Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 04/30/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to send a copy of the residents' discharge notice to the representative of the Office of the State Long-Term Care (LTC) Ombudsman for 1 of 3 residents (Resident #1) reviewed for discharge planning. The facility failed to send a copy of the discharge notice to the facility's Ombudsman when Resident #1 received a discharge notice on 03/19/26 and 04/22/2026. This failure could place residents at risk of being discharged without alternative placement, discharge options, their rights to appeal and access to advocacy services.Findings included: Record review of Resident #1's face sheet dated 04/30/26 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (a lung condition caused by damage to the lungs), Attention-Deficit Hyperactivity Disorder (persistent inattention, hyperactivity, and impulsivity), Insomnia (persistent difficulty falling asleep), Type 2 Diabetes (the body fails to produce enough insulin), and Bipolar Disorder (intense, fluctuating mood shifts). Record review of Resident #1's Quarterly MDS, dated [DATE], reflected a BIMS score of 14, which indicated intact cognitive response.Record review of Resident #1's Progress Notes, from 03/19/26 to 04/30/26, reflected there were no notes related to a written notice of discharge and reasons for the move given to the facility's Ombudsman. Record review of Resident #1's Electronic Health Record on 04/30/26, reflected there were no written notice of discharge and reasons for the move given to the facility's Ombudsman. During an interview on 04/30/26 at 8:45 a.m., the Ombudsman stated there wasn't notification from the facility regarding discharges. She stated Resident #1 received an involuntary 30-day discharge notice in March 2026 and because it was past the 30-day window to appeal, she was unable to help. She stated she was not notified of the second discharge notice given to Resident #1. She stated notification was important because residents have a right to appeal and the Ombudsman educated and assisted residents on discharge options. During an interview on 04/30/26 at 9:20 a.m., the Social Worker stated she was unaware the Ombudsman was notified prior to resident discharge. She stated she was responsible for notifying the residents, responsible parties, and the physician regarding discharges. She stated the Ombudsman's role was to advocate for residents and ensure discharges were safe and legal. During an interview on 4/30/26 at 3:35 p.m., the Regional [NAME] President of Operations stated discharge notices were given to residents, who are their own responsible party, and if not, to their responsible party, and notification to the Ombudsman. The Regional [NAME] President stated the expectation was for the Ombudsman to receive a copy of the discharge notice in case the resident decided to appeal. During an interview on 4/30/26 at 4:37 p.m., the Business Office Manager stated she contacted the Ombudsman 4/29/2026 because Resident #1 was issued two discharge notices. She stated the first discharge notice was 3/19/26 and the second notice on 4/22/26. She stated the Ombudsman was not notified when both discharge notices were issued to Resident #1. She stated she was aware the Ombudsman should have been notified in case the resident wanted to appeal, to be involved in the discharge process, and advocate for the resident. She stated the Ombudsman was not notified in error on her part. She stated the Business Office Manager was responsible for notifying the Ombudsman. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor attempted to interview the Administrator 4/30/26 but he was unavailable throughout the investigation. A record review of the facility's Transfer or Discharge Notice reviewed and revised 03/03/26, revealed, A copy of the notice is sent to the office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 6 residents (Resident #2) reviewed for ADL care.The facility failed to provide Resident #2 assistance with timely incontinence care for at least 5 hours.This failure could place the residents at risk for decreased feelings of self-worth, skin breakdown, and infection.Findings included:Record review of Resident #2's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses of Dementia (a decline in mental ability), Muscle Wasting and Atrophy (loss of muscle mass), Unspecified Protein-Caloric Malnutrition (deficient protein and caloric intake), Type 2 Diabetes (the body resists insulin), and Benign Paroxysmal Vertigo, Bilateral (calcium crystals are dislodged in both inner ears). Record review of Resident #2's quarterly MDS assessment, dated 02/13/2026, reflected a BIMS score of 99, which indicated the resident was unable to complete the interview. Section GG0103-Functional Abilities revealed Resident #2 was dependent on staff for toileting.Record review of Resident #2's care plan revealed Resident #2 had an ADL Self Care Performance Deficit. Interventions/Task: Toilet Use: The resident is totally dependent on 1 staff for toilet use. Record review of the posted Meal Service reflected, Breakfast: Hall Trays-7am; Dining Room-7:30am. During an interview on 04/30/26 at 2:45 p.m., Resident #2 stated (via the Account Manager who translated) she was unsure, but she thought she was not changed today and no one asked if she needed to be changed. During an interview on 04/30/26 at 1:20 p.m., the CNA stated she was assigned to Resident #2. The CNA stated incontinent care was provided every 2 hours or when needed. The CNA stated Resident #2 was last changed before breakfast. The CNA stated she gave other residents bed baths and got them up and she didn't get around to changing Resident #2 again. The CNA stated delayed incontinence care placed residents at risk for skin breakdown. During an interview on 04/30/26 at 2:23 p.m. the RN stated incontinent care was provided every 2 hours and PRN. She stated that a delay placed residents at risk of skin breakdown. She stated that charge nurses were responsible for checking residents every 2 hours to ensure they were provided with incontinent care. She stated the nurse would go specifically to the patient to check on them. She stated she was busy and didn't check Resident #2 for incontinent care. During an interview on 04/30/26 at 4:10 p.m., the DON stated the expectation was for CNAs to check if residents were incontinent and change when needed every 2 hours. She stated charge nurses were responsible for ensuring residents were changed by rounding every 2 hours. She stated delayed incontinence care placed residents at risk for infection, skin breakdown, dignity issues, and pain from sitting. Review of the facility's Activities of Daily Living (ADL) Policy, revised March 2018, reflected, Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care including appropriate support and assistance with: elimination (toileting).