

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675972	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2025
NAME OF PROVIDER OR SUPPLIER Carrollton Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1618 Kirby Rd Carrollton, TX 75006	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222</p> <p>Based on interviews and record review, the facility failed to ensure the right to be free from abuse was provided for one (Resident #1) of seven residents reviewed for abuse.</p> <p>The facility failed to ensure Resident #1 was free from abuse. On 5/18/2024 at 2:10 p.m., CNA A hit Resident #1 with an open hand on the outer left thigh causing a red handprint.</p> <p>The noncompliance was identified as past noncompliance (PNC). The past noncompliance began on 05/18/24 and ended on 05/20/24. The facility had corrected the noncompliance before the state's investigation began.</p> <p>This failure could place residents at risk for abuse and psychological harm.</p> <p>Findings included:</p> <p>Record review of Resident #1's Annual MDS dated [DATE] revealed Resident #1 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses of dementia, stroke, and aphasia (disorder that affects a person's ability to communicate). Section E indicated there have been no changes in Resident #1's behavior, and Resident #1 was not exhibiting any behaviors. BIMS assessment was incomplete.</p> <p>Record review of Resident #1's BIMS assessment prior to the incident dated 4/25/2024 revealed a BIMS score of 0 (indicated severe cognitive impairment).</p> <p>Record review of Resident #1's care plan revealed Resident #1 had right sided weakness, impaired cognitive function, and was resistive to care. Interventions listed for being resistive to care included leaving the room, approaching the resident at a later time, and seeking assistance from another staff member. Another focus listed was that Resident #1 had a potential for behavior problems and interventions included to ensure the resident's safety and not jeopardize the staff's safety with care.</p> <p>Record review of PIR dated 5/20/2024 revealed on 5/18/2024 at 2:10 p.m., CNA A reported to MA B that Resident #1 hit her twice in the arm, and she reacted by hitting him back. CNA A was suspended and escorted out of the building by staff.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 1/14/2025 at 11:19 a.m., MA B reported on 5/18/2024 that CNA A came to her office and stated she had hit Resident #1 back after he hit her. MA B stated she immediately notified the DON and the ADM and MA B told CNA A to go to her car. MA B reported she saw a red handprint on Resident #1's left thigh, but it was gone when she went to change him two hours later. MA B stated Resident #1 did not slap at her hand or give her any indication that it hurt when she changed him. MA B stated Resident #1 was combative with care at times and hit hard. MA B stated there were no changes in Resident #1's behavior after the incident. MA B stated Resident #1 could have become afraid of staff but did not.</p> <p>In an attempted interview on 1/14/2025 at 12:10 p.m., a telephone call was made to CNA A and voicemail left. No return call received.</p> <p>In an interview on 1/14/2025 at 12:24 p.m., the DON reported CNA A was providing care for Resident #1. CNA A walked out of the room and told MA B that she had hit Resident #1. The DON stated CNA A told her it was a reaction, and she was sorry. The DON stated CNA A knew what abuse was and knew not to hit the residents. The DON stated CNA A had received abuse and neglect training, and CNA A was able to state what should have happened in the situation. The DON reported CNA A was walked out of the building and terminated after the investigation. The DON reported the red mark on Resident #1's leg was gone by the next day and Resident #1 did not have any behavior changes after the incident. The DON reported Resident #1 did not appear to be fearful of staff. The DON stated all staff received abuse and neglect training that was updated to include de-escalation techniques. The DON stated the risks to the residents if they were hit by staff would be behaviors, depression, isolation, and risk for fear. The DON reported everyone was responsible for monitoring staff interactions with residents, and everyone was trained to say something if they saw something.</p> <p>Record review of a skin assessment dated [DATE] at 2:25 p.m., revealed Resident #1 had a slight red discoloration to the outer left thigh.</p> <p>Record review of nursing progress note dated 5/18/2024 at 8:20 p.m., revealed Resident #1 did not have any bruises and did not have any signs or symptoms of pain.</p> <p>Record review of nursing progress note dated 5/19/2024 at 6:15 p.m., revealed Resident #1 did not have any bruises and did not have any signs or symptoms of pain.</p> <p>In an observation and attempted interview on 1/14/2025 at 1:19 p.m., Resident #1 was sitting up in his bed looking around the room. Resident #1 was unable to participate in an interview. Resident #1 did not verbally respond to questions and only grunted. Resident #1 appeared calm but gestured for people to leave by waving his hand at the door when he was spoken to.</p> <p>In an attempted interview on 1/14/2025 at 1:29 p.m., a telephone call was made to Resident #1's POA and voicemail left. No return call received.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 1/14/2025 at 5:29 p.m., the ADM stated he was immediately notified of the incident and interviewed CNA A with the DON over the phone. The ADM stated CNA A told him that she hit Resident #1 because it was a reaction to him hurting her. The ADM stated CNA A had training on abuse and neglect and was terminated after the incident because it was abuse. The ADM stated he did not remember if there initially a red mark on Resident #1 was, but there was nothing long-term. The ADM stated the risks to the residents if staff were to hit them would be that they could be hurt emotionally or physically. The ADM stated everyone was responsible for monitoring staff to resident interactions, and the expectation was that there was no tolerance for physical or verbal abuse.</p> <p>Review of training dated 05/18/25 and labeled 'Teachable Moment' and presented by the DON reflected the training included the Abuse Policy, Steps of de-escalation, residents with increased behaviors use two staff for all cares and notify the nurse.</p> <p>An interview on 01/14/25 at 3:25 p.m. with CNA C revealed she received training regarding abuse and neglect. She received abuse and neglect training on computer and during in-service. She stated it takes two aides to provide care due to Resident #1's behavior.</p> <p>An interview on 01/14/25 at 4:07 p.m. with CNA D revealed she received in-service training regarding abuse and has not seen any staff hit any residents, if she saw abuse she would report to the Administrator. She stated it takes two staff to provide care to Resident #1.</p> <p>An interview on 01/14/25 at 4:019 p.m. with CNA E revealed she received in-service training and received monthly on computer and in-services. She stated if the resident is aggressive staff should walk away and come back when resident is calm. She stated she has never seen a staff hit a resident.</p> <p>Record review of facility policy titled Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment, with a revision date of 10/01/2024, revealed it is the policy of this facility that each resident has the right to be free from abuse and definitions included abuse - willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish .Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p>		