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	12/01/2025

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 - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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	12/01/2025

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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for one (Resident #1) of five residents reviewed for pressure ulcers. The facility failed to provide appropriate treatment to Resident #1's skin issues. This failure placed residents at risk for the decline in quality of life and the wounds being infected or deteriorating.Review of Resident #1's face sheet dated 10/06/25 revealed he was a [AGE] year-old male, he was originally admitted on [DATE] and readmitted on [DATE]. Admitting diagnoses included, hypertension, anxiety, major depression, dementia, muscle weakness and need assistance with personal care. Review of Resident #1's quarterly MDS assessment dated [DATE] reflected he had a BIMS score of 01, indicating severe cognitive impairment. The resident had an open lesion on the foot. Review of Resident #1's care plan initiated 09/30/25 reflected, Focus, Has actual impairment to skin integrity r/t TRAUMA WOUND TO RIGHT HEEL. 9/30/2025-0.9 X 0.9 X 0.1 CM. Goal, Skin injury of the RIGHT HEEL will be healed by review date. Intervention, Administer treatments as ordered. Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration (the softening and breakdown of the skin resulting from prolonged exposure to moisture. This can occur from sweat, wound fluids, urine, or other bodily fluids, leading to the skin becoming pale, wrinkly, and more susceptible to injury and infection. It is a common issue for those with chronic wounds, incontinence, or immobility.) etc. to MD. Focus, Has right Hip Fracture. Goal, Will remain free of complications related to hip fracture. Intervention, . Change surgical incision dressing as per order and PRN. Review of Resident #1's physician summary dated 10/06/25 reflected an order dated 09/30/25; cleanse right heel with normal saline, pat dry, apply Santyl (nickel thick) and cover with foam dressing on Monday, Wednesday and Friday every day for wound healing. Review of Resident #1's wounds progress notes from 09/20/25 through 10/05/25 revealed the wounds had not deteriorated. The wound care were to be completed on Monday, Wednesday and Friday. The wound care to the right heel was completed on 09/30/25 (Tuesday) missing the wound care on 10/1/25 and 10/3/25. The wound care on the top side of the right heel was completed on 10/02/25 (Thursday) missing the wound care on 10/3/25. Observation and interview on 10/06/25 at 12:15 pm with Resident #1 reflected the resident was in the wheelchair. The resident was noted with wound dressings to the right heel and on top of the right heel. The dressing on the bottom of the heel was dated 09/30/25 and the dressing on top was dated 10/02/25. In an interview with Resident #1 he stated the wound care dressings had been completed but did not recall when the wound care was completed. Resident #1 denied any signs or symptoms of infection. In an interview on 10/06/25 at 2:15 pm with RN A revealed she worked on the 6a-6p shift. RN A stated she was proving care to Resident #1, and she worked on Wednesday (10/01/25) and Sunday (10/05/25). RN A stated she could not complete the wound care on 10/01/25 because she was too busy and did not complete the wound care. RN A stated she did not inform the night nurse that she was not able to complete the treatment on Wednesday so that the night nurse could complete the wound cares. RN A stated she was expected to inform the DON and ADON of not completing the wound cares, but she did not because she forgot. RN A stated the resident's wound care was completed on 09/30/25 and from the last time she completed the resident's wound care, the wounds did not have signs or symptoms of infection and had not deteriorated. RN A stated wound cares not completed could cause infection and or the wound getting worse. In an interview on 10/06/25 at 3:56 pm with RN B revealed she oversaw Resident #1 care on 10/03/25. RN B stated wound care for the resident was scheduled on 10/03/25 but she could not complete it because she was busy and forgot to report to the oncoming charge nurse. RN B stated she was supposed to report to the DON if she was not able to complete wound care but she did not. RN B stated from the previous wound care the resident's wounds had not deteriorated and the resident had not reported any signs or symptoms of infection. RN B stated wound care not completed per the primary care provider could lead to the wound getting infected or getting worse. In an interview on 10/06/25 at 4:30 pm with the DON revealed she was not aware, and the staff had not informed her of not completing Resident #1's wound care. The DON stated she expected the charge nurses to complete the wound care and if unable