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	05/01/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for one (Resident #3) of four resident reviewed for misappropriation. The facility failed to ensure Resident #3 was free from exploitation when Resident #3 reported that $611.00 was taken from her. This failure could place the residents at risk of unresolved and unreported allegations of misappropriation. Findings included: Record review of Resident #3 face sheet dated 04/30/2025 revealed a [AGE] year-old female readmitted to the facility on [DATE] with an initial admission on [DATE]. Resident #3 discharged from facility on 01/10/2025. Resident #3's Diagnosis included Atherosclerosis of Native Arteries of Other Extremities with Ulceration (a form of peripheral arterial disease (PAD), which affects the blood supply to the limbs); Type 2 Diabetes Mellitus without Complications (the blood sugar levels are being managed effectively, and there are no signs of damage to the body's organs or systems like heart, kidneys, eyes, or feet); Essential (Primary) Hypertension (high blood pressure where the cause is unknown). Record review of Resident #3's discharge MDS dated [DATE] noted BIMS Score to be 14/15 with memory intact. (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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/30/2025 at 11:45 am Resident #3 revealed when she was residing at the facility, MA A befriended her and wrote down her personal phone number she provided her. Resident #3 had conversations with MA A wanting to move out to her own apartment. In January, Resident #3 revealed she moved to an assisted living. Resident #3 received a call from MA A the beginning of February 2025 telling her she was going to rent an apartment for Resident #3 and MA A'a family member to live in. MA A spoke to Resident #3 over the phone from her job while MA A's family member drove her to the bank and had her withdraw $611.00 for the apartment. Resident #3 had MA A's family member sign a paper stating the $611. 00 was for the deposit for the apartment, and then she handed over the money. On 03/05/2025, MA A contacted her saying the apartment fell through because the MA A had an eviction and could not rent the apartment. On 03/11/2025, she messaged MA A to return her money and did not hear back from her until 03/16/2025. MA A messaged Resident #3 back saying she was sorry, but the previous apartment that refused her application deposited the money and she could not get the money back yet. Resident #3 revealed that she contacted the police to report incident and the police recommended her to contact HHSC. Resident #3 spoke to ADM, who first stated he would call her back, but she did not receive a call back from ADM. Resident #3 called ADM back and informed him of the issues with MA A, her family member, and Resident #3's money they took for apartment deposit. The ADM advised Resident #3 to call him back if she didn't hear from him soon. In an interview on 04/30/2035 at 12:20 pm ADM revealed he was aware of the incident between Resident #3, MA A, and MA A's family member. ADM revealed Resident #3 had contacted him to report the incident, however since Resident #3 discharged from the facility on 01/10/2025 and did not feel the facility should be responsible for incident. The ADM revealed the incident happened after Resident #3 discharged to the other facility. This incident occurred between the staff member and the former resident. The ADM was asked if he could provide a policy r/t confidentiality of resident information involving staff members and ADM revealed that he did not believe so, but he would look. In an interview on 04/30/2025 at 3:39 pm MA A revealed she was familiar with Resident #3 who is a former resident of the facility. MA A and her family member became good friends with Resident #3. When asked why she introduced her family member to Resident #3, she stated that her family member had a stroke and needed someone to live with, too. Resident #3 wanted to move out to her own apartment and so did her family member. MA A said that Resident #3 wanted to get an apartment with her family member. MA A was asked where her family member was currently at and she stated her family member was not with Resident #3. MA A revealed that she did not know that Resident #3 gave money to her family member for the apartment. Resident #3 apparently had an eviction and could not get the apartment. MA A revealed she was not sure Resident #3 was in contact with her family member, but she had no recent contact with Resident #3. MA A and Resident #3 became friends, and her family member wanted an apartment and thought they could live together. When asked how did your family member get Resident #3's phone number? MA A revealed she gave her family member Resident #3's number. MA A stated that her family member was going to pay back the money to Resident #3. Requested a facility policy r/t Personal Privacy and Confidentiality of Records r/t employee violations and ADM was unable to produce a policy.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility in response to allegations of abuse, neglect, exploitation, or mistreatment, failed to report immediately to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with Texas law no later than two hours after the allegation is made, for 1 of 5 residents reviewed for abuse and neglect (Resident #1): The Administrator, who is the Abuse Coordinator, failed to immediately report (within 2 hours) an allegation of abuse that Resident #2 hit the arm of Resident #1. This failure could place residents at increased risk for abuse and neglect. Findings Include: Review of Resident #1's Quarterly MDS dated [DATE] reflected a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses in part including hemiplegia (paralysis on one side of the body) and cerebrovascular accident (stroke). The MDS reflected Resident #1 had a BIMS score of 15, suggesting no cognitive impairment. The Intake Investigation Worksheet reflected that the facility on 3/17/24 emailed a notification to ciicomplaints@hhs.texas.gov that Resident #1 reported being hit on the arm by Resident #2. An intake number was assigned with the date created of 03/17/25. The provider investigation report with fax cover sheet dated 3/20/25 was reviewed and indicated an incident occurred on 3-14-25 in which Resident #2 was witnessed grabbing the shirt of Resident #1. Upon investigation the facility confirmed physical abuse. Review of Resident #1's progress note dated 3/15/25 at 05:56 pm written by LVN A reflected the incident between Resident #1 and Resident #2 occurred on 3/15/25. Review of Resident #2's progress note created 4/11/25 at 12:41 pm written by the DON reflected the incident between Resident #1 and Resident #2 occurred on 3/15/25. In an interview on 5/01/25 at 09:20 am, the DON stated she witnessed the incident of physical aggression on Resident #1 by Resident #2 on 3/15/25 in which Resident #2 grabbed Resident #1 by the jacket around her shoulder, and that she reported it to the ADM within an hour. She stated that the ADM is responsible for filing notifications of abuse with the state. She reported that when there is an allegation of abuse, she believed it must be reported within 24 hours but that the ADM handled those things. She reported allegations of abuse were to be reported to ensure the residents are safe. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/1/25 at 09:53 am, the ADM reported he thought he reported the physical altercation between Resident #1 and Resident #2 in which Resident #2 grabbed Resident #1 by her jacket around her shoulder o n 3/15/25, but that he did not get an intake number at that time. He stated that in the report he had mistakenly reported the incident occurred on 3/14/25 but that it had actually occurred on 3/15/25. He stated he may have reported it by phone. He stated that because he did not get an intake number, he again reported the incident on 3/17/25. He stated he did not have any documentation of making the report on 3/15/25 other than texts between himself and facility staff. He stated he was the abuse coordinator and that he was responsible for reporting allegations of abuse to the state and that reports of abuse were made within two hours to assist in protecting residents from abuse. Facility policy titled, Abuse and Neglect, Abuse Prohibition Policy was reviewed with original date 05/01/01 and last revision 11/07/2023. The policy stated, The Abuse Coordinator will report such allegations to the state agency in accordance with state law. The Abuse Coordinator will report all allegations of abuse, neglect with serious bodily injury, mistreatment with serious bodily injury, exploitation with serious bodily injury, and injuries of unknown source with serious bodily injury within two hours of the allegation.