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 _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO HEALTHCARE CENTER	**7805 SOUTHCREST PARKWAY SOUTHAVEN, MS 38671**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI) MS #22182 and CI MS #22193 at the facility on 8/9/23 through 8/10/23. During the survey the SA investigated CI MS #22193 for resident rights and found the facility was in compliance with the requirements for participation in Medicare and Medicaid with no citations. The SA investigated CI MS #22182 for quality of care related to grooming, services not performed, resident assessment and found the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F656 and F773. The facility held a license for 120 beds, with a census of 92.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), 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. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		9/21/23

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

Electronically Signed | 08/23/2023

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F 656	Continued From page 1 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and policy/procedure review, the facility failed to follow their care plan for one (1) of four (4) residents sampled as evidenced by on 7/25/23, the care plan for Resident #1 for a urinary tract infection has an intervention to "Monitor lab values as ordered". Resident #1 had a Complete Blood Count (CBC) and Basic Metabolic Panel (BMP) ordered on 7/25/23 to be collected in 1 week. The CBC and BMP were collected on 7/26/23 without a Medical Doctor's (MD) order.	F 656	1) On 7/26/23, the facility nurse practitioner (NP) and the resident's responsible party (RP) were notified of lab error. The NP spoke directly to the RP regarding the event. A new order was written to d/c all routine lab orders. Resident's care plan was updated to reflect this change. A lab error report/investigation found that there were no adverse effects. Care plan was also updated to reflect that no adverse effects	

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F 656	Continued From page 2 Findings include: Record review of the facility's policy/procedure for "Comprehensive Care Plan" revised on 10/10/2022 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 timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified on the resident's comprehensive assessment." Record review of the "Urinary Tract Infection Care Plan" dated 7/25/23 revealed an approach "...2. Monitor lab values as ordered..." Record review of the July 2023 Physician's Telephone Orders revealed an order dated 7/25/23, ordered by the NP, "...4. CBC, BMP in 1 week." Record review of the facility (Proper Name) lab work performed at the facility for July 26, 2023 revealed the name of Resident #1 with a specimen collected date of 7/26/23 and the test ordered as a CBC and BMP. There is a straight line drawn through that with "ERROR" written beside it. Record review of the facility's "Lab Error Report" revealed that the form is signed by the Nurse Practitioner (NP) and Licensed Practical Nurse (LPN) #1. The "Date of report: 07/26/2023 Date... of Error 07/26/23" are the dates of the error. It reads "Person discovering error: family member inquired about lab draw site". The "Date and time error discovered: 07/26/23". The form	F 656	occurred during this event. 2) All residents in the facility are determined to be at risk of being affected by the cited deficient practice. 3) Corrective action will be accomplished for the affected resident by initiating facility-wide in-services for all licensed practical nurses (LPNs) and registered nurses (RNs). In-services began on 8/11/2023 and completed by 8/23/2023. In-services include Lab policy and procedures, transcribing and entering Physicians Orders, 24-hour Chart checks and Facility Policy for following the Comprehensive Care plan. The in-services will be given to staff by the Staff Education nurse (LPN), Quality Assurance nurses (LPNs), or the Director of Nursing (RN). Initiated a 24-hour chart checklist to be signed and turned in by the night LPN or RN to the Quality Assurance nurses at the end of each shift beginning 8/14/2023. The 24-hour chart checklists are to be reviewed daily by the Quality assurance nurses for 12 weeks to ensure compliance from LPNs and RNs. 4) The facility lab book will be audited for policy compliance daily by the clinical team in the daily clinical meeting beginning on 8/11/2023. Physician orders will also be audited for accuracy daily, in addition to any hospital orders received. Clinical meetings will be reviewed weekly in the facility High-risk meeting for any findings noted during the previous week's	

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F 656	Continued From page 3 revealed "Brief description of error and cause (s): Resident labs were drew before the ordered date..." An interview with the Director of Nurses (DON) on 8/10/23 at 9:50 AM, revealed "Yes, care plan approaches should be followed." An interview on 8/10/23 at 12:20 PM, with LPN #1 revealed she is the facility Quality Assurance (QA) nurse. She stated "Resident #1 had an order for lab for a CBC and BMP. The order was to draw the lab in one (1) week. It was written on 7/25/23. I don't know who wrote it on the facility (proper name) lab log sheet. The order was signed off by (name of) LPN but someone wrote it on the log sheet to be drawn on 7/26/23. Interview with the NP on 8/10/23 at 2:00 PM revealed, "No, I didn't order the lab drawn on 7/26/23. I wrote an order for lab work in one week. It was for a CBC and BMP. The order was written 7/25/23." Record review of Resident #1's Face Sheet revealed she was admitted to the facility on 9/23/2020 with diagnoses that included Diarrhea, Unspecified; Candidacies, Unspecified; Personal History of Urinary (tract) Infections; Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/ Unspecified Chronic Kidney Disease.; Stage 3 Chronic Kidney Disease, Stage 3 Unspecified; Vascular Dementia, Type 2 Diabetes Mellitus without Complications, Chronic Diastolic (Congestive) Heart Failure. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date	F 656	clinical review and any recommendations from the Interdisciplinary Team for 12 weeks beginning 8/17/2023. A review of all clinical findings will be provided in the facility's Quality Assurance Meeting by the director of nursing to the medical director and IDT starting 8/28/2023. Compliance with the 24-hour chart checks is to be reported in the QA meetings on 8/28/23, 9/11/23, 9/20/23, and monthly thereafter. 5) Corrective action to be completed by 9/21/2023.	

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F 656	Continued From page 4 (ARD) of 5/11/23 revealed a Brief Interview for Status (BIMS) score of 6 which indicated Resident #1 was severely cognitively impaired. She requires assistance with making daily decisions.	F 656		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and policy/procedure review, the facility failed to follow Medical Doctors (MD) orders for one (1) of four (4) residents sampled as evidenced by on 7/25/23, the Nurse Practitioner (NP) ordered lab work for a Complete Blood Count (CBC) and Basic Metabolic Profile (BMP) "in one week" for Resident #1. This lab was collected on 7/26/23 without an MD order. Findings include: Record review of the facility's policy/procedure for "Physician Order Review" with an effective date of 1/9/2015 revealed the "PURPOSE: To maintain	F 773	1) On 7/26/23, the facility nurse practitioner (NP) and the resident's responsible party (RP) were notified of lab error. The NP spoke directly to the RP regarding the event. A new order was written to d/c all routine lab orders. Resident's care plan was updated to reflect this change. A lab error report/investigation found that there were no adverse effects. Care plan was also updated to reflect that no adverse effects occurred during this event. 2) All residents in the facility are determined to be at risk of being affected	9/21/23

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F 773	Continued From page 5 appropriate continuity in resident care. POLICY: Every licensed nurse shall ensure that the physician's orders for each resident has been carried out as intended..." Record review of the facility's policy/procedure for "Diagnostic Services: Lab tests and X-ray" last revised on 11/28/2017 revealed the "Procedure: Quality lab tests and radiology (i.e., x-ray, M.R.I. (Magnetic Resonance Imaging)) services only are performed upon medical order from the resident's physician." On 8/10/23 at 9:50 AM, an interview with the Director of Nurses (DON) revealed "The NP ordered a CBC and BMP to be drawn in one week when she ordered the Augumentin and Diflucan on 7/25/23. We contract with a company for our lab work. The lab company came the next day, 7/26/23, and drew the CBC and BMP. I don't know why the lab was drawn a week early. On 8/10/23 at 12:20 PM, an interview with Licensed Practical Nurse (LPN) #1 revealed she is the facility Quality Assurance (QA) nurse. She stated "Resident #1 had an order for lab for a CBC and BMP. The order was to draw the lab in 1 week. It was written on 7/25/23. I don't know who wrote it on the (proper name) lab log sheet. The order was signed off by (name of) LPN but someone wrote it on the log sheet to be drawn on 7/26/23. Someone also put a line through it and wrote error. They didn't initial or date when they drew the line." On 8/10/23 at 2:00 PM, an interview with the NP stated, "No, I didn't order the lab drawn on 7/26/23. I wrote an order for lab work in one week. It was for a CBC and BMP. The order was	F 773	by the cited deficient practice. 3) Corrective action will be accomplished for the affected resident by initiating facility-wide in-services for all licensed practical nurses (LPNs) and registered nurses (RNs). In-services began on 8/11/2023 and completed by 8/23/2023. In-services include Lab policy and procedures, transcribing and entering Physicians Orders, 24-hour Chart checks and Facility Policy for following the Comprehensive Care plan. The in-services will be given to staff by the Staff Education nurse (LPN), Quality Assurance nurses (LPNs), or the Director of Nursing (RN). Initiated a 24-hour chart checklist to be signed and turned in by the night LPN or RN to the Quality Assurance nurses at the end of each shift beginning 8/14/2023. The 24-hour chart checklists are to be reviewed daily by the Quality assurance nurses for 12 weeks to ensure compliance from LPNs and RNs. 4) The facility lab book will be audited for policy compliance daily by the clinical team in the daily clinical meeting beginning on 8/11/2023. Physician orders will also be audited for accuracy daily, in addition to any hospital orders received. Clinical meetings will be reviewed weekly in the facility High-risk meeting for any findings noted during the previous week's clinical review and any recommendations from the Interdisciplinary Team for 12 weeks beginning 8/17/2023. A review of all clinical findings will be provided in the	

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F 773	Continued From page 6 written 7/25/23." Review of the MD's July 2023 orders revealed Resident #1 was diagnosed with a Urinary Tract Infection and Yeast on 7/25/23 by the NP. The orders were to "1. D/C (discontinue) Cephalexin, Colace, Miralax. 2. Augmentin 500 milligram (MG) by mouth (po) two times a day (BID) X 5 days. 3. Diflucan 200 MG po daily X 14 days. 4. CBC, BMP in 1 week." Record review of the "Clinical Testing Requisition Form" revealed the lab company is (proper name) Laboratory Services. The "Date of Collection: 7/26/23 Time 8:15" The lab tests marked are "Basic Metabolic Panel" and "CBC with Automated Differential". The (Proper Name) NP is the "Ordering Physician" and it is signed by a facility LPN. It is dated 7/25/23. Record review of the facility's "Lab Error Report" revealed that the form is signed by the NP and LPN #1. The "Date of report: 07/26/2023 Date & Time of Error 07/26/23" are the dates of the error. It reads "Person discovering error: family member inquired about lab draw site". The "Date and time error discovered: 07/26/23". The form revealed "Brief description of error and cause (s): Resident labs were drew before the ordered date." Record review of the (Proper Name) lab work performed at the facility for July 26, 2023, revealed the name of Resident #1 with a specimen collected date of 7/26/23 and the test ordered as a CBC and BMP. There is a straight line drawn through that with "ERROR" written beside it. Record review of Resident #1's Face Sheet	F 773	facility's Quality Assurance Meeting by the director of nursing to the medical director and IDT starting 8/28/2023. Compliance with the 24-hour chart checks is to be reported in the QA meetings on 8/28/23, 9/11/23, 9/20/23, and monthly thereafter. 5) Corrective action to be completed by 9/21/2023.	

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F 773	Continued From page 7 revealed she was admitted to the facility on 9/23/2020 with diagnoses including Diarrhea, Unspecified; Candidacies, Unspecified; Personal History of Urinary (tract) Infections;.; Stage 3 Chronic Kidney Disease, Stage 3 Unspecified, Type 2 Diabetes Mellitus without Complications, Chronic Diastolic (Congestive) Heart Failure. Record Review of the Minimum Data Set (MDS) for a Quarterly assessment with an Assessment Reference Date (ARD) of 5/11/23 revealed a Brief Interview for Status (BIMS) score of 6 which indicates severe cognitive impairment.	F 773		