STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676178	A. Building B. Wing	12/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Duncanville Healthcare and Rehabilitation Center	419 S Cockrell Hill Rd Duncanville, TX 75116

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35314 Based on interview, observation and record review, the facility failed to ensure pain management was provided to a resident who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences for 1 of 5 resident reviewed for pain management. (Resident #33) The facility failed to ensure the prescription was completed timely to avoid a lapse in pain medication for Resident #33. The facility failed to ensure Resident #33's pain medication was available when he needed it. The facility did not assess Resident #33 for pain on 12/17/21 while his medication was not available. This facility failure could place residents on pain management at risk for unnecessary pain, discomfort and decreased quality of life. Findings included: Record review of Resident #33's face sheet dated 12/17/21 revealed Resident # 33 was a [AGE] year-old male admitted to the facility originally on 03/04/21 and was readmitted to the facility on [DATE]. The resident diagnoses included Chronic heart failure, Chronic Kidney disease, Type 2 diabetes ,Chronic Obstructive Pulmonary Disease(COPD) and pain. Review of the Admission records revealed Resident #33 admitted to the facility on [DATE] at 1:45 pm . Review of the Physician orders dated 12/16/21 revealed Resident #33 was prescribed scheduled Hydrocodone-acetaminophen10-325mg every 6 hours and prescribed Tylenol with codeine #3 ever 4 hours for pain. Review of Resident #33's base line care plan dated 12/17/21 revealed the facility would monitor the resident for pain. Review of Resident #33's MDS dated [DATE] revealed he had a BIMS of 13, which indicated he was cognitively intact. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the MAR for Resident #33 dated 12/17/21 revealed regularly scheduled Hydrocodone-acetaminophen10-325mg every 6 hours had not been giving to Resident #33 since admitting to the facility on [DATE]. Resident #33 was prescribed Tylenol with codeine #3 ever 4 hours for pain. He had not been provided the medication since admitted on [DATE]. An interview with Resident #33 on 12/17/21 at 11:05 am revealed he was admitted to the facility on [DATE]. He stated he had not received any of his scheduled medications since arriving at the facility. He admitted to the facility the afternoon on 12/16/21. He stated the nurse informed him; his medications were not at the facility. He stated he really needed his pain medications. He stated his pain level was 9/10. He had spoken with Med aide B regarding his meds and she stated the medications had not arrived at the facility. An interview with RN A on 12/17/21 at 11:12am she informed the resident on 12/16/21 after he admitted to the facility his medications had not arrived, there had been issue with pharmacy providing the medications to the facility. There were no medications to give to Resident #33 she stated. An interview with Med aide B on 12/17/21 at 11:37 am revealed Resident #33 had requested to have his medications. Resident informed her; he wanted his medications including his pain medications. She informed Resident #33 his medications were no one her cart. She told the resident his medications had not arrived at the facility. She informed RN A Resident #33 medication had not arrived at the facility. Review of Resident#33's pain assessment completed by LVN C dated 12/16/21 revealed the resident did not have a pain regimen. He did not require pain medications. The assessment reflected the resident was not in any pain. An interview with LVN C on 12/17/21 at 2:22pm revealed Resident #33 was admitted to the facility on [DATE]. She stated when the resident arrived at the facility, it was during the time of shift change (2pm) at the facility. She stated the resident did not come to the facility with medications, and the resident medication had not arrived on 12/16/21.The resident admitted from an assisted living facility. The resident informed her he was prescribed pain medications. She completed the pain assessment inaccurately. She stated the resident was provided a Tylenol 500 mg and Melatonin 5mg on 12/16/21. She stated the resident's other medication was not provided to the resident on 12/16/21. She did not document the medications given to the resident on 12/16/21 on his Medication Administration record. She did not document the medications given because it was a lot going on at the facility she stated. Observation and interview on 12/17/21 at 2:04 pm revealed Resident#33 medications arrived at the facility. RN A stated the medications for Resident #33 had arrived at the facility. Observation were completed and revealed all Resident #33's medication had arrived at the facility. An interview with the DON on 12/17/21 at 2:37 pm revealed she was not aware Resident #33 had not received his pain medications while at the facility. She stated the nurses should have informed her if the resident medications had not arrived at the facility. She would have expected the nurse to get a stat order for the resident medication and or check the facility medication kit. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	An interview with the Medical Director on 12/20/21 at 12:39 pm revealed he was not aware Resident #33 had not received his scheduled medication in over 24 hours. He stated he expected the facility to have contacted Resident #33 physician and got a stat order for Resident #33 medications. Review of the facility's Controlled Substance Medication orders policy dated 01/20 revealed Each controlled substance medication order is documented in the resident's medical record with the date, time and signature of the person receiving the prescription. An emergency order is placed with the provider pharmacy and the medication is scheduled to be given as received. Review of the Pain Management Program Policy revised on 08/20 revealed The facility will assess each individual for pain upon admission to the facility. The facility identify the characteristics of pain, such as location, intensity, frequency, pattern and severity.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35314 Based on interview, observation and record review the facility failed to ensure residents were free from significant medication errors for one (Resident #33) of five residents reviewed for medication errors in that: The facility failed to administer Resident #33's medications as ordered for over 24 hours. This failure could place residents at risk of medical complications and a decrease in therapeutic dosages of their medications as ordered by the physician. Findings included: Record review of Resident #33's face sheet dated 12/17/21 revealed Resident # 33 was a [AGE] year-old male admitted to the facility originally on 03/04/21 and was readmitted to the facility on [DATE]. The resident diagnoses included Chronic heart failure, Chronic Kidney disease, Type 2 diabetes ,Chronic Obstructive Pulmonary Disease (COPD) and pain. Review of the Physician orders dated 12/16/21 revealed Resident #33 was prescribed the following medications: Hydrocodone-acetaminophen10-325mg every 6 hours, Tylenol with codeine #3 ever 4 hours for pain, Ambien tablet 10mg for Insomnia, Aspirin tablet 81 mg for Atrial Fibrillation, Isosorbide Mononitrate tablet 30mg for Hypertension, Spironolactone tablet 50 mg for Fluid overload, Xalatan Solution 0.005% for Type 2 Diabetes, Carvedilol tablet 25mg for Hypertension, Colace capsule 100 mg for Constipation, Frusemide tablet 80mg for Fluid overload, Hydralazine tablet 25 mg for Hypertension, Ipratropium Albuterol solution 0.5-2.5mg for Chronic Obstructive Pulmonary Disease, and Norco Tablet 10-325 for pain. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication administration record dated 12/17/21 at 1:24 pm revealed no entries for any of Resident #33 medications were administered. Review of Resident #33's MDS dated [DATE] revealed he had a BIMS of 13, which indicated he was cognitively intact. An interview with Resident #33 on 12/17/21 at 11:05 am revealed he was admitted to the facility on [DATE]. He stated he had not received any of his scheduled medications since arriving at the facility. He admitted to the facility the afternoon on 12/16/21. He stated the nurse informed him; his medications were not at the facility. He stated he really needed his medications. An interview with RN A on 12/17/21 at 11:12am confirmed the medications for Resident #33 had not arrived at the facility She informed the resident on 12/16/21 after he admitted to the facility his medications had not arrived, there had been issue with pharmacy providing the medications to the facility. There were no medications to give to Resident #33 she stated. An interview with Med aide B on 12/17/21 at 11:37 am revealed Resident #33 had requested to have his medications. Resident informed her; he wanted his medications including his pain medications. She informed Resident #33 his medications were no one her cart. She told the resident his medications had not arrived at the facility. She stated confirmed she had not given any medications to Resident #33 to that point. She informed RN A Resident #33 medication had not arrived at the facility. An interview with LVN C on 12/17/21 at 2:22pm revealed Resident #33 was admitted to the facility on [DATE]. She stated when the resident arrived at the facility, it was during the time of shift change at the facility. She stated the resident did not come to the facility with medications. The resident informed her he was prescribed pain medications. She confirmed she completed the pain assessment inaccurately. She stated the resident medication had not arrived on 12/16/21. She stated the resident was provided a Tylenol 500 mg and Melatonin 5mg on 12/16/21. She stated the resident's other medication wereas not provided to the resident on 12/16/21. She did not document the medications given to the resident on 12/16/21 on his Medication Administration record. She did not document the medications given because it was a lot going on at the facility she stated. Observation and interview on 12/17/21 at 2:04 pm revealed Resident#33 medications arrived at the facility. RN A confirmed the medications for Resident #33 had arrived at the facility. Observation were completed and revealed all Resident #33's medication had arrived at the facility. An interview with the DON on 12/17/21 at 2:37 pm revealed she was not aware Resident #33 had not received his pain medications while at the facility. She stated the nurses should have informed her if the resident medications had not arrived at the facility. She would have expected the nurse to get a stat order for the resident medication and or check the facility medication kit. An interview with the Medical Director on 12/20/21 at 12:39 pm revealed he was not aware Resident #33 had not received his scheduled medication in over 24 hours. He stated expected the facility to have contacted Resident #33 physician and got a stat order for Resident #33 medications. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Controlled Substance Medication orders policy dated 01/20 revealed Each controlled substance medication order is documented in the resident's medical record with the date, time and signature of the person receiving the prescription. An emergency order is placed with the provider pharmacy and the medication is scheduled to be given as received.