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	11/08/2025

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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. (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 0691 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 observation, interview and record review, the facility failed to ensure that resident who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for one (Resident #1) of five residents.The facility failed to change Resident #1 colostomy bag upon request.These failures placed residents at risk of embarrassment, at risk of loss of dignity and a decrease in quality of life.The findings include:During a review of the Face Sheet for Resident #1 reflected a [AGE] year old male admitted to the facility on [DATE] with the following diagnoses: unspecified intestinal obstruction (food or stool cannot pass through the small or large intestine, but the specific cause is not yet known or categorized), unspecified as to partial versus complete obstruction; dysphagia (difficulty swallowing, where food or liquids cannot move easily from the mouth to the stomach), cognitive communication deficit (difficulty in communication that arises from an underlying cognitive impairment, affecting mental processes like attention, memory, problem-solving, and executive function), , gastrostomy status (presence of a gastrostomy (G-tube), which is a surgically created opening in the stomach to allow for feeding or to relieve air and fluid pressure). During a review of Resident #1's Minimum Data Set (MDS) assessment, dated 10/31/25, did not reflect a Brief Interview for Mental Status (BIMS) score for Resident #1 and did not reflect colostomy bag.During a review of Resident #1's Care Plan undated, reflected Resident #1 is on antibiotic therapy Ciprofloxacin 500 milligrams twice a day times five related to urinary tract infection initiated 10/30/25.During an observation and interview on 11/08/17 at 10:30 a.m., Resident #1 was in bed covered up, no odor noted, no distress noted. Resident #1 reported to the state surveyor he wanted his colostomy bag changed. Resident #1 pressed his call light; a facility aide came and checked Resident #1 request and informed Resident #1 they would get the nurse. The state surveyor observed the staff member inform the nurse that Resident #1 wanted his bag changed. Resident #1 stated the bag had not been emptied since last night and that the bag had started to lift and that is why he wanted it changed because he did not want it to leak on him again. Resident #1 stated the bag had leaked on his clothes before but could not recall when or how long it took. Resident #1 stated that he had only been here a few weeks so not that long ago.During an interview on 11/08/25 at 10:50 a.m., the complainant she stated that on 10/26/25 she was in the facility and had observed Resident #1's in bed and his colostomy bag required changing as it had leaked onto his clothing. The complainant stated she witnessed the aide inform the nurse that Resident #1 bag needed to be changed and it took over two hours for the nurse to come change the colotomy bag and then the aide cleaned him up. She stated she was not sure how long he had been like that prior to her arrival but took a picture and stated she would provide the picture. During a record review of complainant photo received on 11/08/25 of Resident # 1. Resident #1 was lying in bed in a blue crewneck sweater and blue pants with noted brown and yellowish stains on outside or sweater and pants near Resident #1 right side of the mid-section.During an interview on 11/08/25 at 11:06 a.m., CNA A revealed that only nurses can burp (to expel air through the drainable end or filter opening. Done to manage any odor or splashing), [empty or change colostomy bags. CNA A stated that Resident #1 is the only resident that had a hard time getting his colostomy bag changed. She stated she could tell the nurse, and it could take an entire shift for the nurse to change Resident #1 colostomy bag. CNA A stated if the bag is not changed it could cause resident distress, there was the potential for it to leak on to the skin and cause breakdown and the dignity of the resident, and if not emptied or changed the colostomy bag can have a blowout.During an interview on 11/08/25 at 11:42 a.m., CNA B revealed that aides could not change colostomy bags they were to inform their nurse on duty if resident requested or required their colostomy bag changed. CNA B stated that there had been occasions where a resident requested for their bag to be changed and had to ask the nurse to change the bag multiple times during a shift an entire shift and had witnessed the nurse take all shift before they would change the bag out. CNA B stated when the nurses did not change the bag that the bag would lift and leak onto the resident, which was a dignity issue and could have led to possible skin irritation or breakdown.During an interview on 11/08/25 at 12:25 p.m., LVN C revealed that nurses were the only staff members who could burp/empty/change colostomy bags. LVN C stated that she had one resident on her hall who had a colostomy bag. LNV C stated that Resident #1 had requested it to be changed today on/or before 11 a.m. The LVN stated she had not changed the bag but had burped the bag and would change it after Resident #1 ate lunch. LVN C stated that she asked Resident #1 if