

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 03/05/2026
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on observation, interview, and record review, the facility failed to establish a system of disposition of controlled drugs to enable an accurate reconciliation and failed to maintain account of controlled drugs for 1 of 5 residents reviewed for pharmacy services. MA A was unaware of how to dispose controlled medication. MA B failed to update count sheet for Resident #1 after administering controlled medication to the resident, causing discrepancy between medication card and count sheet. These failures could lead to suspected drug diversion and medication error. Findings included: An observation on 3/5/2026 at 8:30am revealed MA A was passing medication to residents in hall 400. In an interview on 3/5/2026 at 8:30am, MA A stated she had not had a refusal of narcotics or controlled medication from residents before. MA stated if the resident refused controlled medication, she would waste the medication in the sharp bin on her medication cart. She stated she could do it with or without a witness. She stated she did not think a witness was needed to waste controlled medication. She stated after wasting the medication, she would report to the nurse. She stated she was not sure what the risk would be if it was done without a witness. MA A also stated the count sheet should always be documented immediately after a controlled medication was given to the resident to prevent the risk of forgetting to log it later which could cause discrepancy in medication count. She stated she had not had in-service on controlled medication count and disposing of controlled medication since she started in September 2025. An observation on 3/5/2026 at 9:00am of 200 hall cart, managed by MA B, revealed discrepancy of Lorazepam (a controlled medication for anxiety) card and count sheet for Resident #1. Resident #1's card showed 18 tablets of Lorazepam while the count sheet for the medication showed 19 tablets. In an interview on 3/5/2026 at 9:00am, MA B stated he administered Lorazepam to Resident #1 earlier this morning but he forgot to document the count sheet right away. He stated he always documented the count sheet as soon as a controlled medication was given to prevent forgetting documentation but today he stated he got busy and forgot. He stated the risk of not documenting right away was he could be suspected of drug diversion. MA B also stated if he noticed discrepancy when counting medication, he would report to the DON right away. He also stated he always needed a witness to waste a controlled medication to prevent drug diversion. He stated the medication could not be wasted in a sharp bin. He stated all controlled medication must be wasted by putting them in a drug buster (a medication disposal system that included ingredients to deactivate the effectiveness of the medication). In an interview on 3/5/2026 at 9:20am with Resident #1, she stated she took all medication this morning. She stated MA B gave her all medication and she did not notice any missed dose. Record review of Resident #1's MAR on 3/5/2026 revealed Lorazepam was given to the resident this morning at 0700. In an interview on 3/5/2026 at 9:30am, LVN C stated she always needed a witness when a controlled medication needed to be wasted. She stated all controlled medication must be wasted in a drug buster. She also stated once a controlled medication was taken from the cart, the count sheet needed to be documented right away. She stated those actions prevented drug diversion and medication count discrepancy. She stated the last in-service on controlled medication was provided about 2 weeks ago. In an interview on 3/5/2026 at 10:10am, the DON stated all med aides and nurses were trained to (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
---	-------	-----------

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 03/05/2026
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>waste controlled medication with a nurse witness to avoid drug diversion. She stated controlled medication could not be discarded in a sharp bin. She stated each medication cart had a drug buster bottle that staff used to waste medication. She also stated as soon as a controlled medication was pulled from a med cart, the count sheet of that medication needed to be updated with the correct count immediately to prevent count discrepancy. She stated all counts had been completed at shift changes with signatures of both staff who did the medication count. He stated MA A and MA B reported to her immediately after their interviews with this surveyor and education was provided for both staff. She stated the last in-service on narcotic and controlled medication administration was provided on 2/19/2026. Record review of facility's in-service training report, dated 2/19/2026, revealed an in-service was provided on narcotics and controlled medication. The summary of in-service stated, when narcotics are pulled from the cart you must correct the count sheet. Both MA A and MA B attended the training. Record review of facility's Medication administration - Destruction of Medication policy, dated 5/2025, revealed the following methods of destroying medications are utilized by this facility. two personnel licensed or registered in the health field shall document that drugs were destroyed by a. co-signing the medication record, b. recording the date, and drugs destroyed in the resident's medication count sheet. The policy also stated, dispose of medication in a manner that will render the drug unusable.</p>