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	05/20/2025

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure personnel provided basic life support, which included CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives for 1 of 7 residents (Resident #1) reviewed for cardio-pulmonary resuscitation. RN E failed initiate CPR when FM C told him Resident #1 was unresponsive on [DATE]. A Past Non-Compliance Immediate Jeopardy (PNC IJ) was identified and presented to the Administrator and DON on [DATE] at 4:04 PM at exit. The noncompliance began on [DATE] and ended on [DATE]. The facility corrected the noncompliance before the investigation began. This failure could place residents at risk of not receiving life-saving measures, medical complications, distress, and up to and including death. Findings included: Record review of Resident #1's face sheet dated [DATE] reflected she was an [AGE] year-old female that was admitted on [DATE]. DX (diagnosis) included: Unspecified Dementia (memory loss), Mood Disturbance (disruption in emotional state), Anxiety (feeling of worry), Other Symbolic Dysfunctions (affecting speech and memory). The face sheet did not reflect Resident #1's advance directive as it was left blank. Record review of Resident #1's quarterly MDS dated [DATE] reflected she had a Bims score of 3, indicating severe cognitive impairment; Section GG resident functional abilities reflected she required extensive assistance for bed mobility, transfers, eating, toilet, she was a hospice patient, and all medications and DX were addressed. Record review of Resident #1's care plan dated [DATE] reflected the staff and/or responsible party have been provided the information explaining the Advanced Directive process and following Date Initiated: [DATE]. interventions .Obtain a copy of my [full code] status physician order Family and staff are aware of my Full code status .Send the copy of my [full code] status with me on all transfer to physician appointments or hospital .Upon admission my family or I have received a copy of the Advanced Directive and Resident Rights. ADL care reflected Resident #1 required extensive assistance from staff with self-care, transfer, ADL, hygiene .The resident has a terminal prognosis r/t Alzheimer's Disease. (disease causing a decline in cognitive function) (continued on next page)

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's MD orders dated [DATE] reflected resident was a full code .Hospice to evaluate and treat as Indicated, [DATE] .Resident/Responsible Party is aware of Diagnosis: Yes. Record review of Resident #1's progress notes reflected the following: On [DATE] at 3:56 PM, by RN E This nurse was called into room [room number] at 1505 (3:05 PM) resident was not breathing, this nurse (RN E) assessed pulse and respiration and initiated [code blue] and CPR started on the resident and 911 EMS was called, Nurses were doing CPR on the patient when EMS staff arrived by 3:09 PM [EMS] started working on the resident till 4:00 PM. Pulse and BP noted on the resident and EMS staff took her to [hospital.] Resident left the facility with EMS exactly 4:00 PM signed [RN E] Nursing - Registered Nurse (RN) [e-signed.] RN E's note did not mention that the family was present in the room not that the family as the initial notification to him when Resident #1 became unresponsive. Record review of Resident #1's progress notes dated [DATE] at 9:17 PM by ADON reflected the following: Resident expired. An observation of Resident #1 was not conducted as she expired on [DATE] at the hospital. During an interview with ADM on [DATE] at 11:00 AM stated that he was notified by the ADON on of the incident [DATE] at 3:10 PM. ADM said he proceeded to the facility to meet with the corporate staff to investigate the incident. ADM stated that upon his arrival the investigation was initiated. ADM said that his investigation revealed that FM C notified RN E that Resident #1 was nonresponsive. ADM said the resident was a full code. ADM said the hospice nurse was contacted to ensure advance directive due to HLV leaving DNR documents for the family to sign on [DATE] at 10:00 AM. HLVN and ADON both confirmed that Resident #1 was a full code. ADM said a code blue was initiated by RN E. ADM said that RN A immediately assisted with the code blue on Resident #1 in her room until EMS arrived. ADM said there were family members present in the room. The family members were later identified as (FM C and FM T). ADM said he had not interviewed the family that was present, only the POA. ADM said on [DATE] and [DATE] all active staff were in-serviced on CPR protocol, Code Blue, and DNR protocol. After the education, the staff were required to take a test on their knowledge of the incident. All staff passed. ADM said the training and monitoring was ongoing and this was an isolated incident. He stated that RN E was immediately suspended pending investigation findings and terminated on [DATE]. During an interview with DON on [DATE] at 11:10 AM stated she was not working the day of the incident ([DATE]). The DON stated that she was in-service on [DATE] and she has been a monitoring, auditing, and educating staff on CPR (task conducted to save a life during cardiac arrest), code Blue (procedures of the facility), and DNR protocol. The DON stated that (RN E) failed to check code status for Resident #1 and follow administrative and MD orders to initiate CPR and call 911 when she was found unresponsive. The DON expects all nursing staff to review advance directives on assigned residents, know where to locate the information in the electronical files, initiate CPR, and call 911 immediately for residents that have an advanced code of full code. The DON said it was her expectation that the staff continue CPR until EMS arrived and take over. The DON stated the risk to residents when the advance directive was not followed included: failure to honor the resident's wishes and death if no CPR was initiated. DON said the facility initiated corrective actions immediately to ensure other resident's safety and this was an isolated incident. The DON said RN E was terminated on [DATE] at 9:22 AM via phone. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with ED on [DATE] at 11:20 AM stated that he was notified of the incident with Resident #1. ADM said other corporate staff and ADM reported to the facility and investigated. ED said RN E failed to follow the care guidelines for all residents advance directives, initiate CPR immediately for residents that were full code, and notify 911 when a resident was fund non-responsive. The ED expects all staff to follow MD orders and leadership directives quickly to alleviate any delay in care or services for residents. The ED stated that he assisted with the investigation and training along with other corporate staff to ensure staff were trained immediately and residents were safe. The ED stated that RN E was immediately suspended on [DATE] pending the investigation findings, then terminated on [DATE] at 9:22 AM via phone. ED stated that he will be referring RN E nursing license. The ED stated the risk to residents when the advance directives for CPR/full code were not followed included failure to honor the resident's wishes and death if no CPR (task conducted to save a life during cardiac arrest) was initiated. During an interview with ADON on [DATE] at 11:25 AM who stated she received a call from the HLVN and CNA B at 2:45 PM stating that RN E was asked to conduct CPR (task conducted to save a life during cardiac arrest) for Resident #1, and he had not initiated the lifesaving actions for Resident #1. HLVN told the ADON that Resident #1's DNR form had not been signed by the POA or MD, so CPR should be the first course of action for the resident to save her life. ADON notified RN E and CNA B to activate a code blue and initiate CPR and call 911. The ADON headed to the facility along with ADM, ED, and other corporate staff to investigate, educate, monitor, audit staff knowledge and competency on trainings on CPR and code blue protocol. The ADON said all active staff were trained and evaluated on training protocol's and they all passed the test. The ADON said Resident #1 was sent out via ambulance and RN E was suspended pending investigation findings. The ADON said RN E was terminated on [DATE] after the investigation determined he did not follow advance directive protocol for Resident #1. ADON said she did not know if the facility ADM referred RN E to the BON. The ADON stated she expected all staff to be knowledgeable on resident's advance directive and act immediately by calling a code blue, initiating CPR, and notifying 911. The ADON said she expects the nursing staff to continue CPR until EMS arrive and take over care. The ADON said the risk to residents included failure to honor the resident's and families wishes and death if no CPR was initiated. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with CNA B on [DATE] at 11:30 AM revealed she observed FM C telling RN E on [DATE] at 2:40 PM that Resident #1 was full code and he needed to conduct CPR. CNA B overheard FM C talking to RN E at the nursing station. CNA B said she intervened and spoke with FM C to address concerns that Resident #1 was full code and RN E had not initiated CPR. CNA B immediately checked the chart and notified the ADON via phone to report Resident #1's advance directive (full code). The ADON reviewed Resident #1's file and confirmed that Resident #1 was a full code requiring CPR. The ADON told RN E to initiate CPR immediately, call a code blue, and notify 911. CNA B observed RN E take the Crash Cart and head to resident room. CNA B stated she notified RN A of the code blue at the nursing station and LVN T to notify 911 and get Resident #1's files prepared for transport via EMS. CNA B was seeking additional staff to assist with the code blue. CNA B said RN E headed to the resident room with the crash cart to initiate CPR. CNA B stated that she told RN A to go and assist RN E with a code blue. CNA B said she then asked LVN T to contact 911 and gather medical documents for the transport with EMS. CNA B stated she did not enter the room, nor did she observe RN E initiate CPR. CNA B said the risk to residents included failure to honor the resident's and families rights and death if no CPR was initiated. CNA B said all nursing staff were required to know resident advance directive status and immediately conduct CPR for full code to residents until EMS arrives. CNA B said she was not in the room with RN E and RN A to confirm that CPR was initiated immediately. CNA B said she told RN A and LVN T of the code blue verbally at the nurse's station. CNA B said she did not make an announcement on the PA system notifying staff of a code blue on [DATE]. CNA B said that several family members were resident in the room with Resident #1. During an interview with [NAME] on [DATE] at 11:59 AM stated Resident #1 was on hospice and her advance directive on [DATE] at the time of the incident was full code. [NAME] said FM C called HLVN concerned that RN E had not initiated CPR on Resident #1. [NAME] said FM C told RN E several times that Resident #1 was full code, and he ignored her request for 10 to 15 minutes and returned to the nursing station. During an interview with HLVN G on [DATE] at 12:25 PM stated she visited the facility at 10:45 AM. HLVN G stated she received a call from a family member name (later identified as FM C) unknown inquiring about Resident #1's advance directive. HLVN G stated she spoke with RN E time unknown to confirm that the resident did not have a DNR for AD and he (RN E) should proceed with CPR. HLVN then contacted the ADON to report FM C's concerns about RN E not initiating CPR. HLVN told ADON that Resident #1 was full code indicating that the staff would administer CPR and call 911. During an interview with LVN T on [DATE] at 1:25 PM who stated that CNA B called her over to the nursing station on [DATE] at 3:00 PM and asked her to contact EMS for a code blue of a resident, and to gather face sheet, Medication list, and care plan to provide to the EMS when they arrive to transport Resident #1. LVN T said she called 911 at 3:00 PM and they arrived at 3:20 PM. LVN T said she waited at the front door for EMS and escorted them to the Resident #1's room and provided the transfer documents. LVN T said she did not enter the room and could not confirm if CPR was in progress on Resident #1 by RN E or RN A. LVN T family in the room and observed the EMS taking Resident #1 out on a stretcher (tall bed with wheels) while continuing to provide breathing support. LVN T stated she was trained on CPR protocol and code blue on [DATE]. She completed the testing was knew the location in the electronic files to access resident's advance Directives. LVN T stated that risk to residents included failure to honor the resident's choices and death if no CPR was initiated. LVN T did not remember if an announcement was conducted over the PA system notifying all staff of a code blue. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with RN A on [DATE] at 1:57 PM revealed she was notified by CNA B on [DATE] at 3:00 PM that a code blue was activated and to go and assist RN E on the three hundred Hall with CPR protocol. RN A said upon arrival to Resident #1's room, she observed the facilities crash cart outside of Resident #1's room in the hallway. RN A entered Resident #1's room and observed RN E standing in the room talking with family and he had not initiated CPR on Resident #1. RN A said she had observed Resident #1 lying down on the bed unresponsive, assessed her pulse, and then RN E asked if the Resident #1 was a full code, and he (RN A) said yes and 911 had been called. RN A proceed to position Resident #1 and initiated CPR. RN A said the facility staff did not announce a code blue over the PA system. RN A stated she was notified by CNA B verbally at the nursing station. RN A said after she initiated CPR RN E left the room before EMS arrived, therefore he was not available to communicate with the EMS staff on specifics about the patient (Resident #1) and care. During an interview with the Administrator on [DATE] at 5:00 PM, he stated the IJ occurred on [DATE] after the charge nurse (RN E) failed to check code status, initiate code blue, call 911, and initiate CPR protocol for Resident #1 when she was found unresponsive. He stated the hospice company provided the DNR form, however despite directions from family member, hospice nurse, and the ADON he failed to ensure the POA and Resident #1's rights were represented. Resident #1's POA expressed her desire for a DNR order earlier in the day with HLVN. ADM stated the risk to residents not receiving immediate actions for full code status and CPR included failure to honor the resident's wishes, distress, and death if CPR was not initiated. ADM said the facility initiated corrective actions immediately on [DATE] when the failure was identified to ensure other resident's safety, and this was an isolated incident. A phone interview was attempted with RN E on [DATE] at 1:39 PM and a voicemail was left requesting a return call for an interview was left. RN E did not return the call, and he was not interviewed prior to exit on [DATE]. During an interview with Residents #1's POA on [DATE] at 3:32 PM, who stated that she was not present when Resident #1 became non-responsive on [DATE]. POA said she left to allow other family members (FM C and FM T) and others to visit the resident after she was notified by hospice HLVN G that Resident #1 was declining. POA stated that the HLVN discussed changing Resident #1's advance directive to a DNR early that morning and ordered morphine to keep Resident #1 comfortable. POA stated Resident #1 was declining in health and she did not want Resident #1 to be resuscitated. The POA said she had not signed the DNR documents for Resident #1 at the time of the incident ([DATE]). POA stated that the resident passed away before she could return to the facility and sign the DNR. The POA provided contact information for FM H who was present with others in the room when Resident #1 died. She did not have the phone number for FM C and others that were present on [DATE]. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of RN E personnel file reflected a disciplinary action dated [DATE] reflecting Recommended Action: termination. Rule Infracted (violation): Failure to Follow [Facility] Policy .facts regarding incident: On [DATE], a [Resident #1] went into full code. The resident, although on hospice, did not have a DNR in place. At the time of the full code, you failed to perform CPR at that moment which is against [Facility] Policy and CPR had to be initiated by another nurse. This failure to follow policy which requires CPR with no DNR in place Expectations for [facility] associate's behavior: The follow [facility] Policy at all times when it comes to the health and welfare of our residents. Solutions & corrective action to be taken: Immediate termination of employment Associate's statement: was blank Note to Associate: Continued performance problems will result in further disciplinary action, up to and including termination. Associate's Signature verifies that (1) This Disciplinary Action has been presented to me; (2) the Associate does not necessarily agree with its content; and (3) the Associate has had an opportunity to respond to the counseling. Associate signature and date reflected Delivered by phone 9:22 AM. Supervisors signature and date [ED] [DATE] Copy to: Associate's Personnel file Witness (in the event Associate refuses to sign) Associate HR if suspend/terminated. An attempted phone interview with FM H on [DATE] at 3:47 PM a voicemail was left requesting a return call for an interview. FM H did not return call and the interview was not conducted. Record review of the facility's Inservice dated [DATE] policy titled CPR-AED Policy revised [DATE] reflected the following: Full Code/DNR by ADON and [facility) dated [DATE], titled QAPI reflected Immediately on [DATE] nurse who was responsible for resident was suspended pending investigation. Review of in-services on [DATE] reflected, corporate staff in-serviced Administrator and DON on CPR policy that included education on full code status and when to initiate a full code. In serviced on if verbal consent also given however if the DR has not signed the DNR form the resident will remain a full code until DNR paperwork has been signed and facility has copy. Competency was verified via quiz. Review of in-services dated [DATE] DON/Designee initiated in-services with the nursing staff on CPR policy that included education on full code status and when to initiate a full code. In serviced on if verbal consent also given to nursing staff however, if the DNR has not been signed the resident will remain a full code until DNR paperwork has been signed and facility has copy. Competency was verified via quiz. Nursing staff was not allowed to work until in servicing had been completed. the above content was incorporated into new hire orientation by Administrator effective [DATE]. Review of audit on [DATE], an audit was completed of all resident code status by DON/Designee. Medical Director was notified on [DATE] In order to monitor current residents for potential risk, SW/designee will audit the code status of all residents weekly x 4 weeks and monthly thereafter to ensure accuracy. Any negative findings will be corrected and reported to the QAPI committee to ensure continued compliance. The facility QA Committee will meet weekly for the next eight weeks to review compliance with the plan of action. If no further concerns are noted, will continue to monitor as per routine facility QA Committee. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's Full Code/DNR Quiz for staff dated [DATE] reflected the following information questions .1. An RP/POA for a resident communicates verbally that they would like the residents code status changed from CPR to a DNR. Prior to completion of DNR form and physicians order the resident codes you must .Initiate CPR Do nothing until the form is back 2. A patient is listed as a Full Code and becomes pulseless. What should you do first? Begin CPR immediately and call for help .3. A patient becomes unresponsive and pulseless. You are unsure of their code status. What is the first action you should take? Start CPR immediately Call the provider for clarification. Double check the medical record .4. Who is responsible for knowing a resident's code status? All members of the care team. Monitoring of the facility's Plan included record review of Resident #1, #2, #3, #4, #5, #6, and #7's medical charts for compliance with advance directives orders, and notifications. All resident's charts reflected active Advance Directives on the face sheet, MD orders, Care plan with specific interventions and communication with RP. Interviews were conducted with facility staff across all three shifts on [DATE] from 11:00 AM through 2:55 PM. The staff included, ADM, ADON, CNA B, CNA L, DON, ED, HR, LVN T, MA G, MA R, RN A, RN T, and SW. The interviews revealed they had all received in-service training and could accurately describe how to determine the resident's code status, how to determine whether DNR documentation was complete, how and when to initiate CPR, code blue, and how long they should continue CPR. Record review of facility policy titled CPR dated [DATE] reflected In the event of cardiopulmonary arrest of a resident/patient without DNR status, life support measures will be initiated according to either the American Heart Association/American Red Cross guidelines or per State Guidelines. According to the 2001 American Heart Association, BLS (Basic Life Support) for Healthcare Providers, prompt initiation of CPR remains the standard of care .Rescuers who initiate BLS should continue until one of the following occurs: Restoration of effective spontaneous circulation and ventilation; Transfer of care to emergency medical responders or other trained personnel who continue BLS or initiate advanced life support; Transfer of care to a physician who determines that resuscitation should be discontinued; Inability to continue resuscitation because of exhaustion, because environmental hazards endanger the rescuer, or because continued resuscitation would jeopardize the lives of others; Recognition of reliable criteria for determination of death; or Presentation of a valid no-CPR order to the rescuers. (continued on next page)

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the nursing staff were licensed for 1 of 4 staff (RN E) reviewed for competencies. The facility failed to ensure RN E was permitted to practice as a licensed vocational nurse. RN E registered nurse license was expired, the facility failed to ensure RN E was permitted to practice as a registered nurse. Confirmed through board of nursing RN E's nurse license was expired. The findings were: During an interview with the ADM on [DATE] at 10:00 AM requested license for RN E. During an attempted phone interview with (RN E) on [DATE] at 1:39 PM yielded no answer. A voicemail requesting return call was left. RN E did not return call for an interview. During a phone interview on [DATE] at 8:43 AM a request for RN E's nursing license verification was requested from the ADM. An email was sent to the ADM on [DATE] at 9:35 AM requesting RN E's nursing licensing verification for RN E. ADM did not respond to the email request. Record review of the website on [DATE] at 3:33 PM https://txbn.boardsofnursing.org/licenselookup revealed that RN E was listed on the board of nursing as having an expired license as of [DATE]. During an interview with HR on [DATE] at 8:58 AM, she has been working at the facility since [DATE]. HR said it was her role to conduct employee background checks annually, and verification of nursing license monthly. HR said she was not aware that RN E's license had expired until [DATE]. HR said she had not completed a nursing verification or background check on RN E this year. HR stated RN E's date of hire was on [DATE] as a full-time RN charge nurse. HR said RN E changed his employment status on [DATE] to PRN. HR said RN E was terminated on [DATE] after failing to administer CPR to a resident that was on hospice. During an interview with the ADM on [DATE] at 9:20 AM revealed HR responsibility to ensure all licenses for professional staff were run at the time of hire and annually. ADM said he was not aware that RN E license had expired. ADM said he thought RN E's license were current, and if he had known his nursing license were delinquent, he would have suspended RN E until his license was renewed. ADM said that he plans to monitor HR completion of background checks and license verification by checking upon hire and every three months to ensure staff are qualified and clear to work. The ADM said he did not know the risk of nursing staff practicing with an expired license I don't know maybe safety risk. The facility policy was not provided for review as the violations was determined after completing a nurse licensure check online [DATE] at 3:33 PM. (continued on next page)

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	05/20/2025

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 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the requirements for states and long-term care facilities staff qualifications reflected §483.70 (e) (1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70 (e) (2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws .§ 483.35 (a) (3) Nursing services .The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Record review of the Texas Administrative Code, chapter 26 Code § 554.1905(b) - Staff Qualifications reflected (b) Professional staff must be licensed, certified or registered in accordance with applicable state laws.