

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676178	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/05/2025
NAME OF PROVIDER OR SUPPLIER  Duncanville Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 4 of 10 residents (Resident #1, Resident #4, and Resident #5 and Resident #6 ) reviewed for rights. The facility failed to ensure the staff in the main dining room served Resident #4, and Resident #5, at the same time Resident #1 was served his lunch meal. The facility failed to ensure CNA B made up Resident #6's bed in her room before lunch as she had requested. These failures could place residents at risk of feeling like their dignity was being invaded or the facility was not their home. Findings included: Record review of Resident #1's admission MDS assessment, dated 09/23/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnosis which included: heart failure (weakened heart), hypertension (increased blood pressure), and diabetes (increased sugar levels). Resident #1 had severe cognitive impairment and required assistance of one staff for activities of daily living. Record review of Resident #4's quarterly MDS assessment, dated 07/17/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4 had diagnosis which included: heart failure (weakened heart), hypertension (increased blood pressure), and diabetes (increased sugar levels). Resident #4 had moderate cognitive impairment and required assistance of one staff for activities of daily living. Record review of Resident #5's quarterly MDS assessment, dated 09/03/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5 had diagnosis which included: hypertension (increased blood pressure), Aphasia (talking is difficult), Cerebrovascular Accident (stroke) and depression (mental illness). Resident #5 had moderate cognitive impairment and required assistance of one staff for activities of daily living. Record review of Resident #6's quarterly MDS assessment, dated 10/06/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #6 had diagnosis which included: Quadriplegia (paralyzed), neurogenic bladder (bladder muscle does not work), and depression (mental illness). Resident #6 had no cognitive impairment and required assistance of two staff for activities of daily living. Observation of 100 hall on 10/21/2025 at 9:55 a.m., revealed Resident #6's bed had not been made. The mattress had been stripped of all linens and there was a bare mattress noted. There were pillows piled up on the top of the dresser in the room. In an interview on 10/21/2025 with Resident #6 at 10:30 a.m. revealed that this was the way it was on most days, and some days the bed was not made until 6:00 p.m. Resident #6 stated she had told the nurse and the CNA in charge of the hallway, but the bed was still not made. Resident #6 stated that she liked to go to bed around 6:00 pm after she ate her dinner, but last night (10/20/2025) she did not get to go to bed until 8:00 p.m. because the CNA did not make the bed until around that time. Resident #6 stated she complained to the charge, nurse and called the resident complaint line for residents to the cooperation, but the bed was not made this morning either. Resident # 6 stated on most days she admits she does not get out of bed until after 10:00 a.m. but the bed is still not made by lunch time, and it was embarrassing if she had visitors. Observation of Hall 100 on 10/21/2025 at 11:30 a.m. revealed Resident #6's bed had not been made. Observation on 10/21/2025 at 12:05 p.m. revealed Resident #1 was served his lunch meal at a tab [NAME] table where he was sitting with two other residents. Resident #1 proceeded to eat his lunch. In an interview on 10/21/2025 at 12:10 p.m. with Resident #5 revealed they were served at the table all the time like this. Resident #5 stated she did not like sitting at the table watching someone else eat their food and Resident #5 stated, think it is rude for him to even start to eat until we are served. Resident #5 stated she wished that if they going to serve him first serve them also. Resident # 4 could not speak but when ask if she was disturbed by the food being served to the other resident first and she not getting to eat at the same time, she nodded yes. Resident #4 pointed her finger at Resident #5 and Resident #5 stated that is what she does if she agrees with what I am talking about. Observation on 10/21/2025 at 12:15 p.m. Resident #1 was also served an additional grill cheese sandwich that he had requested when his original lunch had been served, Residents #4 and Resident #5 had not been served at this time. Observation on 10/21/2025 at 12:22 p.m. revealed the staff serving Resident #4 and Resident #5 their lunch meal. In an interview on 10/21/2025 with LVN C at 12:30 p.m. it was revealed that all residents at the same table should be served at one time. This prevents other residents from sitting watching the other residents eat their meal. LVN C stated that sometimes that does not happen because the kitchen does not serve the trays out that way. LVN C stated that it is the resident's right. LVN C stated she did not know how it</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one of five (MA A) staff members reviewed for infection control procedures. Medication Aide A failed to perform hand hygiene after direct contact with residents while serving meals in the main dining room. This failure could place residents at risk for healthcare associated cross contamination and infections. Findings included: Record review of Resident #1's admission MDS assessment, dated 09/23/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnosis which included: heart failure (weakened heart), hypertension (increased blood pressure), and diabetes (increased sugar levels). Resident #1 had severe cognitive impairment and required assistance of one staff for activities of daily living. Record review of Resident #2's quarterly MDS Assessment, dated 08/08/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnosis which included: atrial fib (abnormal heart rhythm), hypertension (increased blood pressure), and cerebral vascular disease (stroke). Resident #2 had severe cognitive impairment and required two staff for assistance with activities of daily living. Record review of Resident #3's annual MDS Assessment, dated 09/22/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnosis which included: Cerebral infarction (stroke), diabetes (increased blood sugar), bipolar disorder (mental illness), and hypertension (increased blood pressure). Resident #3 was moderately impaired for cognition and required one staff for assistance with activities of daily living. Observation on 10/21/2025 beginning at 12:00 p.m. revealed MA A had washed her hands, adjusted her clothing, did not use hand sanitizer, and served a lunch tray to Resident #1. MA A touched the hand and shoulder of Resident #1 and prepared the meal tray for the resident to eat his lunch. MA A did not have on gloves. MA A was observed not to wash her hands or use hand sanitizer, available in the dining room. MA A walked over the serving cart that had lunch trays on the cart and took another tray off the cart serving the lunch meal to Resident #2. MA A touched Resident 2's edge of the dining table, unwrapped the eating utensils, and then took the lid off the dessert bowl. MA A left the resident's table without using hand sanitizer. MA A walked over and laid a dirty place on the dish cart, walked to the serving cart and took another tray, serving the tray to Resident #3, assisting her to open her utensils. An interview on 10/22/2025 at 1:45 p.m., MA A stated she did not complete hand hygiene after having direct contact with residents. MA A stated she was supposed to use the hand sanitizer in between serving each tray from the cart. She stated she washed her hands in the sink in the dining area prior to serving trays MA A said she had been educated on completing hand hygiene, by the DON. MA A stated she did not sanitize her hands, because she was trying to get the lunch trays served. An interview with the DON on 10/22/2025 at 4:45 p.m. revealed that all staff must complete hygiene after having contact with residents. She stated all staff should have been trained to use hand sanitizer between each tray that was served. The DON stated there was alcohol gel available at the door of the kitchen to use for all staff. The DON stated if the staff do not use appropriate hygiene, they can spread germs to the residents and themselves. The DON clarified she did not have any in-services that she had completed with the staff on hand hygiene, since she had only been at the facility for two months. Today would be the first in-services given to the staff since she had been working at the facility, the ADON was in the dining room giving the in-service right now. Review of the facility's policy titled Infection Control dated revised January 2020 reflected, An infection prevention and control program is established and maintained to provide a safe sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 11. Prevention of infection a. Important facts of infection prevention included . 3. Educating staff and ensuring that they adhere to proper technique as and procedures. Review of the facility's policy titled Handwashing-Hand Hygiene Policy and Procedure dated revised October 2020 reflected, This facility considers hand hygiene the primary means to prevent the spread of infections. Policy interpretation and implementation 1. All personnel shall be trained and regularly in-service on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub ) shall be readily accessible and convenient for</p>		