

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

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                              |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>676178                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                     | (X3) DATE SURVEY<br>COMPLETED<br><br>08/14/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Duncanville Healthcare and Rehabilitation Center                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>419 S Cockrell Hill Rd<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                              |                                                 |
| F 0761<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, interviews, and record review the facility failed to ensure that medications were secure and inaccessible to unauthorized staff and residents for three (one medication cart for Hall 400 and one medication cart for Hall 200, one medication cart for Hall 300) of seven medication carts reviewed for medication storage. The facility failed to ensure medication supplies were all stored in locked compartments and permit only authorized personnel to have keys, when LVN A's one medication cart for Hall 400 were left unlocked and unattended by LVN A. The facility failed to ensure medication supplies were all stored in locked compartments and permit only authorized personnel to have keys when LVN B's two medication carts for Hall 200 and one medication carts for Hall 300 were left unlocked and unattended by LVN B. This failure could result in resident access and ingestion of medications leading to a risk for harm and possible drug diversion. Findings included: An observation on 08/12/2025 at 4:30 a.m., revealed LVN B's one medication cart were left at the nursing station unlocked for Hall 400. LVN B was in the breakroom on Hall 300, and no other staff was at the nurse's station. The lock on the medication cart were popped out showing the red bottom indicating the carts were unlocked. An observation on 08/12/2025 at 4:30 a.m., revealed LVN A's two medication carts were left at the nursing station unlocked for Hall 200 and Hall 300. LVN A's whereabouts was unknown at this time and no other staff was at the nurse's station. The lock on the medication cart were popped out showing the red bottom indicating the carts were unlocked. An observation and interview on 08/12/2025 at 4:45 a.m., revealed LVN A coming back to the nurse's station and speaking with the investigator and then calling her supervisor on the phone. LVN A was leaning against one of the unlocked medication carts. LVN A stated she had been at the nurse's station the entire time, until the front doorbell rang and she left her carts unlocked. LVN A stated she was at the nurse's station, and she could see everything. LVN A walked the survey team down Hall 400 to the conference room out of the site of the nurse's station, with the medication cart unlocked at the nurse station and no one was at the nurse's station, except the surveyor. An observation on 08/12/2025 at 5:00 a.m., revealed no staff at the nurse's station, with one resident sitting in wheelchair around the nurse's station. One nursing medications cart for Hall 400 remained unlocked and not in direct site of the LVNs. In an interview on 08/18/2025 at 5:10 a.m., LVN B revealed she never left the medication cart unlocked, for Hall 400. LVN B stated she did not know how it was unlocked and wanted to know how the surveyor had gotten the drawers open to the cart. LVN B said she knew the cart was supposed to be locked each time. LVN B stated if the medication cart was left unlocked a resident or a staff member could get the medications, this could lead to medications being stolen or a resident taking something they should not have. In an interview on 08/12/2025 at 5:20 a.m., LVN A revealed she had her medication carts locked and showed the investigator that they were. LVN A was told the medication carts was observed earlier unlocked and the LVN just shrugged and stated, they were locked now. LVN A stated the medication carts that were unlocked were in her direct site. LVN A stated that if the medication carts were left unlocked and unattended the medications could be stolen or taken by a resident that could harm them. In an observation on 08/12/2025 at 9:00 a.m., with LVN (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<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|--------------------------------------------------------------------------|-------|-----------|

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

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                              |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>676178                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                         | (X3) DATE SURVEY<br>COMPLETED<br><br>08/14/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Duncanville Healthcare and Rehabilitation Center                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>419 S Cockrell Hill Rd<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              |                                                 |
| <p>F 0761</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>D of the medication cart for Hall 200 revealed: Medications that could have been taken by staff or another resident for Resident #73 Multivitamin-minerals oral tablet (Supplement), Ascorbic Acid 500mg (Vitamin C), Diltiazem HCL 30mg tablet (Blood pressures med), and Coreg oral tablet 6.25mg (blood pressure). LVN D confirmed these were Resident #73's ordered medications and could have caused harm if taken by unauthorized person. In an observation on 08/12/2025 at 7:00 a.m. with LVN E of the medication cart for Hall 300 revealed: Medications that could have been taken by staff or another resident for Resident #5 Keppra oral solution 100mg (seizures), Insulin Glargine Solution 100 unit (diabetes), syringes, Robinul oral tablet 1mg (secretions), Furosemide oral tablet 20mg (edema), and metoprolol tartrate tablet 12.5mg (blood pressure). LVN E confirmed these were Resident #5's medications and could have caused harmed if taken by unauthorized person. In an observation and interview on 08/12/2025 at 11:15 a.m., with LVN E of the medication cart for Hall 400 revealed: for Resident #29 Mounjaro Subcutaneous Solution injector 5mg/0.5ml (diabetes), melatonin oral tablet 10mg (insomnia), apixaban oral tab 5mg (blood thinner), and protoxin tablet delayed release 40mg (for gastric acid reflux). LVN E confirmed that these were Resident #29's ordered medications. LVN E stated the medication carts should never be left unlocked, except when in use. LVN E stated this could be unsafe as medications could be taken form the cart by the residents or staff, which could result in harm. In an interview on 08/13/2025 at 3:00 p.m., the interim DON stated it was her expectation that medication carts should be locked when not in use. The interim DON said that the nurses were responsible to keep the medication carts locked when not in use. She stated if they were not locked, residents and unauthorized staff could get into the cart and there would be opportunities for harm and medication diversion. When the interim DON was asked who was responsible to monitor the carts to ensure they were locked she said that would be the staff that was using the carts. Review of the Policy and Procedure Medication Administration dated April 2019, reflected, Medications are administered in a safe and timely manner. 19. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide.</p> |                                                                                              |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                              |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>676178                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                         | (X3) DATE SURVEY<br>COMPLETED<br><br>08/14/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Duncanville Healthcare and Rehabilitation Center                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>419 S Cockrell Hill Rd<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                              |                                                 |
| <p>F 0773</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to promptly notify the physician of laboratory results in accordance with facility policy and procedures for notification for 1 of 5 residents (Resident #306) reviewed for laboratory services. The facility failed to send Resident #306's weekly labs to the infectious disease doctor while the resident resided at the facility from 11/27/24 to 12/20/24. This deficient practice placed the residents at high risk of not receiving treatment, and/or developing complications. Findings included: Review of Resident 306's MDS dated [DATE] reflected the resident was [AGE] year-old female admitted to the facility on [DATE] and discharged on 12/20/24. Her diagnoses included diabetes and anxiety disorder. Resident #306 had a BIMS of 6 indicating her cognition was severely impaired. The MDS also reflected the resident had a stage 4 pressure ulcer. Review of Resident #306's care plan effective on 11/28/24 reflected the resident had pressure ulcers to her right heel, unstageable to right hip, and stage 4 to the left lateral ankle. Interventions included to obtain labs per physician orders. Review of Resident #306's discharge hospital records dated 11/27/24 reflected the following: Labs to be followed: weekly CRP (a blood test that measures the level of CRP, a protein produced by the liver in response to inflammation)/BMP (measures eight different substances in your blood and it provides important information about your body's fluid balance, your metabolism and how well your kidneys are working)/CBC (group of blood tests that measure the number and size of the different cells in your blood) faxed to the office of [Doctor] Review of Resident #306's facility clinical record revealed labs were obtained on 12/02/24, 12/09/24, and on 12/16/24. Interview on 05/15/25 at 12:13 PM with Resident #306's family revealed the resident was discharged from the facility on 12/20/24. The family said the infectious disease doctor had ordered for the resident to have weekly labs drawn and faxed over to his office and the doctor's clinic said they had never received any of the lab requested. Interview on 05/15/25 at 11:47 AM with the Infectious Disease Doctor's clinic revealed they had called the facility on 12/02/24, 12/18/25 and on 12/31/24 to try and obtain Resident #306's labs copies. The clinic said that on 12/31/24 the facility finally sent one set of labs that were dated for 12/02/24. The Infectious Disease Clinic further stated the doctor would have wanted to keep up with the resident's infection treatment. Interview on 05/15/25 at 2:42 with ADON N revealed he will send or fax labs when he was asked but he could not specifically recall if he had sent Resident #306's labs to the infectious disease clinic. Interview on 05/15/25 at 2:55 PM with the DON revealed she thought she was sure she had asked ADON N to fax Resident #306's labs results to the infectious disease clinic. The DON further stated she did not know what else could have happened with the labs during that time. Review of the facility's policy titled Lab and Diagnostic Test Results - Clinical Protocol revised on 09/2012 reflected the following: Assessment and Recognition 1. The physician will identify and order diagnostic lab testing on diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests. 3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility 1. A physician can be notified by phone, fax, voicemail, e-mail, mail, pager, or a telephone message to another person acting as the physician's agent a. Facility staff should document information about when, how, and to whom the information was provided and the response</p> |                                                                                              |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>676178                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                     | (X3) DATE SURVEY<br>COMPLETED<br><br>08/14/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Duncanville Healthcare and Rehabilitation Center                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>419 S Cockrell Hill Rd<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |                                                 |
| <p>F 0812</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve foods in accordance with the professional standards for food service safety in the facility's kitchen. 1. The facility failed to ensure food items in the refrigerator, freezer and dry storage room were labeled and stored in accordance with the professional standards for food service.2. The facility failed to ensure stored canned goods, had an uncompromised seal, free from dents.3. The facility failed to discard items stored in refrigerator, freezers or dry storage that were not properly labeled or past the 'best buy', consume by or expiration dates. These failures could place residents at risk for food-borne illness and cross contamination. Findings Included: Observation of the walk-in food storage room on 08/12/2025 at 5:15 a.m., revealed the following:- 1 Box of graham cracker crumbs in unsealed zip top bag. 5 lbs., date was written by facility 5.13.2025.- 12 slices of white bread in an unsealed, unlabeled bag.- 1 opened 24oz ketchup bottle, 1/2 full, BB date: 9.28.2026. date written by facility 8.8.2025. Manufacture label states, Refrigerate after opening.- 1 bag of cake mix - Icing in an unsealed manufacturers bag, 5 lbs. in an unsealed zip top bag, not dated.- 2 cans of Chunk Light skip jack tuna, 66.5 oz, facility dated both cans 7.25.2025. First can has 2 dents on upper seal, 1 dent approximately 2, the other dent is approximately 1. There is no best buy date or use by date on either can. 2nd can of Chunk Light skip jack tuna, 66.5 oz, dented on the bottom seal approximately 1. - 1 Can of pinto beans vegetarian 110 oz approximately 2 dent on bottom seal, dated by facility 8.5.2025. BB date June 2027.- 1 can Salad Sliced Beets 6 lbs. 8 oz, facility dated 10.01.2024. Rust around top and bottom of the seal, there is no BB date or expiration date. Observation of the walk-in refrigerator on 08/12/2025 at 6:20 a.m., revealed the following:- 3 large produce boxes were noted without any dates. One box contained approximately 15 cucumbers, the second box contained approximately 10 cantaloupes, and the third contained approximately 20 zucchinis. The produce in all three boxes was observed to be collapsing in areas, slimy to the touch, and exhibiting wrinkled and discolored skin with visible fuzzy mold growth. The boxes were noted to be soggy, stained, and wet from decomposing juices, with dark spots spreading across the cardboard. Observation of the walk-in freezer on 08/13/2025 at 11:46 a.m., revealed the following:- 1 large bag of meat patties, no label, and no date. - 1 box of chicken thighs was observed stored in a plastic bag that was opened and exposed to air, the bag was dated July 22nd. In an interview with the DM on 08/12/2025 5:31 a.m., she said the dented cans go in her office and all staff is responsible for removing dented cans if they notice a dent. She said if there is no date on the can there is a code on the can that she can look up to see what the date is. DM said that residents could become ill if their food that is expired or improperly stored is consumed. Interview with DM on 08/12/2025 5:51 a.m., she said all kitchen staff who removes food items from the freezer, refrigerator or dry storage are responsible for putting the food item back labeled with open date and properly sealed. Record review of the facility's Refrigerator and Freezer Storage policy undated, states, 2. All items must be dated with the date that the food was delivered. 3. If a food is taken out of the original container what the manufacturer placed the product in it must be labeled and dated. 4. All left over foods should be labeled and dated with the date in and the date out (date the food is to be discarded) this date can be no more than 72 hours after it was put in the refrigerator. 9. If an item is opened, the food must be tightly sealed. It should be dated with the date that it was opened. If the product was removed from its original container, then the product should also have the name of the product. If using large bags to seal open items in their original packaging, the bag may be reused but needs to be re-dated. If the food is directly in the bag, the bag must be labeled and dated, and when the bag is emptied, it should be discarded. Bags must be sealed. Record review of the facility's Dry Storage policy undated, states, .3. Items must be dated with the date that the food was delivered. 4. If a food is taken out of the original container (what the manufacturer placed the product in) it must be labeled and dated. 5. Iron foods must be removed from (continued on next page)</p> |                                                                                              |                                                 |

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

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                              |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>676178                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                     | (X3) DATE SURVEY<br>COMPLETED<br><br>08/14/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Duncanville Healthcare and Rehabilitation Center                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>419 S Cockrell Hill Rd<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                              |                                                 |
| F 0812<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | <p>the storeroom. 6. All dented cans must be removed from the storeroom or marked do not use until it is picked up. 9. If an eye opened, the food must be tightly sealed. It should be dated with the date that it was opened. If the product was removed from its original container, then the product should also have the name of the product. If using large bags to seal open items in their original packaging, the bag may be reused but needs to be redated. If the food is directly in the bag, the bag must be labeled and dated, and when the bag is emptied, it should be discarded. Bags must be sealed. 11. Bags of bread products should be closed and dated with the date that it was opened. Use the open product first. Review of the U.S. FDA Food Code 2022 reflected: Definitions 3. Food Receiving and Storage - When food, food products or beverages are delivered to the nursing home, facility staff must inspect these items for safe transport and quality upon receipt and ensure their proper storage, keeping track of when to discard perishable foods and covering, labeling, and dating all PHF/TCS foods stored in the refrigerator or freezer as indicated. Review of the U.S. FDA Food Code 2022, Chapter 3, 3-201.11 Compliance with Food Law FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted and pitted or dented cans may also present a serious potential hazard.</p> |                                                                                              |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                              |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>676178                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                         | (X3) DATE SURVEY<br>COMPLETED<br><br>08/14/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Duncanville Healthcare and Rehabilitation Center                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>419 S Cockrell Hill Rd<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                              |                                                 |
| <p>F 0880</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Provide and implement an infection prevention and control program.</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 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 five (Resident #74, #46, #5, #73, and #29) of eight residents observed for infection control in that: CNA C failed to wear a gown, change her soiled gloves and wash hands during incontinent care to Resident #74. LVN D failed to clean off the overbed table prior to and after usage, while replacing tubing on Resident #46' G-tube. LVN E failed to disinfect the blood pressure cuff, in between vital sign checks for Resident #5, and Resident #73. LVN E failed to disinfect the glucometer (machine used to check blood sugar) in between usage on Resident # 29 and Resident #5. LVN E failed to change her soiled gloves and wash hands during tracheostomy care to Resident #5. Findings included: 1. Review of Resident #74's quarterly MDS assessment, dated 05/22/2025, reflected he was a [AGE] year-old male admitted to the facility on [DATE], with the following diagnoses: dependence on renal dialysis (the need of a machine to make kidneys clean the blood), and end stage renal failure (kidneys do not work well). Resident #74 BIMs score of 11 indicated the resident had moderate cognitive impairment and required assistance from one staff for activities of daily living. Review of Resident #74's Care Plan dated 08/11/2025 reflected, Focus: Resident requires Enhanced Barrier Precautions. dialysis catheter. Goal: to reduce the potential spread of Multidrug-resistant organism, (infections). interventions planned. Enhanced Barrier Precautions used during high-contact resident care activities. such as: dressing, transferring, changing briefs or assisting to toilet. Observation on 08/12/2025 at 4:45 a.m. revealed a sign outside of Resident #74's door: the sign gave instructions to the staff concerning EBP (Enhanced Barrier Precautions) the sign instructed the staff what type of PPE (Person Protection Equipment) to use when assisting the resident. There was a three drawer container holding gowns, gloves, and mask, with a face shield outside the doorway. Observation of incontinence care on 08/12/2025 at 4:50 a.m., revealed CNA C did not use hand gel or wash her hands she did not don a gown in the hallway before entering the room. Resident #74 was lying on his back. CNA C placed on gloves and unfastened the resident's brief tabs and wiped the pubic area with a disposable wipe, discarding the wipe in the trash bag. CNA C wiped the genitals, discarding the wipe in the trash bag. CNA C wiped the shaft of the penis and discarding the wipe in the trash bag, and then cleaned the head of the penis and discarded the wipe in the trash bag. CNA C positioned Resident #74 on his right side with the help of the resident. CNA C wiped the rectal area that was soiled with bowel movement and discarded the wipe, using another wipe CNA C completed cleaning the rectal area of bowel movement, and discarded the wipe. CNA C wiped the right buttocks, which was soiled with urine, discarded the wipe. CNA C repositioned Resident #74 with her soiled gloves to his left side, CNA C cleaned the left buttocks, which was soiled with urine, discarded the wipe. CNA C assisted, with her soiled gloves, with the help of the resident to reposition Resident #74 on his back. CNA C took off her soiled gloves, did not wash her hands or use hand sanitizer, left the room and obtained a clean brief. CNA C returned to the room placed on another pair of gloves, without washing her hands or using hand sanitizer, placed and pulled the clean brief up underneath him and fastened the brief, removing the soiled brief placing it in the trash. CNA C then pulled the pants up on the resident. CNA C removed her dirty gloves did not wash her hands or use hand sanitizer, placed on new gloves, and continued to assist the resident to adjust clothing. CNA C removed her gloves in the room and assisted Resident #74 into his wheelchair. CNA C stated the resident had to be ready for pick-up between 5:00 and 6:00 a.m. for dialysis pick-up. CNA C left the room, not washing her hands or using hand sanitizer. CNA C entered another resident's room, closing the door. During an interview on 08/12/2025 at 5:00 a.m., CNA C revealed she was in a hurry because he has the non-emergency pick-up for dialysis between 5:00 a.m. and 6:00 a.m. and if he is not ready the transport people get (continued on next page)</p> |                                                                                              |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                              |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>676178                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                     | (X3) DATE SURVEY<br>COMPLETED<br><br>08/14/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Duncanville Healthcare and Rehabilitation Center                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>419 S Cockrell Hill Rd<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                              |                                                 |
| <p>F 0880</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>upset. CNA C stated she was supposed to place on a gown outside the doorway because he had a tube in his arm, where he receives dialysis. CNA C stated that anyone with a tube of any kind, or wounds, has a set of drawers outside their door and a sign on the door, explaining what you must wear, according to what you have to do for the resident. CNA C said this was more the protection of us and the resident. I just got in a hurry and forgot, the same with the washing of my hands and changing my gloves, I got into a hurry, because you came into the room with me and it made me nervous. CNA C said not washing her hands when changed her gloves could cause the spread of infection, she said she had recently had the in-service for infection control. 2. Review of Resident #46's quarterly MDS assessment, dated 05/14/2025, reflected she was a [AGE] year-old female admitted to the facility on [DATE], with the following diagnoses: hypertension (high blood pressure), peripheral vascular disease (poor blood circulation), diabetes (high blood sugar), and cardiovascular accident (stroke). Resident #46 BIMs score of 6 indicated the resident had severe cognitive impairment and required assistance from two staff for activities of daily living. Further review reflected Resident #46 had a feeding tube (nutritional tube placed in the stomach) that was present upon admission. The resident receives 51% or more of nutrition and fluid delivered through the feeding tube. Observation on 08/12/2025 at 5:38 a.m., LVN D entered Resident #46's room to replace the tubing for the resident's tube feeding. LVN D washed her hands and placed on gloves, she laid all her supplies on the overbed table, she did not clean the table prior to laying supplies on it. The overbed table had dried dark sticky substance on it. LVN D completed the replacement of the tubing turned the pump back on after priming the tubing for the G-Tube (feeding tube), spilling formula on top of the overbed table. LVN D cleaned up the remaining old tubing, removed her gloves washed her hands and left the room taking her trash with her, but not cleaning the overbed tabletop. In an interview on 08/12/2025 at 5:45 a.m., LVN D said she knew the overbed tabletop should have been cleaned before placing clean supplies on the overbed tabletop. LVN D stated she noticed it was sticky, but thought it was dried formula, she said if the surface was not clean then it could cause the spread of germs to the new supplies. LVN D stated she had infection control in-service in the past couple of months. 3. Review of Resident #5's 30-day MDS assessment, dated 07/30/2025, reflected she was a [AGE] year-old female admitted to the facility on [DATE], with the following diagnoses: hypertension (high blood pressure), seizures (abnormal brain waves), diabetes (high blood sugar), and acute respiratory failure with hypoxia (unable to breath loss of oxygen). Resident #5 BIMs score of 99 indicated the resident had severe cognitive impairment and required assistance from two staff for activities of daily living. Review of Resident #5's the consolidated physician orders dated August 2025 reflected: order dated 08/13/2025, Keppra (for seizures) oral solution 100 mg/ml via G-tube two times a day one tab by mouth two times a day, Furosemide oral tablet (for increased fluid &amp; swelling) 20mg give 20mg via G-tube two times a day, and metoprolol tartrate (for high blood pressure) tablet give 12.5mg [NAME] G-tube daily. Further review revealed physician orders to check blood pressure, every shift and to check blood sugar three times a day and inject Humalog (for diabetes) 100units/ml per sliding scale. Observation on 08/12/2025 at 6:52 a.m. revealed LVN E performed morning medication pass, during which time she checked the blood pressure of Resident #5. LVN E failed to sanitize the blood pressure cuff before or after using it on Resident #5. Observation on 08/12/2025 at 11:30 a.m. revealed LVN E performed a blood sugar test on Resident #5. LVN E failed to sanitize the glucometer machine (an instrument for measuring the concentration of glucose in the blood) before or after using it on Resident #5. Observation on 08/12/2025 at 11:35 a.m., revealed LVN E performed Tracheostomy Care (tube opening in the throat at the neck allowing resident to breath) LVN E entered the room with her supplies, placing on gloves without washing her hands or using hand sanitizer. LVN E cleaned the overbed table with Sani Wipes and then placed her supplies on the overbed table after the cleanser had dried. LVN E changed her gloves to the sterile gloves in the trach kit, not washing her hands or using hand sanitizer. LVN E performed [NAME] care, suctioning, and cannula replacement, removed her sterile gloves, placed on another pair of non-sterile gloves, without washing her hands or using (continued on next page)</p> |                                                                                              |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                              |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>676178                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                     | (X3) DATE SURVEY<br>COMPLETED<br><br>08/14/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Duncanville Healthcare and Rehabilitation Center                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>419 S Cockrell Hill Rd<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              |                                                 |
| <p>F 0880</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>hand sanitizer. LVN E adjusted the humidifier over the trach opening, made sure the blankets were strait on the bed, then performed mouth care for Resident #5. LVN E took off her gloves washed her hands and then left the room. 4. Review of Resident #73's 5-day MDS assessment, dated 07/31/2025, reflected he was a [AGE] year-old male admitted to the facility on [DATE], with the following diagnoses: hypertension (high blood pressure), end stage renal disease (kidneys do not work right), malnutrition (poor food intake), and infection of cardiovascular graph (heart surgery). Resident #73 BIMs score of 13 indicated the resident was cognitively intact and required assistance from one staff for activities of daily living. Review of Resident #73's the consolidated physician orders dated August 2025 reflected: order dated 08/08/2025, hydralazine (high blood pressure) tablet 100mg one tab by mouth three times a day, nifedipine ER (high blood pressure) 60mg by mouth two times a day, and coreg oral tab (high blood pressure) 60mg give one tablet by mouth two times a day. Further review revealed physician orders to check blood pressure, every shift. Observation on 08/12/2025 at 7:15 a.m. revealed LVN E performing morning medication pass, during which time she checked the blood pressure of Resident #73. LVN E failed to sanitize the blood pressure cuff before or after using it on Resident #73. 5. Review of Resident #29's quarterly MDS assessment, dated 06/26/2025, reflected she was a [AGE] year-old female admitted to the facility on [DATE], with the diagnosis of: diabetes (high blood sugar). Resident #73 BIMs score of 13 indicated the resident was cognitively intact and required assistance from one staff for activities of daily living. Review of Resident #29's the consolidated physician orders dated August 2025 reflected: order dated 08/08/2025, blood sugar checked three times a day prior to meals. Further review revealed physician orders to administer Humalog Kwik pen (for diabetes) 100units/ml per the sliding scale following blood sugar checks. Observation on 08/12/2025 at 11:15 a.m., revealed LVN E performed a blood sugar test on Resident #29. LVN E failed to sanitize the glucometer machine (an instrument for measuring the concentration of glucose in the blood) before or after using it on Resident #29. In an interview on 08/12/2025 at 11:55 a.m., LVN E said she thought that washing hands, then placing on gloves was the only time, she had forgotten you should wash your hands or use hand sanitizer between each glove change. LVN E stated the equipment such as the blood pressure cuff and the glucometers were the same, both should be cleaned with sanitizing wipes before and after each use and allowed to dry. She used hand sanitizer before using the equipment, but that was not enough. LVN E stated she had just gotten in a hurry and had not followed the infection control protocol. LVN E stated that by doing that she could be spreading infections to others, including herself. In an interview on 08/13/2025 at 9:30 a.m., the Administrator revealed in-services had been completed monthly since June and infection control had been discussed with all the staff, by himself after the recertification had begun on 08/12/2025. The staff should know what to do and the Administrator said he was surprised they had made mistakes. Interview on 08/14/2025 at 10:00, a.m. the interim DON revealed she expected all staff to use hand sanitizer, or wash their hands, prior to placing on gloves and between glove changes, when conducting any direct resident care. The DON stated the staff should also follow the EBP protocols that are placed outside the doorway, when caring for the residents. The interim DON stated the staff has had in-services on infection control for cleaning equipment, incontinent care, EBP, and tach care about changing gloves, handwashing and using hand sanitizer. Review of the in-services given in the past three months reflected an in-service dated June 19th, 2025, July 7th, 2025, and August 12, 2025, for infection control and cleaning of equipment. CNA C, LVN D, and LVN E had attended the meetings. Review of the facility's policy Infection Control Plan revised dated June 2025, 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 disease and infections. Policy interpretations and Implementation. 3. The infection prevention and control program is a facility-wide effort involving all disciplines and individual. ensure that reusable equipment is appropriately cleaned, disinfected, or reprocessed. 6. Resident care equipment. 3. Non-invasive resident care equipment is cleaned. as need between use. all reusable items and (continued on next page)</p> |                                                                                              |                                                 |

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

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                              |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>676178                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                     | (X3) DATE SURVEY<br>COMPLETED<br><br>08/14/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Duncanville Healthcare and Rehabilitation Center                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>419 S Cockrell Hill Rd<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                              |                                                 |
| F 0880<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | <p>equipment requiring special cleaning, disinfection . shall be cleaned in accordance with our current procedures governing the cleaning. Review of the facility's policy Enhanced Barrier Precautions reviewed June 2025, reflected, Enhanced Barrier Precautions . designed to reduce transmission of multidrug-resistant organisms that monotargeted gown and glove use during high contact resident care activities. used in conjunction with standard precautions and donning of gloves and gown and gloves during high-contact resident care activities that provide opportunities for transfer of organisms to staff hands and clothing.EBP are indicated for residents with any of the following: .wounds and/or indwelling medical devices.Donning PPE for Residents on EBP based on activity provided/assistance while in resident room.changing briefs or assisting with toiling. Review of the facility's policy Handwashing-hand Hygiene revised dated October 2020 reflected, This facility considers hand hygiene the primary means to prevent the spread of infections. policy interpretation and implementation.6. Wash hands a. when hands are visible soiled. 7. Use alcohol-based hand rub.b. before and after direct contact with residents.f. before donning sterile gloves. m. after removing gloves. 9. The use of gloves does not replace hand washing/hand hygiene. 10. Hand hygiene is recognized as the best practice for preventing healthcare associated infections.Applying an Removing Gloves 1. Perform hand hygiene before and after applying non-sterile gloves.</p> |                                                                                              |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                              |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>676178                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                     | (X3) DATE SURVEY<br>COMPLETED<br><br>08/14/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Duncanville Healthcare and Rehabilitation Center                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>419 S Cockrell Hill Rd<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              |                                                 |
| <p>F 0628</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Provide the required documentation or notification related to the resident's needs, appeal rights, or<br/>bed-hold policies.</p> <p>Based on record reviews and interviews the facility failed to send a copy of the residents' discharge<br/>notice, prior to discharge, to the representative of the Office of the State Long-Term Care (LTC)<br/>Ombudsman of the residents' transfer or discharge and the reasons for the move, for 1 of 5 residents<br/>(Resident #8) reviewed for notifying the LTC Ombudsman of the residents' discharge. Resident #8 was<br/>discharged on 07/01/2025 without a notice to the LTC state ombudsman. This failure could place<br/>residents at risk of not knowing their rights or receiving the services of the state LTC<br/>Ombudsman. The findings included: A record review of Resident #8's admission record dated 7/3/2025<br/>revealed diagnoses which included Secondary Parkinsonism (similar to Parkinson disease caused by<br/>certain medicines, a different nervous system disorder or another illness), Muscle Weakness,<br/>Unspecified Lack of Coordination, Calculus of Ureter (kidney stone that has traveled into the ureter,<br/>the tube connecting the kidney to the bladder), Calculus in Bladder (bladder stones), Unsteadiness on<br/>Feet, Abnormal Weight Loss, Post-Traumatic Stress Disorder (mental health condition),<br/>Protein-Calorie Malnutrition, Quadriplegia (paralysis of all four limbs and the torso). A record review of<br/>Resident #8's MDS quarterly assessment, dated 07/13/25, reflected a BIMS score of 15 which<br/>indicated cognitively intact. A record review of Resident #8's medical record revealed no evidence of a<br/>discharge notice to the LTC ombudsman. During an interview on 8/13/2025 at 3:19 PM, the LTC<br/>Ombudsman stated she had no evidence the facility had notified her of Resident #8's discharge. The<br/>LTC Ombudsman stated she visited the facility and had not received discharge notice from the<br/>facility. During an interview on 8/14/2025 at 1:45 PM, the SW revealed she was not aware of any<br/>reports for discharges of residents were sent to the LTC Ombudsman. The SW stated a review of<br/>Resident #8's records could not evidence a notice to the LTC Ombudsman for Resident #8's discharge<br/>to hospital. During an interview on 8/14/2025 at 2:20 PM the Administrator stated he was unaware of<br/>the rule to notify the LTC Ombudsman of any resident discharges. A record review of the facility's<br/>Transfer or discharged Notices Policy Statement dated March 2025, revealed, Notice of Transfer or<br/>Discharge (Anticipated). 4. A copy of the notice is sent to the Office of the State Long Term Care<br/>Ombudsman at the same time the notice of transfer of discharge is provided to the resident and<br/>representative. Notice of Transfer or Discharge (Emergency). 2. Notice of Transfer is provided to the<br/>resident and representative as soon as practicable before the transfer and to the Long-Term Care<br/>(LTC) ombudsman when practicable (e.g., in a monthly list of residents that includes all notice<br/>content requirements).</p> |                                                                                              |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                              |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>676178                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                         | (X3) DATE SURVEY<br>COMPLETED<br><br>08/14/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Duncanville Healthcare and Rehabilitation Center                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>419 S Cockrell Hill Rd<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                              |                                                 |
| <p>F 0755</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</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 provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs residents for one (Resident #5) of three residents reviewed for medication review. LVN E failed to ensure Keppra (a medication given to prevent seizures) was administered to Resident #5 appropriately. LVN E did not hold the G-tube feeding an hour before and one hour after the medication was given. This failure could place residents at risk for not receiving medications as ordered by their physician and not receiving the intended therapeutic benefit of the medications. Findings included: Review of Resident #5's 30-day MDS assessment, dated 07/30/2025, reflected she was a [AGE] year-old female admitted to the facility on [DATE], with the following diagnoses: hypertension (high blood pressure), seizures (abnormal brain waves), diabetes (high blood sugar), and acute respiratory failure with hypoxia (unable to breath loss of oxygen). Resident #5 BIMs score of 99 indicated the resident had severe cognitive impairment and required assistance from two staff for activities of daily living. Review of Resident #5's the consolidated physician orders dated August 2025 reflected: order dated 08/13/2025, Keppra (for seizures) oral solution 100 mg/ml via G-tube two times a day one tab by mouth two times a day. Record review of Resident #5's care plan revised on 7/06/2025 revealed Resident #5 had a seizure disorder and medications should have been administered as ordered. Record review of Resident #5's August 2025 MAR revealed Keppra oral solution 100mg/ml give 10ml via G-tube two times a day for seizures was signed as administered each day from 08/01/205 until 08/12/2025. There was no guidance to the nurse to hold the G-tube feeding for one hour before or one hour after administering the medication. In an interview and observation on 8/12/2025 at 06:52 a.m., LVN E during a medication pass prepared to administer the Keppra, as well as other medications to Resident #5. LVN E entered the room and turned off the running G-tube pump, checked the tube for placement and administered eight medications, including the Keppra. Following each medication, LVN E administered 5mls of water. LVN E provided a flush before and after completion of the medications that were given, then the LVN restarted the feeding pump and left the. In an interview on 08/12/2025 at 7:15 a.m., LVN E stated she did not turn the pump off before or after the administering the Keppra because she did not recall that she was supposed to do that. LVN E said when she thinks about it she did recall something about that in nursing school but that had been a long time ago. LVN E stated after looking it up on the phone, that it was about an absorption problem, and she would have to start doing that so the resident received all the medication appropriately. LVN E thought maybe that should be added to the MAR, so other nurses would do the same thing. In an interview on 08/13/2025 at 2:00 p.m., the DON said the G-tube should be stopped for one hour before giving the Keppra and on hour after, that was basic nursing 101 and she was shocked the nurse did not know this and practice best practices. This could affect the absorption of the medication causing the levels to not be correct and the resident could have seizures form not having the medication absorbed correctly. In an interview on 08/13/2025 at 2:45 p.m., with the Medical Director revealed he did not know about the specifics of the administration of the Keppra in a G-tube, he just wanted his resident to have the right amount, at the right times, and the medication to have the best potential to work. If this was the recommendation of the research that had been done the nursing facility nurses should be giving it this way. Record review of facility policy titled Medication Administration, with a revision date of April 2019, revealed Medications are administered in a safe and timely manner, and as prescribed . Policy interpretation and Implementation. 4. Medications are administered as in accordance with prescribed orders. 5. Medication administration times are determined by resident need and benefit, not staff convenience, factors that are considered include: a. optimal therapeutic effect of the medication. 31. Each Nurses' (continued on next page)</p> |                                                                                              |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                              |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>676178                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                     | (X3) DATE SURVEY<br>COMPLETED<br><br>08/14/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Duncanville Healthcare and Rehabilitation Center                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>419 S Cockrell Hill Rd<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              |                                                 |
| F 0755<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | station has a current Physician's Desk Reference (PDR) and/or other medication references. Record review of reference, Developing guidance for feeding tube administration of oral medications <a href="https://www.ncbi.nlm.nih.gov/">https://www.ncbi.nlm.nih.gov/</a> revealed: When administering Keppra (levetiracetam), it is generally recommended to hold the enteral nutrition (EN) infusion for one to two hours before and after the administration of the medication. This practice is aimed at minimizing the potential for interactions between the medication and the EN, which can affect the drug's absorption and efficacy. The exact timing and duration of EN withholding may vary depending on the specific drug and the patient's individual circumstances. It is crucial to consult with a healthcare provider to determine the best approach for each patient. |                                                                                              |                                                 |

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

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                              |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>676178                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                     | (X3) DATE SURVEY<br>COMPLETED<br><br>08/14/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Duncanville Healthcare and Rehabilitation Center                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>419 S Cockrell Hill Rd<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                              |                                                 |
| F 0732<br><br>Level of Harm - Potential for<br>minimal harm<br><br>Residents Affected - Many                                       | Post nurse staffing information every day.<br><br>Based on observation, interview, and record review the facility failed to ensure Nurse Staffing Information was posted daily for one of one building. The facility did not post and maintain the required staffing information on August 12, 2025. This failure could place residents and visitors at risk of not knowing how many nursing staff were on duty and the actual hours worked per shift daily. findings included: During an observation on 08/12/25 at 04:35 AM, there was no Nursing Staffing Information posted up in the facility in an area visible to all residents and visitors. In an interview on 08/12/25 at 11:42 AM, The Staffing Coordinator state that she places the staffing sheets every morning when she arrives. She stated that she will adjust if there is a call out but the sheets are placed in the holder at on the wall near the Director of Nursing's office. She state that she also does the weekend sheets and they are accessible for the weekend supervisor or charge nurse to place and or update if needed. She stated that she placed it this morning but does not know who removed it. She stated that she has the actual sheet and brings it to the surveyor for proof. She stated some weekend s she may come in for other matters and she will make sure the information is posted. In an interview on 8/14/25 at 1:09 PM The Administrator stated they always have the information posted and the staffing coordinator updates that information. He reported he would provide a copy of the policy for posting staffing. Record review of facility policy Posting Direct Care Daily Staffing Numbers. Review 3-2023Page 1 Policy Statement: Our facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. Within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs, LPNs and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. |                                                                                              |                                                 |