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	09/18/2025

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 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all allegations involving abuse, neglect, and misappropriation were reported immediately, but no later than 2 hours after the allegation was made to the State Survey Agency for 1 of 6 residents (Resident #1) reviewed for abuse and neglect.The facility did not report to the State Survey Agency (HHSC) an incident in which Resident #1 tied the call light cord around his neck.This failure could place residents at risk for abuse/neglect and could lead to a diminished quality of life and psychosocial harm. The findings included: Record review of Resident #1's face sheet, dated 09/18/2025, reflected an [AGE] year-old male with an initial admission date of 08/15/2025. Resident #1 had diagnoses which included chronic diastolic heart failure (a condition where the heart becomes stiff and cannot relax properly, making it difficult for the heart to fill with blood), severe intellectual disabilities (a condition characterized by significant limitations in cognitive functioning), and cognitive communication deficit (Communication difficulty stemming from an underlying problem with a person's thinking processes). Record review of Resident #1's admission MDS Assessment, dated 08/22/2025, reflected a BIMS score of 11, which indicated the resident was moderately impaired (a condition with a serious limitation in a specific area of functioning, requiring significant support or assistance to carry out daily tasks).Record review of Hospice Agreement dated and signed 09/09/25 reflected Resident #1 had been admitted to hospice. Record review of Resident #1's Progress Notes, dated 09/09/2025 written by the ADON, reflected, hospice mattress arrived res was very lethargic and very difficult to arouse for most of this shift. Family members arrived and expressed that it was [Resident #1's] wish to not eat - he is tired. family wants to keep meds on board to ease his discomfort [sic]. Record review of Resident #1's Care Plan, updated 09/09/25, reflected, [Resident #1] was admitted to Hospice with Terminal DX: CHF, DC all routine labs and radiological studies. Do not call 911 or send resident to hospital without calling Hospice. Call with any falls, occurrences or any change in condition. An interview on 09/18/25 at 2:37 PM with ADON revealed she had just talked to Resident #1 and his family prior to him tying the call light cord around his neck. She stated the family stated they had accepted that the resident was not going to get better and had placed him on hospice. She stated Resident #1 had not informed her of any suicidal plans and she had not seen any suicidal ideations when she visited his room that day or she would have reported it to the DON, the administrator, social services, and hospice. She stated the hospice representative was still in the building on 09/10/25 when Resident #1 tied the cord around his neck because she had just finished talking to him and his family.In a telephone interview on 09/18/25 at 3:13 PM with the NP revealed Resident #1 had never expressed to her that he wanted to harm himself. She stated she met with the dietitian, the family, and the previous DON regarding Resident #1 refusing to eat. She suggested Resident #1 received a feeding tube for nutrition, but the family refused. She stated hospice was suggested, and the family wanted to think about it for a few days. She stated after a few days the family decided to place Resident #1 on hospice on 09/07/25. In a telephone interview on 09/18/25 at 3:19 PM with previous DON revealed she and the dietitian met with the family of Resident #1 regarding him not eating. She stated she could not remember the exact date of the meeting but that it was around the beginning of the month. She stated the family stated Resident #1 was not eating because of recent dental work and he wanted to give up because of his sickness. She stated Resident #1 never stated he had suicidal ideations. She stated when the family stated he was giving up and not eating was not an indication to her that he would attempt suicide. She stated he had not attempted suicide prior to being admitted to the facility. She stated her assessments prior to admission nor during admission revealed any thoughts of suicide. An interview on 09/18/25 at 6:23 PM, the ADM stated Resident #1 tying the call light cord around his neck was not reported to the State Survey Agency because there was no indication in the Provider Letter that the incident should have been reported. He stated Resident #1 was found by one of the Medication Aides. He stated Resident #1 had not shown any evidence of suicidal ideations in any assessment completed during admission or when there was a change in condition when he was placed on hospice. He stated the only time Resident #1 made a statement that he wanted to harm himself was after he was found with the cord around his neck on 09/10/25. He stated the resident had no documented history of suicide attempts or wanted to harm himself. He stated when the statement was made by the resident that he wanted to kill himself, he was placed one to one until he was taken to the hospital for psychological evaluation, his family and hospice were notified. He stated Resident #1 passed away from his heart condition prior to the evaluation being