covering or packaging with the food in direct contact with the metal shelf. The cookies, the beef patties, and the sausage were not labeled or dated.</p> <p>During an interview on 05/16/2024 at 11:23 AM, the Dietary Manager stated the policy is for all food to be sealed, labeled, and dated with the received or open date and expiration or best use by date. The three cases of food were open, and their interior bags were open and should not have been. The Dietary Manager further stated she was responsible for ensuring the food was properly sealed to maintain freshness . She reported that the food should be dated and labeled at the time it is taken off of the supply truck.</p> <p>Record review of the facility policy, HSG Policy 017, revised 02/2023, indicates that, All food items will be appropriately labeled and dated either through manufacturer packaging or staff notation and that, All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.</p> <p>(continued on next page)</p>

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070</b></p> <p>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 one of three (CNA A) staff members and four of six residents (Resident #11, #26, #134, &amp; #150) reviewed for infection control procedures.</p> <p>CNA A failed to perform hand hygiene after direct contact with residents #11, #26, #134, and #150 while serving meals on the hallways .</p> <p>This failure could place residents at risk for healthcare associated cross contamination and infections.</p> <p>Findings included :</p> <p>Record review of Resident #11's annual MDS assessment, dated 04/26/24, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #11 had diagnoses which included: atrial fib (fast heart rate), hypertension (high blood pressure), and diabetes (high blood sugar). Resident #11 was cognitive and able to make decisions and required assistance of one staff for activities of daily living.</p> <p>Record review of Resident #26's annual MDS Assessment, dated 04/10/24, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #26 had diagnoses which included: dementia (brain disease that effects memory), hypertension (increased blood pressure), and diabetes (high blood sugar). Resident #26's, moderately impaired for cognition and required one staff for assistance with activities of daily living.</p> <p>Record review of Resident #134's annual MDS Assessment, dated 04/20/24, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #134 had diagnosis which included: Cardiovascular accident (stroke), heart failure, atrial flutter (irregular rhythm of the heart), and diabetes (increased sugar levels). Resident #134 was severely impaired for cognition and required one staff for assistance with activities of daily living.</p> <p>Record review of Resident #150's annual MDS Assessment, dated 03/15/24, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #150 had diagnosis which included: Hypertension (high blood pressure), depression (mental illness), and hypothyroidism (low thyroid function). Resident #9 was cognitively able to make decisions and required assistance of one staff for activities of daily living.</p> <p>Observation on 05/15/24 beginning at 12:00 p.m., revealed CNA A had walked down the hallway, did not use hand sanitizer, and served a lunch tray to Resident #11, touched, and moved the overbed table in the resident's room, touched the hand and shoulder of Resident #11 and prepared the meal tray for the resident to eat her lunch. CNA A did not have on gloves. CNA A was observed to not wash his hands or use hand sanitizer, available in the hallway.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 05/15/24 beginning at 12:07 p.m., CNA A was observed to enter Resident's #26, #134, and #150 rooms setting up the resident's lunch trays, adjusted the overbed table, and unwrapped the utensils removed tops off drinks, for each resident. He did not complete hand hygiene before going to the next resident.</p> <p>An interview on 05/15/24 at 1:00 p.m., CNA A stated he did not complete hand hygiene after having direct contact with residents. CNA A stated he was supposed to use the hand sanitizer in between serving each tray and wash hands with soap and water after the third tray from the hall cart. CNA A said he had been educated on completing hand hygiene. CNA A stated he did not sanitize his hands, because he was nervous and trying to get the lunch trays served as the nurse handed them to him.</p> <p>An interview with the DON on 05/16/24 at 11:30 a.m., revealed that all staff must complete hand hygiene after having contact with residents. She stated CNAs were trained to wash their hands with soap and water prior to tray service, then use hand sanitizer between each tray and on the third tray they are to use soap and water and wash their hands. The DON stated if the CNAs do not use appropriate hygiene, they can spread germs to the residents and themselves.</p> <p>Record review of an undated in-service log revealed CNA A received handwashing and hand sanitizing training, to prevent the spread of infection. Further review of in-service logs revealed an in-service conducted on 05/15/24 reflected: when passing trays in the hallways, sanitize after going in every room. Remember to wash your hands after every third use of hand sanitizer. CNA had received this training after surveyor intervention.</p> <p>Record review of the Facility's Policy titled Handwashing/Hand Hygiene revised June 2010 reflected: 1. all personnel shall be trained be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections 2. all personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to, other personnel, residents, and visitors 5. Employees must wash their hands c. before and after direct resident contact g. before and after assisting a resident with meals</p>		