STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676178	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Duncanville Healthcare and Rehabilitation Center	419 S Cockrell Hill Rd Duncanville, TX 75116

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44021 Based on observations, record reviews and interviews, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for one (Resident #5) of five residents reviewed for accidents. The facility failed to update interventions for falls or accidents on Resident #5's care plan from 10/31/24 to 12/03/24. Resident #5 had two falls on 11/10/24 and 11/23/24, no interventions were entered on Resident #5's care plan. This failure could place residents at risk of not addressing individualized needs and services. Findings included: Record review of Resident #5's face sheet dated 10/31/24 revealed Resident #5 was a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of Unsteadiness on Feet. Record review of Resident #5's MDS dated [DATE] revealed Resident #5 had a BIMS score of 15, indicating intact cognition. Resident #5 was required extensive assistance in toileting, transfers and bed mobility requiring the assistance of at least one staff member. Record review of Resident #5's care plan dated 1/22/25 revealed: (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident is a fall risk related to Poor Balance and unsteady gait, 11/10/24 Resident states he was self-transferring to wheelchair. No injury, 11/23/24 Resident states he was reaching for his pillow and slid to the floor. No injury, 12/8/24 Resident found on his knees between bed and wheelchair, stated he lowered himself to floor to get something. Date Initiated: 12/03/2024, Created on: 12/03/2024, Revision on 12/09/2024. Goal: The resident will resume usual activities without further incident through the review date. Date initiated 12/03/2024, Created on 12/03/2024, Target Date: 05/05/2025. Interventions/Tasks: Bed to be in lowest position while resident in bed with floor mat in place, Date initiated 12/03/2024, Created on 12/03/2024, Revision on 12/10/2024, Educate resident on using call light for assistance. Ensure call light is within reach at all times. Ensure that resident's belongings are within reach. For no apparent acute injury, determine and address the causative factors of the fall. Monitor/Document /report PRN x 72h[hours] to Medical Director for signs/symptoms: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Staff to assist with all transfers. Date Initiated 12/03/2024, Created on 12/03/2024, Revision on 12/03/2024. Record review of the facility Incident/Accident report dated 11/01/2024 to 01/22/2025 revealed that Resident #5 had falls without injuries on 11/10/24, 11/23/24 and 12/08/24. In an interview on 1/22/25 at 10:54 AM Resident #5 stated that he did have a few falls at the facility. He stated that the first fall happened in his first two weeks at the facility and he did not consider them falls. He stated that one time he had been truing to transfer himself out of his wheelchair to his bed and had ended up kneeling on the floor and could not get up, and the second time he had ben reaching for a pillow and had ended up sliding out slowly from his bed to the floor. He stated that nothing that he noticed had particularly changed in his room like floor mats or keeping his bed low or anything after his falls, but he stated he had suffered no pain or injuries from the falls. In an interview on 1/23/25 at 10:38 AM CNA C stated the aides have a spot in the Electronic Health record system where they check on how many persons are needed to assist residents, if resident's have particular needs, or any other instructions. She stated that the instructions come from the resident's care plans and it was the nurses that usually update the care plans. She stated that it is important to follow the instructions in the care plans to be able to help residents better. In an interview on 1/23/25 at 10:46 AM CNA D stated that she follows what is on the care plan to be able to assist residents. She stated if e care plan says to reposition a resident every two hours, she will do that. She stated that if specific instructions are not in the care plan, then she wouldn't do specific things. She stated that if there were not orders for a fall mat or to lower a bed in a care plan then she would not know to do it unless a nurse told her directly. She stated that it is important to follow the instructions in care plans to make sure residents stay safe. In an interview on 1/23/25 at 12:05 PM the ADON revealed that interventions are used to prevent residents from having repeated falls. She stated that interventions include counseling he resident on the use of call lights, fall mats, and having the bed in the lowest position. She stated that after a fall the care plan should be updated within 24 to 48 hours to reflect new interventions and that both the family and the medical Director are to be notified especially if there is any injury. She stated that is important to have the care plan up to date to make sure the CNA's are doing the correct things to keep residents from having falls or accidents. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/23/25 at 12:09 PM Regional RN E stated that it is expected for resident care plans to be updated with new interventions within 24 to 48 hours after a fall or accident. She stated that not updating he care plans in a timely manner could leave residents at an elevated risk for falls or accidents. In an interview on 1/23/25 at 12:25 PM DON stated that when falls are found or discovered on the incident report the nurses are expected to update the resident care plan within 24 to 48 hours. If interventions are not immediately put into place it could cause residents to experience unnecessary falls, accidents, or injuries. Review of a facility Policy titled Care Plans, Comprehensive Person-Centered Dated [DATE] stated . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents condition change.

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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** 50222 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for three (Resident #1, Resident #2, and Resident #3) of seven residents reviewed for pharmaceutical services. 1. LVN A failed to follow physician orders for administering medications (Carafate, amlodipine, aspirin, folic acid, losartan, pantoprazole DR, vitamin D3, finasteride, multivitamin, Potassium ER, and sertraline) by mouth to Resident #1 and administered the medications via Resident #1's gastrostomy tube (abdominal feeding tube). 2. LVN A failed to ensure proper placement of Resident #1's gastrostomy tube prior to administering medications. 3. LVN A failed to identify medications that should not be crushed for administration. LVN A crushed Potassium ER and pantoprazole DR and administered these medications to Resident #1. 4. LVN A administered insulin labeled with Resident #4's name to Resident #3. 5. MA B failed to ensure Resident #2 received the ordered amount of liquid Potassium Chloride. 6. MA B failed to ensure Resident #2 received Miralax powder that was mixed with the ordered amount of water. These failures could place residents at risk for not receiving the intended therapeutic benefits of their medications and for not receiving their medications as ordered. Findings included: Resident #1 Record review of Resident #1's Quarterly MDS dated [DATE] revealed Resident #1 was [AGE] year-old male admitted to the facility on [DATE] with diagnoses of dysphagia (difficulty swallowing), vitamin deficiency, and gastrostomy status (gastrostomy tube). BIMS score was 10 (suggested moderate cognitive impairment). Record review of Resident #1's care plan revised on 1/16/2025 revealed Resident #1 required tube gastrostomy related to dysphagia (difficulty swallowing) and would remain free of aspiration. The care plan also revealed Resident #1 was diagnosed with GERD and would receive Pantoprazole (GERD medication). Record review of Resident #1's physician orders revised 11/19/2024 revealed the following medications were to be given by mouth: sertraline 100mg one tablet by mouth (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	multivitamin give one tablet by mouth finasteride 5 mg give one tablet by mouth vitamin D3 25 mcg give one tablet by mouth losartan 100mg give one tablet by mouth folic acid 1mg give one tablet by mouth aspirin 81mg give one tablet by mouth amlodipine 5 mg give one tablet by mouth Carafate 1 gram give one tablet by mouth pantoprazole DR 20 mg give one tablet by mouth Potassium ER 20 mEq give one tablet by mouth Further review revealed medications may be crushed. The Order did not specify which medications. Record review of Resident #1's MAR for January 2025 revealed the following medications were to be given by mouth: sertraline 100mg one tablet by mouth multivitamin give one tablet by mouth finasteride 5 mg give one tablet by mouth vitamin D3 25 mcg give one tablet by mouth losartan 100mg give one tablet by mouth folic acid 1mg give one tablet by mouth aspirin 81mg give one tablet by mouth amlodipine 5 mg give one tablet by mouth Carafate 1 gram give one tablet by mouth pantoprazole DR 20 mg give one tablet by mouth (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 1/22/2025 at 9:36 a.m., LVN A crushed Resident #1's medications which included Potassium ER, pantoprazole DR, Carafate, amlodipine, aspirin, folic acid, losartan, vitamin D3, finasteride, multivitamin, and sertraline. LVN A administered these medications via the gastrostomy tube and did not check for placement or check residuals (remaining gastric contents) prior to administering the medications. LVN A reported she had never checked for residuals (remaining gastric contents) prior to administering medications and would not check for gastrostomy tube placement as long as the gastrostomy tube was able to be flushed with water. LVN A reported she did not know what the risk to the residents were if the gastrostomy tube was not in place or if residuals were not checked. In an interview on 1/22/2025 at 11:49 a.m., LVN A reported if medications were not supposed to be crushed then it would be listed in the directions on the medication order and medications should be given as ordered. LVN A stated she knew she was not supposed to crush delayed release medications or extended-release medications. LVN A also stated potassium should not be crushed but she crushed the potassium ER and pantoprazole DR because Resident #1 could not swallow whole pills. LVN A stated administering crushed potassium could cause stomach irritation. Resident #2 Record review of Resident #2's Quarterly MDS dated [DATE] revealed Resident #2 was an [AGE] year-old-female admitted to the facility on [DATE] with diagnoses of dementia and malnutrition. BIMS score was 03 (suggested severe cognitive impairment). Record review of Resident #2's care plan revised on 9/06/2024 revealed Resident #2 was at risk for constipation and was at risk for adverse reactions related to polypharmacy (taking multiple medications). Record review of Resident #2's physician orders revised 4/25/2024 revealed: Potassium chloride oral solution 20mEq/15mL give 15mL by mouth Record review of Resident #2's physician orders revised 4/08/2024 revealed: Polyethylene Glycol Power (MiraLax) give 17 grams of power mixed with 4 to 8 ounces of water In an interview and observation on 1/22/2025 at 10:33 a.m., MA B measured 15mL of liquid potassium into a medicine cup. MA B spilled the medicine cup of potassium on her medication cart leaving a visible puddle of medicine that was approximately four inches wide and 2 inches long. MA B administered the remaining medication to Resident #2. MA B measured 17 grams of MiraLAX powder and poured the powder into a clear cup with no measurements. MA B then poured an unknown amount of water into the cup that had the powder. MA B stirred the water and powder mixture and administered the medication to Resident #2. MA B reported she did not know how much potassium spilled out of the medicine cup and did not know how much potassium Resident #2 was given since it spilled. MA B reported she did not know how much water was mixed with the MiraLAX powder, but the order stated to mix with 4 to 8 ounces of water. The order was visible on the computer screen and revealed 4 to 8 ounces of water should be mixed with the MiraLAX powder. MA B stated not administering the correct amount of medication or mixing the medication as ordered placed residents at risk for not receiving the correct amount of medicine. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #3 Record review of Resident #3's Quarterly MDS dated [DATE] revealed Resident #3 was a [AGE] year-old-male admitted to the facility on [DATE] with a diagnosis of diabetes. Section N revealed Resident #3 received insulin injections. BIMS score was 15 (suggested no cognitive impairment). Record review of Resident #3's care plan revised on 1/16/2025 revealed Resident #3 refused to take his medications at times and interventions included administering medications as ordered. Record review of Resident #3's physician order revised 9/11/2024 revealed Lispro insulin was ordered for Resident #3. In an observation and interview on 1/22/2025 at 11:49 a.m., LVN A administered 2 units of Humalog (name brand for Lispro) insulin to Resident #3 that was labeled with Resident #4's name. LVN A stated it was the same insulin ordered for Resident #3 and that she did not have a vial of insulin on her cart for Resident #3 . LVN A did not state if a vial for Resident #3 was available anywhere else. In an interview on interview on 1/22/2025 at 3:45 p.m., the DON stated a nurse consultant comes out and does medication training. The DON stated insulin should only be given to the patient it was prescribed to. The DON reported the risk to the resident was that it might not be the right medicine and it could harm them. The DON reported orders for medications via gastrostomy tube should indicate the route and potassium should be dissolved and never crushed. The DON stated she was unsure of the risk to the resident if medications were crushed that should not be, but there are pharmaceutical guidelines. The DON stated it was the same risks for ER and DR. The DON stated staff should not give spilled medications to residents and should get new medications because they may not be getting the right amount. The DON also reported nurses should check for placement of gastrostomy tubes and check for residuals anytime something was administered through it. The DON stated the risk to resident was that they could have too much residual and must notify the doctor. The DON stated the resident was also at risk for medications or feeding going to the wrong place. The DON also stated she expected nurses to follow the doctor's orders and clarify any orders that were not clear. In an interview on 1/23/25 at 9:17 a.m., the Pharmacist Consultant stated she was a pharmacist that reviewed MARs, psychotropic medications, and physician orders for the facility. The Pharmacist Consultant stated crushing potassium can cause gastrointestinal harm. The Pharmacist Consultant reported crushing pantoprazole DR may cause the medication not to work because it would break down in the stomach instead of the intestines. In an interview on 1/23/2025 at 9:30 a.m., the MD stated there was no harm if medications were given via gastrostomy tube, but he expected nurses to follow the physician's orders. The MD stated residents should not be given other residents' medications. The MD reported crushing potassium ER and pantoprazole DR does not cause any harm. The MD also reported there was no risk to the resident if their liquid potassium was spilled one time. The MD stated there could be risks to the resident if the wrong amount was given long-term. In an interview on 1/22/2025 at 3:45 p.m., the DON reported a nurse consultant came to the facility weekly and completed training for medication, gastrostomy tubes, checking blood sugars, and additional nursing training with the nursing staff. The DON reported she did not have documentation for those trainings. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility's policy titled Enteral Tube Medication Administration, with a revision date of 10/01/2019, revealed the physician's order must specify the route of administration of any medication via feeding tube, H. Check for proper tube placement using air and auscultation only. Never check with water, and check gastric content for residual feeding .report any residual greater than 100mL. Record review of facility's policy titled Medication Administration, with a reviewed date of 7/08/2024, revealed Medications are administered in accordance with prescriber orders, and The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. This policy also revealed 26. Medications ordered for a particular resident may not be administered to another resident.