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	01/30/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of accident hazards as was possible for 3 of 6 residents (Resident #5, #6, and #7) reviewed for accident prevention.The facility failed to ensure Resident #5 did not have a can of Lysol spray in his room on 01/30/2026.The facility failed to ensure Resident #6 did not have a can of aerosol air freshener spray in her room on 01/30/2026. The facility failed to ensure Resident #7's cell phone charging cord was plugged correctly into the outlet in her room on 01/30/2026.These failures could prevent the residents from having an environment that was free from hazards. Findings included:Record review of Resident #5's Face Sheet, dated 01/30/26, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #5 had diagnoses of Dementia (memory decline) and depressionRecord review of Resident #5's Quarterly MDS Assessment, dated 12/21/25, reflected Resident #5 had severe cognitive impairment. The Quarterly MDS Assessment reflected the resident had an active diagnosis of Dementia.Record review of Resident #5's Comprehensive Care Plan, dated 01/13/26, reflected a plan of care for an impaired cognitive function. In an observation on 01/30/26 at 9:28 AM, Resident #5 was observed with a can of Lysol in his room sitting on top of a 5-drawer chest. Record review of Resident #6's Face Sheet, dated 01/30/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #6 had diagnoses of major depression disorder.Record review of Resident #6's Quarterly MDS Assessment, dated 12/06/25, reflected Resident #6 had moderate cognitive impairment. The Quarterly MDS Assessment reflected the Resident #6 had an active diagnosis of depression.Record review of Resident #6's Comprehensive Care Plan, dated 12/28/25, reflected a plan of care for an impaired cognitive function. In an observation on 01/30/26 at 9:30 AM, Resident #6 was observed with a can of aerosol air freshener spray sitting on top of her nightstand. In an observation and interview on 01/30/26 at 9:28 AM, RN A was shown Resident #5 and Resident #6 with having the can of Lysol and can of aerosol air freshener spray in their rooms and she stated they were not to have the items in the room because it was an biohazard and dangerous for the residents. Record review of Resident #7's Face Sheet, dated 01/30/26, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #7 had diagnoses of Dementia and conduct disorder.Record review of Resident #7's Quarterly MDS Assessment, dated 12/12/25, reflected Resident #7 had severe cognitive impairment. The Quarterly MDS Assessment reflected the resident had active diagnoses of Dementia and conduct disorder.Record review of Resident #7's Comprehensive Care Plan, dated 12/28/25, reflected a plan of care for an impaired cognitive function. In an observation on 01/30/26 at 1:55 PM, Resident #7 was observed lying in bed. She was pointing at a phone charger cord that she stuck directly into an electrical outlet on a wall alongside her bed, without the charging plug. The phone charging plug was observed on top of her 5-drawer chest. The resident had a sign on the wall above the outlet, which stated Please help mom with these things. Phone: make sure her phone is plugged in and (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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrollton Health and Rehabilitation Center	1618 Kirby Rd Carrollton, TX 75006

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	turned on. In an interview and observation on 01/30/26 at 2:06 PM, RN A and CNA L were shown Resident #7's phone charger cord that she stuck directly into an electrical outlet. They stated staff should have connected the resident's phone to the charger after placing the resident into her bed, because the resident wanted her phone near her so she could contact the Responsible Party. RN A stated the resident could injure herself if she attempted to charge the phone herself.In an interview on 01/30/26 at 2:06 PM, The Administrator and DON were informed of Resident #7 having the phone charger cord stuck directly into an electrical outlet and staff not following the Resident's Responsible Party request to have the phone charger connected by staff for the resident. The DON stated staff should have plugged in the charger for the resident once they placed her back in bed. The DON stated the resident could have harmed herself by plugging the charging cord directly into the outlet. The facility's policy Resident Rights (undated) reflected The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide--1. A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.a. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure that residents, who needed respiratory care, were provided care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for four of six residents (Resident #1, #2, #3 and #4) reviewed for respiratory care.The facility failed to ensure Resident #1 and #2's breathing treatment mask was properly stored in a bag when not in use on 01/30/26. The facility failed to ensure Resident #3 and #4's nasal canula was properly stored in a bag when not in use on 01/30/26. These failures could place residents at risk for respiratory infection and not having their respiratory needs met.Findings included: Record review of Resident #1's Face Sheet, dated 01/30/26, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had a diagnosis of COPD (obstructed airflow).Record review of Resident #1's Quarterly MDS Assessment, dated 12/21/25, reflected Resident #1 had severe cognitive impairment. The Quarterly MDS Assessment reflected the resident had an active diagnosis of COPD.Record review of Resident #1's Physician Orders, dated 01/30/26, reflected Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML inhale every 6 hours as needed for shortness of breath. In an observation on 01/30/26 at 9:14 AM, Resident #1's nebulizer mask was observed sitting on top of her nightstand unbagged.Record review of Resident #2's Face Sheet, dated 01/30/26, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had a diagnosis of COPD (obstructed airflow). Record review of Resident #2's Quarterly MDS Assessment, dated 12/24/25, reflected Resident #2 had severe cognitive impairment. The Quarterly MDS Assessment reflected the resident had an active diagnosis of Chronic Respiratory Failure (low blood oxygen).Record review of Resident #2's Physician Orders, dated 01/30/26, reflected Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML inhale every 8 hours as needed for shortness of breath.In an observation on 01/30/26 at 9:18 AM, Resident #2's breathing treatment mask was observed sitting on top of her nightstand unbagged Record review of Resident #3's Face Sheet, dated 01/30/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 had a diagnosis of COPD (obstructed airflow). Record review of Resident #3's Quarterly MDS Assessment, dated 12/24/25, reflected Resident #3 had severe cognitive impairment. The Quarterly MDS Assessment reflected the resident had an active diagnosis of COPD.Record review of Resident #3's Physician Orders, dated 01/30/26, reflected no physician orders for oxygen use.In an observation and interview on 01/30/26 at 9:26 AM, Resident #3's nasal canula was observed hanging on his oxygen concentrator unbagged. The resident stated he did not use the oxygen device much and had not used it in a few days.In an observation and interview on 01/30/26 at 9:28 AM, RN A observed Resident #4's nasal canula hanging on his oxygen concentrator unbagged. She stated the resident used the oxygen device on an as needed basis and the nasal canula should be bagged when not in use to avoid infection. Record review of Resident #4's Face Sheet, dated 01/30/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 had a diagnosis of chronic kidney disease. Record review of Resident #4's Initial MDS Assessment, dated 01/30/26, reflected Resident #4 had severe cognitive impairment. The MDS Assessment reflected no active diagnoses.Record review of Resident #4's Physician Orders, dated 01/30/26, reflected O2 AT 2 L/MIN CONTINUOUS PER Nasal cannulaIn an observation and interview on 01/30/26 at 9:34 AM, Resident #4's nasal canula was observed hanging on his oxygen tank, attached to the wheelchair, unbagged.In an observation and interview on 01/30/26 at 9:28 AM, RN A observed Resident #4's nasal canula hanging on his oxygen tank, attached to the wheelchair, unbagged. She stated the nasal canula should be bagged when not in use to avoid the resident getting an infection. In an interview on 01/30/26 at 10:00 AM, the DON was informed (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Carrollton Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1618 Kirby Rd Carrollton, TX 75006	

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of Resident #1, #2, #3 and #4 not having not having their breathing mask or canula bagged. She stated the items needed to be bagged to avoid the resident getting an infection. She stated a nurse had already brought this to her attention and she was going to -In-service them on the expectation.In an interview on 01/30/26 at 2:14 PM, LVN U stated she works at a different facility but was helping today. She stated she covered the hall of Resident #1 and #2. She was informed of Resident #1 and #2 not having their breathing mask bagged. She stated nasal canula's and breathing mask should be in a plastic bag when not in use to keep them from getting contaminated. She stated nurses should be checking for this when they make their rounds.Review of the facility's policy Oxygen Administration, 10/2010, reflected The purpose of this procedure is to provide guidelines for safe oxygen administration. 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.2. Review the resident's care plan to assess any special needs of the resident.The policy had no reference to bagging the breathing devices when not in use.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents were adequately equipped to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from three of six residents (Resident #7, #8, and #9) reviewed for Resident Call System. The facility failed to ensure the call light system in Resident #7, #8, and #9's rooms were in a position that was accessible to the residents on 01/30/26.This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings included: Record review of Resident #7's Face Sheet, dated 01/30/26, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #7 had diagnoses of lack of coordination and history of falling.Record review of Resident #7's Quarterly MDS Assessment, dated 12/12/25, reflected Resident #7 had severe cognitive impairment. The Quarterly MDS Assessment reflected the resident had active diagnoses of lack of coordination and need for assistance with personal care. Record review of Resident #7's Comprehensive Care Plan, dated 12/28/25, reflected the resident was a fall risk and an intervention was to have call system within the resident's reach. In an observation on 01/30/26 at 2:00 PM, Resident #7 was observed lying in her bed. She did not have a call light, but she did have a bell attached to a bedside table. The bedside table was observed across the room, near a 5-drawer chest, out of reach from the resident. In an interview and observation on 01/30/26 at 2:06 PM, RN A and CNA L stated the resident used a bell, attached to a bedside table, to contact staff if she needed any assistance. They stated the resident was unable to self-transfer in and out of bed and needed staff assistance. RN A stated when staff placed the resident back in bed, they should have placed the bedside table near the resident. RN A stated the resident kept yanking the call light cord out of the wall and destroying it. Record review of Resident #8's Face Sheet, dated 01/30/26, reflected he was an [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included muscle weakness and lack of coordination. Record review of Resident #8's Quarterly MDS assessment, dated 12/21/25, reflected severe cognitive impairment. For ADL care, it reflected the resident required extensive assistance. Active diagnoses included muscle weakness and lack of coordination. Record review of Resident #8's Comprehensive Care Plan, dated 6/30/25, reflected the resident was a fall risk and one of the interventions was to ensure call light was within reach of the resident. Record review of Resident #9's Face Sheet, dated 01/30/26, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included lack of coordination and unsteadiness on feet. Record review of Resident #9's Quarterly MDS assessment, dated 12/22/25, reflected severe cognitive impairment. For ADL care, it reflected the resident required substantial assistance. Active diagnoses included lack of coordination and unsteadiness on feet. Record review of Resident #9's Comprehensive Care Plan, dated 08/05/25, reflected the resident was a fall risk and one of the interventions was to ensure call light was within reach of the resident. In an observation on 01/30/26 at 9:16 AM, Resident 8's call light was observed on the floor behind the bed, out of reach of the resident, and Resident #9's call light was observed hanging down from the head of the bed, out of reach of the resident. In an interview and observation on 01/30/26 at 9:18 AM, CNA E observed Residents #8 and #9's call light not being within reach of the residents. She stated the residents often knock the call light off the bed, but she would get a clip to clip it to the bed. She stated the call lights needed to be within reach of the resident so they could call for assistance if needed.In an interview on 01/30/26 at 02:10 PM, the DON was advised of the call lights for Resident #7, #8, and #9 not being within reach of the resident so they could be able to contact staff if they needed (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	help. She stated all staff were responsible for ensuring the call lights were within reach of the residents.In an interview on 01/30/26 at 02:14 PM, LVN U stated she works at a different facility but was helping today. She stated she covered the hall of Resident #8 and #9. She was informed the residents were lying in bed and their call lights were not within their reach. She stated call lights should be within the resident's reach so they could call for help.Record review of the facility's policy on Call System, Residents, January 2025, revealed Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.