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	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desoto Healthcare Center	7805 Southcrest Parkway Southaven, MS 38671

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 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, resident and staff interviews, record review, and facility policy review, the facility failed to implement residents' care plans for Percutaneous Endoscopic Gastrostomy (PEG) site care (Resident #2 and Resident #9) and nail care for dependent residents' (Resident #7 and Resident #48) for four (4) of 19 care plans reviewed. Resident #2, #7, #9, and #48Findings Include: A review of the facility policy titled Comprehensive Plan of Care, revised 2/17/25, revealed under 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 and all services that are identified in the resident's comprehensive assessment and meet professional standards of practice . Resident #2 A review of Resident #2's Care Plan Report revealed under Focus: The resident requires tube feeding related to (r/t) LACK OF MENTAL ALERTNESS TO CHEW OR SWALLOW/INABILITY TO CHEW OR SWALLOW WITHOUT CHOKING OR ASPIRATING. The Interventions included: PEG: Clean peg site with daily wound care (w/DWC) and apply new drainage sponge at bedtime. Observation of medication administration for Resident #2 on 9/16/25 at 2:29 PM with Licensed Practical Nurse (LPN) #3, revealed no drainage sponge present around the PEG tube site. An interview with LPN #3, she confirmed there was not a drainage sponge present. Record review of the admission Record revealed Resident #2 was admitted to the facility on [DATE] with medical diagnoses that included Dysphagia following Cerebral Infarction, and Cognitive Communication Deficit. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/24/25 revealed, under Section C revealed, a Brief Interview for Mental Status (BIMS) should not be conducted due to resident is rarely/never understood. Resident #7 (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #7's Care Plan Report revealed under Focus: The resident has an Activities of daily living (ADL) self-care deficit related to limited mobility, tremors, a diagnosis of Alzheimer's disease, and a need for assistance with all ADLs. The Interventions included: Fingernails and toenails to be cleaned, filed, and clipped as needed. During an observation on 9/15/25 at 2:59 PM, Resident #7 was observed sitting in a Geri-chair in her room. Her left hand was contracted, with fingers turned inward toward the palm. The fingernails on her left hand were excessively long, jagged, and measured approximately three-eighths (3/8) of an inch. During an observation and interview with LPN #4 on 9/16/25 at 2:32 PM, she confirmed Resident #7 had long fingernails on her contracted left hand and her care plan for nailcare was not followed. An interview with the Director of Nursing (DON) on 9/18/25 at 9:12 AM revealed the purpose of the care plan was to inform staff of the care that should be provided to residents. She explained her expectation was that staff follow the care plan developed for all the residents. A record review of the admission Record revealed the facility admitted Resident #7 on 3/24/22 with medical diagnoses including Essential (Primary) Hypertension. A record review of the MDS with an ARD of 7/16/25 revealed, under Section C, a BIMS score of 4, which indicated Resident #7 was severely cognitively impaired. Resident #9 A review of Resident #9's Care Plan Report revealed under Focus: The resident requires ENTERAL PEG feeding related to dysphagia. The Interventions included: PEG: Clean peg site w/DWC and apply new drainage sponge at bedtime. Date Initiated 4/16/25. On 9/17/25 at 10:30 AM, during an observation and interview LPN #2 revealed that PEG sites are to be cleaned each shift. She confirmed Resident #9's PEG site did not have a drainage sponge in place and the care plan was not followed. In an interview on 9/18/25 at 9:30 AM, the DON revealed that Resident #2 and Resident #9's care plans were not being followed. She confirmed that each resident's PEG site was to be cleaned and have a drainage sponge in place as ordered by the physician, and acknowledged the facility failed to ensure this was being done. Record review of Resident #9's admission Record revealed the resident was admitted on [DATE] with medical diagnoses which included Encounter for attention to Gastrostomy. Record review of Resident #9's MDS with an ARD of 7/13/25 revealed a BIMS score of 14, which indicated the resident is cognitively intact. Resident #48 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #48's Care Plan revealed that he had an ADL self-care performance deficit related to muscle weakness, lack of coordination, unsteadiness on feet, need for assistance with interventions that included Nail Care as Needed. An observation on 09/15/25 at 11:16 AM and on 09/16/25 at 8:38 AM revealed that Resident #48 had long, jagged fingernails on both hands. His fingernails were approximately one-half inch long and had brown substance underneath. Resident #48 stated, My fingernails need cutting and revealed that his fingernails had not been clipped in a while. An interview on 09/16/25 at 4:10 PM with MDS Nurse revealed that the purpose of the comprehensive care plan was to show what specific care they need. She revealed that the care plans were personalized for each resident and that personal hygiene including fingernail care was included in the interventions to be completed. She also agreed that since Resident #7 and Resident #48's fingernails were not cleaned or trimmed, the care plans were not followed. Record review of Resident #48's admission Record revealed an admission date of 08/03/23 and that he had diagnoses that included Congestive Heart Failure and Need for Assistance with Personal Care. Record review of Resident #48's Medication Review Report revealed that fingernails and toenails to be cleaned, filed and clipped as needed every day shift every Friday. Record review of Resident #48's MDS with ARD of 06/13/25 under Section C revealed a BIMS score of 03 which indicated that he had severe cognitive deficits.

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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. Based on observation, interview, record review and facility policy review the facility failed to provide nail care for residents who required assistance with Activities of Daily Living (ADLs) for 2 (two) of nineteen sampled residents. Resident #7 and Resident #48.Findings Include: Review of the facility policy Fingernail and Toenail Care with revision date of 05/02/22, revealed, All residents of (Proper Name) facilities shall receive nail care, on a regularly scheduled basis .2. Routine cleaning, inspection, and nail care, to include trimming and filing, will be provided on a regular schedule and as needed. Resident #7 An observation of Resident #7 on 9/15/25 at 2:59 PM revealed she was sitting in a Geri-chair in her room. Her left hand was contracted, with fingers turned inward toward the palm. The fingernails on her left hand were excessively long, jagged, and measured approximately three-eighths (3/8) of an inch. An observation and interview with Licensed Practical Nurse (LPN) #4 on 9/16/25 at 2:32 PM confirmed Resident #7 had long fingernails on her contracted left hand. LPN #4 stated it was the activity staff's responsibility to trim the residents' nails. She acknowledged the resident was at risk for skin issues due to the contracture and the long nails. An interview with LPN #5 on 9/16/25 at 3:18 PM revealed she worked in activities and was responsible for cutting Resident #7's fingernails every two weeks. She reported, Maybe she needs her nails cut more often, and acknowledged Resident #7's risk of skin breakdown related to her hand contracture. A record review of Resident #7's Medication Administration Record (MAR) for September 2025 revealed an order dated 10/11/23: Fingernails and toenails to be cleaned, filed, and clipped as needed every day shift every Friday, Activities to document. The order was initialed as completed on 9/12/25. A record review of Resident #7's Certified Nurse Aide Kardex indicated under Resident Care that the resident needed her nails kept short to reduce the risk of scratching or injury from picking at skin. An interview with the Director of Nursing (DON) on 9/16/25 at 4:08 PM revealed her expectation was that residents receive nail care weekly, including cleaning, trimming, and filing. She explained that nail care was the activity staff's responsibility; however, if aides observed a need while bathing residents, they should also provide the care. A record review of the admission Record revealed the facility admitted Resident #7 on 3/24/22 with medical diagnoses including Essential (Primary) Hypertension. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/16/25 revealed, under Section C, a Brief Interview for Mental Status (BIMS) score of 4, which indicated Resident #7 was severely cognitively impaired. Resident #48 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 09/15/25 at 11:16 AM and on 09/16/25 at 8:38 AM revealed long, jagged fingernails on Resident #48's hands bilaterally. His fingernails were approximately one-half inch long and had brown substance underneath. Resident #48 stated, My fingernails need cutting and revealed that his fingernails had not been clipped in a while. An observation also revealed a thick, crusty brownish yellow substance covering the palm of his right hand and it had a mild odor. During an observation and interview on 09/16/25 at 2:25 PM with Certified Nursing Assistant (CNA) #2 in Resident #48's room, she confirmed that he had long, dirty fingernails. She also confirmed the brownish yellow substance and mild odor in the palm of his right hand. CNA #2 revealed that long, dirty fingernails could make him sick by spreading germs and he could scratch himself, causing a skin tear. She revealed that the staff should be washing his hands at least daily and that his fingernails should be clipped and filed every week and as needed. During an observation and interview on 09/16/25 at 2:35 PM with DON, she confirmed that Resident #48 had long, jagged fingernails with brown substance underneath. She also confirmed the mild odor and the brownish, yellow substance covering the entire palm of Resident #48's hand. DON revealed that the staff should be looking at fingernails every day and should be washing hands more than one time a day. She also revealed that long dirty fingernails could cause skin tears and possible infection. DON revealed that it was her expectations for fingernails to be assessed by the CNAs during a resident's bath or shower time and if fingernails needed attention, they should provide the care. Record review of Resident #48's admission Record revealed an admission date of 08/03/23 and that he had diagnoses that included Congestive Heart Failure and Need for Assistance with Personal Care. Record review of Resident #48's Medication Review Report revealed that fingernails and toenails to be cleaned, filed and clipped as needed every day shift every Friday. Record review of Resident #48's MDS with ARD of 12/13/24 under Section GG revealed that he required substantial to maximal assistance with his personal hygiene. Record review of Resident #48's MDS with ARD of 06/13/25 under Section C, revealed a BIMS score of 03 which indicated that he had severe cognitive deficits.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review and facility policy review, the facility failed to ensure that treatment and care were provided in accordance with professional standards of practice and physician orders by not utilizing and changing a drainage sponge at the insertion site of a Percutaneous Endoscopic Gastrostomy (PEG) tube as ordered for two (2) of three (3) residents with a PEG tube. Resident #2, and Resident #9Findings Include: A typed statement on company letterhead dated 9/17/25 and signed by the Director of Nursing (DON) revealed that the facility did not have a specific policy related to the care of PEG tubes. The facility staff are to follow the physician's orders concerning PEG tubes. Resident #2 Observation of medication administration for Resident #2 on 9/16/25 at 2:29 PM with Licensed Practical Nurse (LPN) #3, revealed no drainage sponge present around the PEG tube site. During an interview on 9/16/25 at 2:29 PM with LPN #3, she confirmed there was not a drainage sponge present. Record review of Resident #2's Order Listing Report with a Revision Date of 03/26/2025, revealed an order under PEG: Clean PEG Site with Daily Wound Care (DWC) and apply new drainage sponge at bedtime . Record review of the admission Record revealed Resident #2 was admitted to the facility on [DATE] with medical diagnoses that included Gastrostomy Status and Dysphagia following Cerebral Infarction. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/24/25 revealed, under Section C, a Brief Interview for Mental Status (BIMS) should not be conducted due to resident is rarely/never understood. Resident #9 During an observation and interview on 9/17/25 at 10:15 AM, LPN #1 confirmed that Resident #9's PEG tube insertion site had a brown dried substance present and no drainage sponge in place. LPN #1 stated the floor nurses are responsible for providing PEG care. During an observation and interview on 9/17/25 at 10:30 AM, LPN #2 revealed that PEG sites are to be cleaned each shift. She confirmed Resident #9's PEG site had a brown dried substance present, was not clean, and did not have a drainage sponge in place. LPN #2 stated that when PEG sites are not properly cleaned, residents are at risk for infection, and that the drainage sponge is used to protect the resident's skin around the tubing. She further reported that she last cleaned the site on Thursday, 9/11/25, when she previously worked and it appeared that it had not been cleaned since then. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the DON on 9/17/25 at 11:10 AM revealed that PEG sites are to be cleaned daily and documented in the Electronic Medication Administration Record (EMAR). The DON confirmed the insertion site is always to be kept clean and a drainage sponge is to be applied to prevent infection and reduce skin irritation and breakdown. Record review of Resident #9's Order Summary Report with an Order Date of 04/04/2025, revealed an order under PEG: Clean PEG Site with/DWC and apply new drainage sponge at bedtime Record review of Resident #9's admission Record revealed the resident was admitted on [DATE] with Medical Diagnoses which include Encounter for attention to Gastrostomy. Record review of Resident #9's MDS with an ARD of 7/13/25 revealed a BIMS score of 14, which indicated the resident is cognitively intact.