STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675972	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrollton Health and Rehabilitation Center	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)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675972	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrollton Health and Rehabilitation Center	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)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the residents' right to be treated with respect and dignity during wound care for 1 of 4 residents (Resident #2) reviewed for respect and dignity in that: The facility failed to ensure RN B provided privacy by leaving the door open and not pulling privacy curtain, exposing Resident #2's abdomen when providing Resident #2 while changing gastroenterology tube (feeding tube) supplies. This failure could place residents at risk of emotional distress and low self-esteem. Findings included: Record review of Resident #2's quarterly MDS assessment, dated 06/06/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: Cerebral Vascular Disease (stroke), aphasia (unable to speak), dysphagia (unable to swallow), and hypertension (high blood pressure). Resident #2's cognition was severely impaired, and were unable to make decisions and required assistance from one staff for activities of daily living. Record review of Resident #2's care plan dated 09/28/2025 reflected that the resident had dysphagia [SH1] from Cardiovascular Accident, and required enteral feed (feeding tube) to maintain nutritional status. Record review of Resident #2's physician orders dated 09/30/2025 reflected, for staff to change all enteral feeding tubing and water bags every night shift on Wednesday. An observation on 11/20/2025 at 5:00 a.m., revealed RN B entered the room of Resident #2 while he was in his bed. RN B did not close the door or pull the privacy curtain of Resident #2's room during the entire process of changing out the gastroenterology supplies. Resident #2's abdomen was visible to the hallway. Further observation revealed Resident #2 was trying to pull up the sheet and pull the hospital gown down over his abdomen. During an interview on 11/20/2025 at 5:15 a.m., RN B revealed she forgot to close the door or pull the privacy curtain. RN B stated she did guess she was more nervous than she thought and did not think about it, until she had completed her task. When asked about the training she received on resident's rights, RN B stated, by not closing the door and the curtain, the privacy and dignity of Resident #2 was compromised as anyone passing by the room could see the abdomen of the resident. RN B stated was fully aware of resident rights to have privacy, dignity, and respect, and received in-service on resident's rights at least once a year. An interview on 11/20/2025 at 5:20 a.m. with Resident #2 revealed he was non-verbal but understood and could shake his head yes and no. Resident #2 revealed he did not like to have his door open to the hallway. Resident #2 wanted the door closed when the staff was caring for him. During an interview 11/20/2025 at 10:35 a.m., the DON stated privacy and dignity must be provided during nursing care, and the door and privacy curtain to Resident #2's room should have been closed completely by RN B. She said the trainings were an ongoing process, and resident rights was one of them. The DON stated the facility ensured all the new hires had gone through skill checks and all nursing staff had to complete an annual evaluation to ensure their nursing skills and knowledge, including competency in respecting residents' rights and privacy. The DON stated RN B should have closed the door when she entered the room, then pull the privacy curtain. Review of facility's policy Resident Rights dignity and respect revised dated 2015, reflected: It is the policy of this facility that all residents be treated with kindness, dignity, and respect.4. residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the residents from passer-by. 5. Privacy of a Resident's body shall be maintained during toileting, bathing and other activities of personal hygiene. 6. Violation of the Residents' Rights to dignity and respect should be promptly reported to the Director of Nursing Services and/or Administrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675972	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrollton Health and Rehabilitation Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675972	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrollton Health and Rehabilitation Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents' environment remained as free of accident hazards as is possible and ensured each resident received adequate supervision for one (Resident #1) of four residents reviewed for accidents and hazards. The facility failed to ensure Resident #1 was free of injury from accident hazards when CNA D failed to follow policy and procedure and report to the nurse in charge, when CNA D found Resident #1 was on the floor in her room. CNA D picked the resident up from the floor and placed her in wheelchair taking the resident to the dining room for breakfast. The LVN did not assess Resident #1 before she was moved by CNA D. These failures could place residents at risk for harm, pain, and injury.Findings included: Record review of Resident #1's significant change MDS assessment, dated 10/27/2025, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. The resident had diagnoses which included: Hypertension (high blood pressure), non-Alzheimer's dementia (mental confusion), cerebrovascular accident (stroke), and repeated falls. The MDS reflected she had a BIMS score of 01, which indicated severe cognitive impairment. The resident used a wheelchair for mobility, she could wheel up to 150 feet with supervision, and could stand to transfer from wheelchair to bed and bed to wheelchair, but could not walk safely. Resident #1 required the assistance of one staff for activities of daily living. Record review of Resident #1's care plan dated 09/01/2025 indicated she was limited in her ability to transfer due to impaired mobility. She was unable to ambulate but could stand with stand by assist. Interventions included: assist with transferring using stand by assist or a gait belt (a type of device used to wrap around an individual to give assistance to stand safely and transfer), 1-person assist, keep call light within reach, monitor extremities to avoid injury, notify nurse if any injury/fall occurs, provide 1-person assistance for transferring, and when transferring, resident should be face-to-face with caregiver. Further review of Resident #1's care plan dated 09/01/2025 indicated she was at risk for falling r/t impaired mobility, decreased muscle strength. Resident #1 used a w/c for mobility with partial staff assistance. Her falls were related to standing up without assistance and sitting on the floor. Interventions included: transfer to hospital for evaluation, keep bed in lowest position with brakes locked, always keep call light in reach, keep personal items and frequently used items within reach when appropriate. Record review of the incident/accident report for August-November 2025 indicated on 09/21/25 Resident #1 was located on the floor in her room assessed and no injuries noted, 10/31/2025 Resident #1 was located on the floor in the room actual time 6:15 a.m., the resident was not assessed at that time, assessed later by charge nurse when the facility was notified by the Responsible party the resident was on the floor in her room early in the morning and a [CNA] had come in Resident #1's assisted her up and placed her in the wheelchair and wheeled her out of the room, without a nurse assessing her. The Responsible party reported that no one had contacted her about the fall. An observation on 11/20/2025 at 4:45 a.m. revealed Resident #1 was asleep, in a low bed, in her room. Her wheelchair was located in the bathroom. An interview on 11/20/2025 at 4:50 a.m. with CNA C revealed she had taken care of Resident #1 for three months, and she knew her from the past. CNA C stated Resident #1 would get up out of her bed or her wheelchair and sit on the floor. CNA C stated Resident #1 could not get back up on the bed or into the wheelchair without assistance of one person, she would scoot around on the floor. CNA C stated Resident #1 previously had a stability mat, but it had been removed, and she was unstable on it when she tried to stand up. CNA C stated when any resident was found on the floor, they were to be left there, and staff were to get the nurse so the resident could be assessed for injuries. CNA C stated they recently had in-service on fall and reporting in the past three months. An interview on 11/20/2025 at 5:30 a.m., with Resident #1, using a google translator, revealed the resident stated that she could get up and go to the bathroom by herself and she would not fall. Resident #1 stated she used her wheelchair most of the time. Resident #1 stated she liked living here, and the staff was nice and took care of her. Observation on 11/20/2025 at 5:15 a.m. with CNA C of Resident #1 revealed CNA C assisted Resident #1 to stand. She could bear weight. She was placed in the wheelchair, then taken to the bathroom. Resident #1 was brought into the room and she was dressed and prepared for the breakfast meal. CNA C then transported her to the dining room. Further observations during activities of daily living revealed no bruising or skin tears to resident's body. Interview with CNA D on 11/20/2025 at 8:00 a.m., revealed she came in on 10/31/2025, and as she was making her rounds on her assigned hall, she found Resident #1 scooting around in her room on the floor. CNA D stated she entered the room, assisted the resident up

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675972	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrollton Health and Rehabilitation Center	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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles in locked compartments and permit only authorized personnel to have access to the keys for 1 (Resident #2) of 4 reviewed for storage of drugs, in that: The facility failed to ensure Resident #2's calmoseptine ointment (ointment applied to the bottom to treat and prevent redness) was secured. This failure could place residents at risk of medication misuse and diversion.The findings were: Record review of Resident #2's quarterly MDS assessment, dated 06/06/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: Cerebral Vascular Disease (stroke), aphasia (unable to speak), dysphagia (unable to swallow), and hypertension (high blood pressure). Resident #2's cognition was severely impaired, he was unable to make decisions and required assistance from one staff for activities of daily living. Record review of Resident #2's physician orders dated 11/2025 reflected no orders to self-administer medications. During an observation and interview on 11/20/2025 at 5:00 a.m., a medication cup with a pink substance on the top of the dresser in Resident #2's room wasd unsecured and unattended. RN B stated, Oh that is probably the cream the staff uses on his bottom, when they change him. The RN did not attempt to remove the cream and left the room. An observation on 11/20/2025 at 5:15 a.m. revealed the pink ointment in the medication cup was still on the dresser in Resident #2's room. An interview on 11/20/2025 at 5:15 a.m. with CNA C revealed she did not use the pink ointment in the medication cup on Resident #2 when she changed him. She stated she used incontinent wipes and placed on no cream. CNA C stated she did not know what the ointment was. An interview on 11/20/2025 at 6:15 with CNA D revealed the CNA did not know what the pink stuff was, CNA D stated she had never seen it before. An interview on 11/20/2025 at 12:06 p.m., with LVN E revealed all the treatments for the residents, to include ointments, other medications, and supplies were all in the treatment cart and locked. LVN E stated that the nurses were required to perform the treatments or if the treatment was more than one time a day. LVN E stated the treatment for skin conditions should never be left outside of the locked cart only when being used by the nurse, or if this was an order to leave it in the residents' room. During an interview on 11/20/2025 at 12:17 p.m., the DON stated she expected the nurses to know better than to leave medications in any resident's rooms. The DON stated negative effects could occur to the residents if medications were left in their rooms. During the interview the DON did not confirm what the cream was. The DON stated, anybody can get them and have access to them. The DON stated this could cause harm to another resident or even staff. Record review of the Facility's Policy titled Pharmacy Services revised dated May 2007 reflected: It is the policy of this facility that drugs and treatments shall be administered/carried out upon the order of a person duly licensed and authorized to prescribe such drugs and treatments.2. All drugs and biologicals orders shall be dated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675972	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrollton Health and Rehabilitation Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675972	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrollton Health and Rehabilitation Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 2 (CNA A and RN B) staff members and 2 of 2 residents (Residents #3, and #2) reviewed for infection control procedures. CNA A failed to change their soiled gloves and perform hand hygiene during incontinent care on Residents #3. RN B failed to change her soiled gloves and perform hand hygiene during replacement of gastroenterology tube (feeding Tube) supplies for Residents #2. These failures could place residents at risk for cross contamination and infectionsFindings included: Record review of Resident #3's quarterly MDS Assessment, dated 09/01/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: Hypertension (increased blood pressure), diabetes, (increased blood sugar), and dementia (confusion). Resident #3's cognition was severely impaired, unable to make all decisions for herself, and required one staff member for assistance with activities of daily living. Record Review of Resident #3's plan of care dated 09/05/2025 reflected goals and approaches for incontinent care to be provided by the nursing staff every 2 hours to keep Resident #3 clean and dry and prevention of skin problems. During an observation on 11/20/2025 at 4:30 a.m., CNA A entered the room to perform incontinent care and activities of daily living with Resident #3. CNA A did not use hand gel in the hallway or wash his hands before placing on gloves that he got from the box on top of the dirty linen cart. CNA A picked up his incontinent wipes from the top of the dirty linen cart and entered the room. Resident #3 was lying on her back in the bed. CNA A explained to the resident what he was going to do, and the resident agreed. CNA A pulled the pants of Resident #3 down; she had taken off her brief. CNA wiped the pubic area with a disposable wipe, discarded the wipe. CNA A used another wipe on the peri area and discarded it. CNA A assisted with repositioning Resident #3 to her right side; he then used another wipe on the left buttocks and discarded it. CNA A assisted with repositioning Resident #3 to her left side while pulling the clean brief under the resident. CNA A without changing his soiled gloves or washing his hands, he fastened the tabs of the clean brief, placed on the resident's pants, assisting with repositioning her on back, and covered her with a blanket. CNA A placed his gloves in the trashcan, gathered the trash bag, and left the room, without washing his hands or using hand sanitizer. The CNA placed the incontinent wipes back on top of the dirty linen cart, with the box of gloves. An interview on 11/20/2025 at 4:45 a.m. with CNA A revealed the CNA stated, he got nervous when the surveyor entered the room with him and he forgot what to do. CNA B stated he knew he did not change his gloves, and he should not have kept supplies on top of the dirty linen cart. CNA B stated he had been trained in infection control, changing gloves, and handwashing. He stated the DON had worked with him in the past three weeks. The CNA stated that if he did not change his gloves and wash his hands or use sanitizer, he could spread germs to himself and other residents. Record review of Resident #2's quarterly MDS assessment, dated 06/06/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: Cerebral Vascular Disease (stroke), aphasia (unable to speak), dysphagia (unable to swallow), and hypertension (high blood pressure). Resident #2 was severely cognitive and unable to make decisions and required assistance from one staff for activities of daily living. Record review of Resident #2's plan of care reflected goals and approaches for feeding tube insertion site will be free of any sign's symptoms of infections. Provide local feeding tube care as ordered to prevent any signs and symptoms of infections. Using enhanced barrier precautions (the use of PPE, personal Protective equipment) Record review of Resident #2's physician orders dated 09/30/2025 reflected, change all enteral feeding tubing and water bags every night shift on Wednesday. An observation on 11/20/2025 at 5:00 a.m., revealed RN B performing the replacement of the gastroenterology tube (feeding tube) supplies for Resident #2. During which time the RN placed on gloves and the PPE, personal protective equipment (gloves, gown and mask) and began to remove the used tubing and the used water bag. The RN placed the used supplies in the trash. RN B opened the door to the bathroom, took the cap off the new water bag, and filled it with water. RN B returned to the bedside of Resident #2, replacing the tubing RN B connected the new tubing to the gastronomy tube and hanging the new water bag and a new bottle of formula. The RN took her gloves off and left the room. The RN never replaced the gloves or sanitized her hands from the dirty supplies used to the new supplies. An interview with the DON, who was the infection control preventionist on 11/20/2025 at