

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  03/26/2026
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure residents did not get ice from the ice cooler used for 1 of 1 (Resident #1) resident reviewed for infection control. Resident #1 got ice for her cup from an ice cooler, without the help of staff. This failure could result in contaminated ice that could transmit organisms to other residents, resulting in waterborne illnesses. Findings included: Record review of Resident #1's face sheet, dated 03/26/2026, revealed a [AGE] year-old woman admitted to the facility with a primary diagnosis of epilepsy (brain condition causing seizures). Other pertinent diagnoses included down syndrome, major depressive disorder, and mild intellectual disabilities (below-average intellectual functioning). Record review of Resident #1's MDS, dated [DATE], revealed she had a BIMs score of 07, indicating severe cognitive impairment. During an observation on 03/26/2026, the ADON had assisted Resident #1 with opening the lid on her cup. Resident #1 proceeded to walk down the hall near the dining room. Resident #1 poured a can of soda into her cup, and the cup and lid from her cup sat on top of the ice cooler. Resident #1 said she got ice for her cup herself, indicating staff did not assist. Resident #1 did not state how she got the ice. At that time, RN A assisted Resident #1 to the therapy room. During an interview on 03/26/2026 at 11:05 AM with RN A revealed Resident #1 did sometimes get ice from the cooler herself but other residents did not. She said staff did try to assist Resident #1 with getting ice if they saw her walking around, because Resident #1 may be walking to get ice. RN A said Resident #1 needed assistance and staff usually caught her (before she got ice herself) but she got upset if staff tried to help her. RN A said the risk of residents getting ice from the ice cooler was contamination to the ice and risk of infection. During an interview on 03/26/2026 at 12:10 PM with the DON, she revealed she had been notified about Resident #1 getting ice out of the ice cooler herself. The DON said she had an in-service going around and dietary staff cleaned the coolers. She said normally CNAs passed out ice in the mornings and evenings, and ice coolers were not left near the dining room. During an interview on 03/26/2026 at 12:54 PM with CNA B, he indicated Resident #1 did get her own ice often residents were not supposed to get their own ice because of cross contamination. He said the risk was residents could get sick. During an interview on 03/26/2026 at 1:57 PM with the ADON revealed she had opened Resident #1's cup for Resident #1 and indicated she did not think that Resident #1 was going to get ice because Resident #1 did not always get ice (for her cup). She said the risk of residents getting their own ice was infection. She said staff strongly encouraged residents to ask for help, but Resident #1 would listen for about 15 minutes and then say she forgot, but staff would reeducate. During an interview on 03/26/2026 at 2:50 PM with the DON, she said she talked to staff and created a task in Resident #1's care plan for staff to check to see if Resident #1 needed ice when doing rounds every 2 hours. The DON said staff were to get ice for residents because staff did not know if Resident #1 had cleaned her hands, did not know if her cup was clean, and staff used a scoop (to prevent contamination). During an interview on 03/26/2026 at 3:30 PM with the ADM revealed staff were supposed to check in with residents during rounds to see if they needed ice. The ADM said she helped with getting ice for residents. The ADM said the ice coolers were cleaned and new ice was put (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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