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	06/25/2026

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to electronically submit to CMS complete and accurate direct care staffing information, including information, for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specification established by CMS for 1 of 4 FY quarters (FY Quarter 1 2026 (October 1 - December 31) reviewed for administration. The facility failed to submit staffing data to CMS for FY Quarter 1 2026 (October 1 - December 31). This failure could place residents at risk for personal needs not being identified and met, decreased quality of care, decline in health status, and decreased feelings of well-being within their living environment. Findings Included: Review of the CMS PBJ report for CMS for FY Quarter 1 2026 (October 1 - December 31) indicated the facility had failed to submit data for the quarter triggered. During an interview on 06/25/2026 at 11:50 AM, HR stated they have been HR for approximately 5 years. The hours they worked were provided to me via invoices. HR stated they communicated with each employee or the Department head in order to fill out a time adjustment form and submit the form to HR. Then entry was made into the workday system. At the end of the month verified the hours with the DON, ADMIN and verified if there were other adjustments to be made. The service center had access to the Workday program and pulled the hours for the PBJ. The MD, Dietician and Pharmacist, and then CNA (the receptionist) and marketer who worked the floor. Based off of invoices at the end of the month. It was entered into workday; which is the payroll tracking system. After being entered into the Workday system, the Home Office (service center pulls them over). At which point it was uploaded and submitted to CMS. During an interview on 06/25/2026 at 12:50 PM, the DON stated they had been DON at the facility for 4 years. DON stated they got the nursing hour reports from HR, they then verify hours were verified with HR entering the hours into Workday, which is our central hub for managing employee data and HR processes. It covers recruitment, onboarding, payroll, benefits administration, time tracking, and performance management, allowing organizations to handle the entire employee lifecycle efficiently in one platform. The Home Office (Service Center) pulled the hours from this entry and submitted them to CMS for PBJ. It appeared there was a glitch with the submission form from the Service Center which tripped the notification of not being submitted on time. DON stated the potential for the facility to be inadequately or inappropriately staffed, but should not monitoring staffing appropriately, and it can affect the residents negatively. When the facility was notified the DON stated it was added to our QAPI meeting to be reviewed quarterly, to ensure it was accurate to provide the SC the correct information in a timely manner. During an interview on 06/25/2026 at 12:34 PM, the ADMIN stated had had been the ADMIN for 6 months, because it was nursing hours it was usually the DON and HR working together to make sure the hours were correct and accurate. The ADMIN would pull a report to determine if there were any nursing hours that might be missing. This report covered LVNs, CNAs and med aides. Based off of invoices at the end of the month. It was entered into Workday; it was the facility's payroll tracking system. Facility staff entered into Workday, the Home Office (service center pulls them over). At which point it was uploaded and submitted to CMS. The ADMIN stated it would affect the facility's star rating and cause the facility to default to a 1 star for 4 quarters. The ADMIN said it (continued on next page)

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

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	would affect the facility's quality measures by causing the facility to lose stars. When asked how late or omitted PBJ submissions could affect the facility residents, the Administrator said it created the potential for the facility to be inadequately or inappropriately staffed, but should not if monitored staffing appropriately, and it could affect the residents negatively. The ADMIN stated, since that time, no staffing issues were reported. He stated the information was compiled and data submitted to the SC and they in turn submitted it to CMS. Record review of the Facility's Q4 PBJ submission internal investigation revealed. The PBJ data submitted to CMS 2/13/26 at approximately 4:30 PST by facility payroll Vendor.- At 12:26 am 2/14/26 CMS loaded the [NAME] report showed failed submission (Top right of [NAME] report)- Submitted PBJ data for 256 employees. 1 of those employees didn't match due to new software that went live 1/1/26. This caused submission failure. (see page 2 of the [NAME] report 4016/Fatal)- On 2/16/26 realized the report didn't submit and initiated internal root cause analysis while also enlisting Simple LTC to aid in research.- Root Cause Analysis PBJ submission in the correct format occurred prior to the deadline but was rejected due to a coding error attached to employee positions contained within the file. Facility payroll vendor system was upgraded in January and February of 2026, resulting in an unanticipated increased length of time for the Facility to review and validate data to be submitted and facility was not notified of this increased time requirement. The coding issue was not identified or recognized prior to the contracted service submission of the PBJ file. The contracted service did not discover the issue until the submission error occurred and extensive investigation identified the coding error several days past the submission deadline, preventing resubmission. Upgrades to payroll vendors and contracted service providers occurred too close and overlapping with data validation process of the PBJ reporting submission date preventing opportunity for the Facility to complete thorough review and validate submission.- After finding the root cause to be software change issues, on 2/23/26 an appeal was filed with CMS to try and resubmit data. Software issues are one of the few reasons they list for possible appeal.- 2/23/26 AHCA also contacted CMS on 's behalf.- 2/24/26 CMS denied the Appeal- Plan of Correction was created by the Facility leaders in conjunction with. (please see doc Process Improvement Plan: F851 - Payroll-Based Journal (PBJ) Staffing Data Submission)- Plan of Corrections run through QAPI in anticipation of May 15, Q1, deadline. Record review of the facility's Email correspondence with CMS, dated 02/24/26, revealed CMS Nursing Home Staffing RE: Appeal for late PBJ Submissions. Stated the following: Unfortunately, it is not possible to submit or correct PBJ data once a submission deadline has passed. There are no exceptions. To post staffing measures and ratings for all facilities on a set schedule, it is critical that the submission deadline is met. We calculate the measures for all ~15,600 facilities at once {not individual facility's measures one-by-one). We hope you can understand that to maintain a complex system that collects and processes millions of pieces of data effectively, we cannot easily deviate from set processes. Also, in order to maintain fairness and objectivity for all facilities, we need to hold all facilities accountable to the same standards {which have been public for quite some time). All providers should be running the staffing reports that are available in CASPER to check the accuracy and completeness of their final submissions before the submission deadline has passed. Providers are given 45 days from the end of the quarter, and we have cautioned providers that they should not be waiting until the last few days before the deadline to be making their final submissions as they must allow time to deal with any issues that may occur. Providers using a third-party vendor are still ultimately responsible for their PBJ submissions. This Appeal and Request for Reconsideration is being filed on behalf of 45 individual facilities, by their contracted service provider and authorized agent, performs certain administrative services for and on behalf of approximately 357 skilled nursing facilities, including but not limited to the processing and submission of PBJ data. This Request seeks approval for the 45 affected facilities to resubmit their PBJ data for the quarter ending December 31, 2025. It is based on the PBJ Technical Manual and related authority which expressly grants CMS the discretion to rescind, modify or otherwise respond to a submission failure resulting from unexpected (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	circumstances. Each of the 45 facilities that experienced a fatal error relative to their PBJ submission were impacted by the same technical data migration issue which prevented the submission from being successful. We have attached the following documentation in support of this request: 1. Separate appeal documents for each of the facilities with appropriate identifying information(e.g., name, CCN, etc.) as well as a detailed description of the issue and the basis for theappeal. (PBJ Appeal detaLI.s_.zip)2. CMS confirmation report letters for each of the affected facilities. (PBJ ConfirmationReports.zip). Record request from the ADMIN on 05/05/26 at 12:26 PM, for their PBJ policy, the ADMIN stated, We don't have a policy other than following CMS guidelines for PBJ reporting. Record review of the CMS, Electronic Staffing Data Submission Payroll-Based Journal, Long-Term Care Facility Policy Manual, Version 2.7, June 2025, section 1.2 Submission Timeliness and Accuracy, reflected Direct care staffing and census data will be collected quarterly, and is required to be timely and accurate. Further review revealed Report Quarter 1 date range as October 1-December 31. Policy manual reflected, Deadline: Submissions must be received by the end of the 45th calendar day (11:59 PM Eastern Time) after the last day in each fiscal quarter in order to be considered timely.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the resident's right to personal privacy during medical treatment and personal care for three of twenty residents (Residents #46, #70, and #81) reviewed for privacy. 1.The facility failed to ensure RN B pulled the privacy curtain or closed the door during Resident #46's blood sugar check on 06/24/2026. 2.The facility failed to ensure RN B pulled the privacy curtain or closed the door during Resident #70's blood sugar check on 06/24/2026. 3.The facility failed to ensure CNA F and CNA G closed pulled the privacy curtain during Resident #81's incontinent care on 06/23/2026. These failures could place the residents at risk of not having their personal privacy maintained while treatment and care were provided that could result to embarrassment.Findings included: 1.Record review of Resident #46's Face Sheet, dated 06/24/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus (high blood sugar). Record review of Resident #46's Comprehensive MDS (assessment used to determine functional capabilities and health needs) Assessment, dated 06/08/2026, reflected that the resident had moderate impairment (resident may need additional support and monitoring) in cognition with a BIMS (screening tool used to assess cognitive status) score of 09. The Comprehensive MDS Assessment indicated that the resident had diabetes mellitus and was receiving insulin. Record review of Resident #46's Comprehensive Care Plan, dated 06/11/2026, reflected that the resident had an alteration in endocrine (glands that produce hormones) status related to diabetes mellitus and one of the interventions was to administer diabetes medications as ordered. Record review of Resident #46's Physician Order, dated 06/16/2026, reflected Admelog SoloStar 100 UNIT/ML Solution pen-injector Inject as per sliding scale (a chart of insulin dosages): if 151 - 200 = 2 units FOR BS BELOW 60, PLEASE FOLLOW DIABETIC PROTOCOL ORDERS ; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units FOR BS GREATER THAN 400, GIVE 10 UNITS AND NOTIFY ON-CALL PROVIDER, subcutaneously (administer under the skin) before meals and at bedtime for DM2 Inject subcutaneously per sliding scale before meals and at bedtime (MAX 10 units PER DOSE). During an observation on 06/24/2026 at 7:19 a.m., RN B was about to check Resident #46's blood sugar. She sanitized her hands, put on a pair of gloves, went inside the resident's room, and proceeded with checking blood sugar. She did not close the door nor pull the privacy curtain while checking the resident's blood sugar, and the treatment could be seen from the hallway. 2.Record review of Resident #70's Face Sheet, dated 06/24/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus. Record review of Resident #70's Comprehensive MDS Assessment, dated 05/04/2026, reflected that the resident had moderate impairment in cognition with a BIMS score of 08. The Comprehensive MDS Assessment indicated that the resident had diabetes mellitus and was receiving insulin. Record review of Resident #70's Comprehensive Care Plan, dated 05/31/2026, reflected that the resident had an alteration in endocrine status related to diabetes mellitus and one of the interventions was to administer diabetes medications as ordered. Record review of Resident #70's Physician Order, dated 06/16/2026, reflected Insulin Aspart Injection Solution 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 150 - 200 = 2 units FOR BS BELOW 60, PLEASE FOLLOW DIABETIC PROTOCOL ORDERS; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units FOR BS GREATER THAN 400, GIVE 10 UNITS ANDNOTIFY ON-CALL PROVIDER, subcutaneously before meals and at bedtime for Diabetes. During an observation on 06/24/2026 at 7:44 a.m., RN B was about to check Resident #70's blood sugar. She sanitized her hands, put on a pair of gloves, went inside the resident's room, and proceeded with blood sugar check. She did not close the door nor pull the privacy curtain while checking the resident's blood sugar, and the treatment could be seen from the hallway. During an interview on 06/24/2026 at 11:21 a.m., RN B said the door should have been closed, or the privacy curtain should have been pulled when doing any treatment to (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provide privacy for the residents. She said it did not matter if the residents minded it or not, but the staff still needed to practice providing privacy, to prevent embarrassment of any sort. 3.Record review of Resident #81's Face Sheet, dated 06/24/2026, reflected a 74-year- old male admitted to the facility on [DATE]. The resident was diagnosed with hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body). Record review of Resident #81's Comprehensive MDS Assessment, dated 05/04/2026, reflected that the resident had severe impairment (resident required significant assistance and support in daily life) in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated that the resident was incontinent (unable to control) for bladder and bowel. Record review of Resident #81's Comprehensive Care Plan, dated 05/30/2026, reflected that the resident had bowel/bladder incontinence and one of the interventions was to provide incontinent care as required. During an observation on 06/23/2026 at 9:15 a.m., CNA F and CNA G were about to perform Resident #81's incontinent care. They washed their hands, put on a pair of gloves, and proceeded with incontinent care. They did not pull the privacy curtain between the resident and the resident's roommate. It was observed that the roommate was inside the room and the care being done could be seen from the roommate's side of the room. During an interview on 06/23/2026 at 9:38 a.m., CNA F said he forgot to pull the privacy curtain separating the Resident #81 from his roommate while he was performing incontinent care. He said the curtain was to provide privacy while he was changing Resident #81's brief. He said the roommate might see Resident #81's private area because the curtain was not pulled. During an interview on 06/23/2026 at 9:43 a.m., CNA G said she did not notice that CNA F did not pull the privacy curtain between Resident #81 and his roommate. She said she should have pulled the curtain because the resident's roommate was inside the room as well. She said the curtain was inside the room to provide privacy when care was being done. During an interview on 06/25/2926 at 6:28 a.m., the DON said the door should be closed, or the privacy curtain should be pulled every time the staff provided care or treatment to provide privacy and prevent embarrassment. She said other individuals, like non-clinical staff, visitors, and other residents should not see the care and treatments being done. She said closing the door and/or pulling the privacy curtain could make the residents more comfortable during treatment and care. She said the expectation was for the staff to provide privacy during every treatment and every care. She said she already started an in-service about providing privacy during treatment and care. During an interview on 06/25/2026 at 6:59 a.m., the Administrator said the staff must make sure that the residents were provided privacy when care and treatments were being done to prevent embarrassment. She said the expectation was for the staff to be mindful about privacy when providing care and treatment. She said she would collaborate with the DON to re-educate the staff about the importance of providing privacy. Record review of the facility's policy, Resident Rights Policy/Procedure - Nursing Administration, undated, reflected POLICY: It is the policy of this facility that all resident rights be followed . The Resident has the right . 29. To privacy.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide treatment and care in accordance with the comprehensive person-centered care plan and in accordance with professional standards of practice for three of four residents (Resident #39, #46, and #40) reviewed for quality of care. 1.The facility failed to ensure that CNA J would dry up Resident #39's bottom, who had MASD, on 06/23/2026. 2.The facility failed to ensure that Resident #46's kerlix dressings to both feet were changed, as ordered, when they were wet due to the resident's weeping edema on 06/23/2026. 3.The facility failed to ensure that Resident #40's non-pressure right shin wound was cleansed in accord with the facility's wound care policy on 06/24/26. These failures could place the residents at risk for worsening non-pressure injuries and could result in a decline in health. Findings included: 1.Record review of Resident #39's Face Sheet, dated 06/24/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with weakness and muscle wasting (loss of muscle leading to its shrinking and weakening). Record review of Resident #39's Comprehensive MDS Assessment, dated 04/11/2026, reflected that the resident was unable to complete the interview to determine the BIMS score. The staff assessment for mental status denoted that the resident had a memory problem. The Comprehensive MDS Assessment indicated that the resident had moisture associated skin damage. Record review of Resident #39's Comprehensive Care Plan, dated 06/02/2026, reflected that the resident had potential impairment to skin integrity and one of the interventions was to keep it clean and dry. Record review of Resident #39's Physician Order, dated 04/08/2026, reflected MASD (skin damage caused by prolonged exposure to moisture) - Cleanse and apply Calmoseptine (moisture barrier ointment) every shift and PRN soiling every shift for MASD until resolved. During an observation on 06/24/2026 at 1:31 p.m., CNA J was about to transfer Resident #39 from the gerichair (seating device designed for individuals with limited mobility) to her bed. It was observed that the resident's pants were halfway on her legs, that the resident did not have a brief on, and the gerichair did not have any clean towel or blanket to cover the seat of the gerichair. It was observed that the resident's bare perineal area (area between the legs) was touching the seat directly. After transferring the resident, it was observed that the seat of the gerichair was wet. It was also observed that the resident's bottom had scratches on it. During an interview on 06/24/2026 at 1:42 p.m., CNA J said she had just finished Resident #39's shower and she was about to transfer the resident to her bed. She said she would raise the resident's pants once she was transferred to her bed. When asked why the resident did not have any brief on or why the seat did not have any cover, CNA J did not answer. She said she saw scratch marks when she was showering the resident, and she would notify the nurse after she was done transferring the resident. When asked if the scratch marks touched the seat of the gerichair, she did not reply. She said she did not know if the seat of the gerichair was clean. During an interview on 06/24/2026 at 1:47 p.m., LVN D said Resident #39's bottom was sensitive due to MASD, and it should always be dried. Keeping the bottom wet could cause irritation of the skin. She said if the resident had scratch marks, the more that it should not be touching the seat with a bare bottom. She said she would talk to CNA J to educate her and assess the resident's bottom. During an interview on 06/24/2026 at 2:26 p.m., LVN D said Resident #39's bottom did not have an open wound but had abrasions, maybe due to the resident scratching her bottom. She said even though those were abrasions, they should still not be in direct contact with the seat of the gerichair. She said one of the causes of MASD was prolonged exposure to moisture and not drying the skin of the bottom immediately could lead to inflammation of the skin. 2.Record review of Resident #46's Face Sheet, dated 06/24/2026, reflected an 87-year- old male admitted to the facility on [DATE]. The resident was diagnosed with fluid overload (body retains more fluid than is needed) and unsteadiness of the feet. Record review of Resident #46's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Comprehensive MDS Assessment, dated 06/08/2026, reflected the resident had moderate impairment in cognition with a BIMS score of 09. The Comprehensive MDS Assessment indicated that the resident had edema (swelling caused by fluid trapped in the tissues of the body). Record review of Resident #46's Comprehensive Care Plan, dated 06/11/2026, reflected the resident had actual impairment to skin integrity r/t edema to BLE with weeping areas and one of the interventions was to cover with kerlix daily and PRN due to weeping legs. Record review of Resident #46's Physician Order, dated 06/13/2026, reflected Left foot: Cleanse area with wound cleanser, cover with xeroform, apply abd pad, kerlix and secure with tape to dressing not skin. Change daily and prn if leaking every day shift for weeping. Record review of Resident #46's Physician Order, dated 06/13/2026, reflected Right lower extremity: Cleanse area with wound cleanser, cover areas with xeroform apply abd pad, kerlix and secure with tape to dressing not skin. Change daily and prn if leaking everyday shift for weeping. During an observation on 06/23/2026 at 8:56 a.m., Resident #46 was sitting in his wheelchair in the hallway. It was observed that both his feet were wrapped in a wet, white dressing. During an interview on 06/23/2026 at 11:31 a.m., RN A said she had already changed Resident #46's dressings to both feet. She said the dressings were wet because the resident had weeping edema (fluid retention where excess fluid leaks through the skin). She said she did not know that the dressings were wet and for how long they had been wet. She said had she known, she could have changed it immediately. She said the resident had an order to change the kerlix as needed. She said the leakage was a sign of a skin breakdown and if the dressings were wet and saturated, it could impair healing and the fluid could further irritate the skin. During an interview on 06/25/2926 at 6:28 a.m., the DON said Resident #39 had MASD and her bottom should be kept dry to prevent any skin injury. She said she assessed the resident and did not see anything on her bottom. She said Resident #46's kerlix should have been changed promptly for the same reason. She said she had already started an in-service about wound care. During an interview on 06/25/2026 at 6:59 a.m., the Administrator said she was not a clinician, and she would let the DON take the lead about the issue. 3.Record review of Resident #40's face sheet dated 06/23/26 revealed a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: Type 2 Diabetes (high blood sugar levels) and Cellulitis of Right Lower Limb (a common bacterial infection of the deeper layers of your skin and the tissues just beneath it). Record review of Resident #40's MDS dated [DATE] revealed that the Resident had a BIMS score of 11 (moderate cognitive impairment) and at risk of pressure-ulcer. Record review of Resident #40's current physicians order revealed an order dated 05/21/26 for the right shin wound care: Cleanse wound with wound cleanser and pat dry. Apply thin layer of Iododorb to Calcium Alginate Sheet, then apply to open wound. Cover with dry dressing. Change daily and as needed for soilage or dislodgement. It also revealed an order date 06/17/26 for Peri-area and inner groin: cleanse area and apply calmoseptine / nystatin mixture three times a day and as needed due to MASD three times a day for MASD. Record review of Resident #40's care plan dated 03/20/26 revealed the resident had arterial/ischemic ulcers (poor circulation sores or blocked blood flow wounds) of the Right Shin, Right Anteromedial Shin (the front-inside part of your lower leg, running along your shinbone) related to History of ulcers, Peripheral Arterial Disease (poor circulation in the legs), Vascular insufficiency (poor blood circulation). With goal of: Will be free from infection or complications related to arterial ulcer through review date and intervention to Treat wound per order. Use non-occlusive wound dressings. Record review of Resident #40's progress note dated 06/18/26 revealed the resident has MASD due to Incontinence Associated Dermatitis. Wound care observation and interview on 06/24/26 at 10:25 a.m. to 10:50 a.m., revealed RN S failed to use proper wound cleaning procedures when cleaning Resident #40's right shin wound, she cleansed the inside of the wound after cleaning the surrounding skin with the same gauze. When asked about the wound care procedure the facility directs, she stated that the proper wound cleaning procedure is to clean from the inside of the wound to the outside of the wound, going from least contaminated area to the most contaminated area. She stated that not following the proper wound cleaning technic could cause (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	delayed wound healing and even sepsis if the wound becomes infected. During an interview on 06/25/26 at 11:49 a.m. with the DON, she stated that it is the policy and procedure for wound care to go from the center, least dirty area to the periphery of the wound which is the most contaminated area. She stated that it is necessary to go from the inside to outside to keep a healthy wound bed and promote wound healing. Record review of the facility's policy Skin and Wound Monitoring and Management Policy & Procedure revised April 2024 reflected Policy: It is the policy of this facility that . 2. A resident having pressure injury(s) receives necessary treatment and services to . prevent infection. Record Review of the facility's undated Policy and Procedure for Wound Care revealed: Cleanse wound with the solution ordered. Use no-touch technique. Do not directly touch any item that will come in contact with the wound. Wash from the center of the wound to the periphery. Always wash from the area of least contamination to the area of most contamination Policy for MASD requested on 06/24/20206 at 2:07 p.m. but was not provided prior to exit.

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	06/25/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for three of six residents (Resident #69, Resident #40 and Resident # 38) reviewed for medication administration. The facility failed to ensure MA D did not give Resident #69's 6:30 a.m. medications at 7:56 a.m. on 06/24/2026. The facility failed to ensure MA D did not give Resident #40's 6:30 a.m. medications at 8:04 a.m. on 06/24/2026. The facility failed to ensure MA D did not give Resident #38's 6:30 a.m. medications at 8:12 a.m. on 06/24/2026. These failures could place residents at risk of not receiving the full therapeutic benefits of the medications and not receiving medications as ordered and could result in adverse effects. Findings include: 1. Record review of Resident #69's face sheet, dated 06/24/26, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with dementia (a condition characterized by loss of memory and ability to reason) and Type 2 Diabetes with hyperglycemia (adult-onset diabetes with consistently high blood sugar). Record review of Resident #69's quarterly MDS Assessment, dated 05/22/26, revealed the resident had a severe impairment with cognition with a BIMS score of 06. The resident was diagnosed with Diabetes mellitus and Dementia. Record review of Resident #69's Physician Order, dated 05/28/25, revealed an order for Metformin HCL Oral Tablet 500 MG 9Metformin HCL), give one tablet by mouth two times a day for DM. The medication was scheduled to be administered at 6:30 a.m. and 4:30 p.m. Record review of Resident #69's Comprehensive Care Plan, dated 06/22/25, revealed the resident had potential for altered endocrine status r/t Diabetes Mellitus with intervention: Diabetes medication as ordered by the doctor. Monitor/document for side effects and effectiveness. During an observation and interview on 06/24/26 at 7:56 a.m., revealed MA C was passing medications in hall 200, it was also observed the resident's eMAR was red. Resident #69 was observed in her room eating breakfast. When asked when the medication was supposed to be administered, MA C stated it was scheduled for 6:30 a.m. He stated the residents woke up early and left her room to the foyer. He attempted to administer the medication at the time using the Korean language line to explain the importance of taking the medication to the resident, however, the resident refused. MA C notified the RN C who notified the physician. 2. Record review of Resident #40's face sheet, dated 06/23/26, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #40 had diagnoses which included: Type 2 Diabetes (high blood sugar levels), Cellulitis of Right Lower Limb (a common bacterial infection of the deeper layers of your skin and the tissues just beneath it) and Dysphagia, oropharyngeal phase (trouble starting a swallow). Record review of Resident #40's quarterly MDS, dated [DATE], revealed the Resident had a BIMS score of 11 (moderate cognitive impairment). Resident #40 was at risk for pressure-ulcer. Record review of Resident #40's current physicians order revealed an order, dated 10/15/25, for Protonix Tablet Delayed Release 40 MG (Pantoprazole Sodium), Give 1 tablet by mouth in the morning for Heartburn ; indigestion. The medication was scheduled to be given at 6:30 a.m. During an observation and interview on 06/24/26 at 8:12 a.m. revealed MA C was passing medications in hall 200, it was also observed that the resident's eMAR was red. Resident #40 was observed in her room sleeping with her breakfast tray untouched. When asked when the medication was supposed to be administered, MA C stated it was scheduled for 6:30 a.m. Resident #40 stated she could take the medication now, MA C proceeded to administer the medication to Resident #40. 3. Record review of Resident #38's face sheet, dated 06/24/26, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #38 had diagnoses which included: Gastro-esophageal Reflux Disease - GERD (acid reflux or heartburn) and Dysphagia, oropharyngeal phase (trouble starting a swallow). Record review of Resident #38's quarterly MDS, (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated [DATE], revealed the resident had a BIMS score of 04 (Severe cognitive impairment). Resident #38 had a diagnosis to include Gastro-esophageal Reflux Disease. Record review of Resident #38's current physicians order revealed an order, dated 10/15/25, revealed an order for Omeprazole 20 MG Capsule delayed release, Give 1 tablet by mouth in the morning for GERD, do not crush. The medication was scheduled to be given at 6:30 a.m. During an observation and interview on 06/24/26 at 8:34 a.m. revealed MA C was passing medications in hall 200, it was also observed the resident's eMAR was red. Resident #38 was observed in her room lying in bed resting. When asked when the medication was supposed to be administered, MA C stated it was scheduled for 6:30 a.m. MA C proceeded to administer the medication to Resident #38. During an interview on 06/25/26 at 9:47 a.m. with MA C, he stated the facility policy was that medications should be given within an hour before or after window of the scheduled time. He stated the doctors' orders should be followed, he stated an example was medications that had to be given before meals, with meals or after meals. He stated giving the medications on time would prevent the drug to drug interaction and provide the best therapeutic effects to the resident. During an interview on 06/25/26 at 10:12 a.m. with RN C, she stated when a medication was late the MA must notify the nurse. If the medication was late the nurse notified the DON and MD and the MD would determine if the medication should still be administered or not. She stated if the medication was given late, it was a medication error. She stated if there was a blood pressure pill due and it's late, the blood pressure could remain high and if a Diabetic medication was not given on time, the resident could experience an increase in sugar levels. She stated the resident blood sugar can could drop and possibly have a fall if the blood sugar was lower than the threshold. During an interview on 06/25/26 at 11:49 a.m. with the DON, she stated for medication passes, the medication should be given within the correct time frame, she stated the time frame for medication should be an hour before or after. She stated the MA should notify the nurse and DON to call the doctor to get an order of what he wanted them to do. She stated it depended on their disease process and the medications should be on time to have the full effects. She stated it could result in side effects depending on the disease process and the medication given or not given. Record review of the facility's, undated, policy and procedure policy Number 7C for Medication Administration revealed the following It is the policy of this Facility, medication shall be administered as prescribed by the resident's physician, nurse practitioner, or physician's assistant. Medications must be given in accordance with the resident's service plan.Medications must be administered in accordance with the written orders of the attending physician. Should a drug be withheld, refused, or given other than at the scheduled time, the staff administering must indicate the reason on the MAR. For those utilizing eMARs, the appropriate code must be entered with any follow up documentation as appropriate for the situation. Twelve (6) residents were observed during medication pass.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record reviews the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 11.11%, based on 3 errors out of 27 opportunities, which involved three of six residents (Resident #69, Resident #40, and Resident #38) and one of one staff (MA D) reviewed for medication errors. The facility failed to ensure MA D did not give Resident #69's 6:30 a.m. medications at 7:56 a.m. on 06/24/2026. The facility failed to ensure MA D did not give Resident #40's 6:30 a.m. medications at 8:04 a.m. on 06/24/2026. The facility failed to ensure MA D did not give Resident #38's 6:30 a.m. medications at 8:12 a.m. on 06/24/2026. These failures could place residents at risk for treatment failure, disease progression, reduced effectiveness, and adverse reactions. Findings include: 1. Record review of Resident #69's face sheet, dated 06/24/26, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with dementia (a condition characterized by loss of memory and ability to reason) and Type 2 Diabetes with hyperglycemia (adult-onset diabetes with consistently high blood sugar). Record review of Resident #69's Comprehensive MDS Assessment, dated 05/22/26, revealed the resident had a severe impairment with cognition with a BIMS score of 06. The Comprehensive MDS Assessment indicated the resident was diagnosed with Diabetes mellitus and Dementia. Record review of Resident #69's Physician Order, dated 05/28/25, revealed an order for Metformin HCL Oral Tablet 500 MG 9Metformin HCL), give one tablet by mouth two times a day for DM. The medication was scheduled to be administered at 6:30 a.m. and 4:30 p.m. Record review of Resident #69's Comprehensive Care Plan, dated 06/22/25, revealed the resident had potential for altered endocrine status r/t Diabetes Mellitus with intervention: Diabetes medication as ordered by the doctor. Monitor/document for side effects and effectiveness. During an observation and interview on 06/24/26 at 7:56 a.m., revealed MA C was passing medications in hall 200, it was also observed the resident's eMAR was red. Resident #69 was observed in her room eating breakfast. When asked when the medication was supposed to be administered, MA C stated it was scheduled for 6:30 a.m. He stated the Residents woke up early and left her room to the foyer. He attempted to administer the medication at the time using the language line to explain the importance of taking the medication to the resident, however, the resident refused. MA C notified RN C who notified the physician. 2. Record review of Resident #40's face sheet, dated 06/23/26, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #40 had diagnoses which included: Type 2 Diabetes (high blood sugar levels), Cellulitis of Right Lower Limb (a common bacterial infection of the deeper layers of your skin and the tissues just beneath it) and Dysphagia, oropharyngeal phase (trouble starting a swallow). Record review of Resident #40's current physicians order revealed an order, dated 10/15/25, revealed an order for Protonix Tablet Delayed Release 40 MG (Pantoprazole Sodium), Give 1 tablet by mouth in the morning for Heartburn; indigestion. The medication was scheduled to be given at 6:30 a.m. Record review of Resident #40's quarterly MDS, dated [DATE], revealed the Resident had a BIMS score of 11 (moderate cognitive impairment). Resident #40 was at risk for pressure-ulcer. During an observation and interview on 06/24/26 at 8:12 a.m. revealed MA C was passing medications in hall 200, it was also observed the resident's eMAR was red. Resident #40 was observed in her room sleeping with her breakfast tray untouched. When asked when the medication was supposed to be administered, MA C stated it was scheduled for 6:30 a.m. Resident #40 stated she could take the medication now, MA C proceeded to administer the medication to the Resident #40. 3 Record review of Resident #38's face sheet, dated 06/24/26, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #38 had diagnoses which included: Gastro-esophageal Reflux Disease - GERD (acid reflux or heartburn) and Dysphagia, oropharyngeal phase (trouble starting a swallow). Record review of Resident #38's current physicians order revealed an order, dated 10/15/25, revealed an order for Omeprazole 20 MG Capsule delayed release, Give 1 (continued on next page)

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Carrollton Health and Rehabilitation Center	1618 Kirby Rd Carrollton, TX 75006

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tablet by mouth in the morning for GERD, do not crush. The medication was scheduled to be given at 6:30 a.m. Record review of Resident #38'squarterly MDS, dated [DATE], revealed the resident had a BIMS score of 04 (Severe cognitive impairment). Resident #38 was diagnosed with Gastro-esophageal Reflux Disease. During an observation and interview on 06/24/26 at 8:34 a.m. revealed MA C was passing medications in hall 200, it was also observed the resident's eMAR was red. Resident #38 was observed in her room lying in bed resting. When asked when the medication was supposed to be administered, MA C stated it was scheduled for 6:30 a.m. MA C proceeded to administer the medication to Resident #38. During an interview on 06/25/26 at 9:47 a.m. with MA C, he stated the facility policy was medications should be given within an hour before or after window of the scheduled time. He stated the doctors' orders should be followed, he stated an example was medications that had to be given before meals, with meals or after meals. He stated giving the medications on time would prevent drug to drug interaction and provide the best therapeutic effects to the resident. He stated the facility expected he should let the nurse know if the medication was late, if to give the medication or not. He stated giving the medication past the time could affect the resident due to possible medication interactions. During an interview on 06/25/26 at 10:12 a.m. with RN C, she stated when a medication was late the MA must notify the nurse. If the medication was late the nurse notified the DON and MD and the MD would determine if the medication should still be administered or not. She stated if the medication was given late, it was a medication error. She stated if there was a blood pressure pill due and it's late, the blood pressure could remain high and if a Diabetic medication was not given on time, the resident could experience an increase in sugar levels. She stated the resident could bottom out and possibly have a fall if the blood sugar was lower than the threshold. During an interview on 06/25/26 at 11:49 a.m. with the DON, she stated for medication passes, the medication should be given within the correct time frame, she stated the time frame for medication should be an hour before or after. She stated the MA should notify the nurse and DON to call the doctor to get an order of what he wanted them to do. She stated it depended on their disease process the medications should be on time to have the full effects. She stated it could result in side effects depending on the disease process and the medication given or not given. Record review of the facility's, undated, policy and procedure policy Number 7C for Medication Administration revealed the following It is the policy of this Facility, medication shall be administered as prescribed by the resident's physician, nurse practitioner, or physician's assistant. Medications must be given in accordance with the resident's service plan.Medications must be administered in accordance with the written orders of the attending physician.Should a drug be withheld, refused, or given other than at the scheduled time, the staff administering must indicate the reason on the MAR. For those utilizing eMARs, the appropriate code must be entered with any follow up documentation as appropriate for the situation.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for three of eighteen residents (Residents #9, #29, and #40) reviewed for medication storage. 1.The facility failed to ensure Resident #29's zinc oxide was not on top of the resident's side table on 06/23/2026. 2.The facility failed to ensure Resident #9 did not have a Vicks Vapor Stick on her bedside table on 06/23/26 3.The facility failed to ensure Resident # 40 did not have peri-guard wipes and a container of calmoseptine / nystatin mixture on her bedside table on 06/23/26. These failures could place residents at risk of misuse of medications and possible adverse reactions. Findings included: 1. Record review of Resident #29's Face Sheet, dated 06/24/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with urinary tract infection (infection involving the organs that produce urine). Record review of Resident #29's Comprehensive MDS Assessment, dated 06/11/2026, reflected the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident was incontinent for bladder and bowel. Record review of Resident #29's Comprehensive Care Plan, dated 06/23/2026, reflected the resident was incontinent for bladder and bowel and one of the interventions was to provide incontinent care. The plan did not indicate that the resident could store medications inside her room. Record review on 06/24/2026 of Resident #29's Clinical Assessment List reflected the resident had no assessment for self-administration of medications, an assessment that the resident was competent to apply the barrier cream, or an assessment that the resident could store medications inside her room. During an observation and interview on 06/23/2026 at 9:05 a.m., Resident #29 was in her bed, awake. It was observed a tube of zinc oxide (medicated cream used to prevent skin irritation) was on top of the resident's side table and was in plain view. The resident said the staff would use it when they changed her brief. The resident said the barrier cream had always been in her bedside. During an interview on 06/23/2026 at 11:31 a.m., RN A said she did not notice Resident #29 had a tube of zinc oxide when checked on the resident. She said zinc oxide should not be inside the residents' room because confused residents might accidentally consume it, thinking that the cream was something edible. She said most of the residents already had poor eyesight and might mistakenly use the cream as toothpaste. She said she did not know who left the zinc oxide inside the room of the resident. She said she would talk to the resident regarding the zinc oxide. During an interview on 06/25/2926 at 6:28 a.m., the DON said the zinc oxide should not be within reach of the residents because residents might use them inappropriately and could result in adverse reactions. She said zinc oxide was applied topically and could be harmful when ingested. She said the expectation was for the staff not to leave the zinc oxide accessible to the residents. She said she already started an in-service about medication storage. During an interview on 06/25/2026 at 6:59 a.m., the Administrator said the expectation was for the staff to make sure there were no tubes of zinc oxide inside the rooms of the residents because residents might use them incorrectly like consuming them. She said the facility had a population that would go inside the rooms of other residents and might be able to grab the zinc oxides. She said she would coordinate with the DON about the issue. 2. Record review of Resident #9's face sheet, dated 06/24/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with Type 2 Diabetes (high blood sugar in the blood), chronic kidney disease stage 5 (kidney failure or end-stage kidney disease) and Need for assistance with (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	personal care. Record review of Resident #9's Comprehensive MDS Assessment, dated 04/26/26, reflected the resident was cognitively intact with a BIMS score of 15. The resident was dependent for ADLs. Record review of Resident #9's Comprehensive Care Plan, dated 02/04/26, reflected the resident had an ADL self-care performance deficit, Encourage to participate to the fullest extent possible with each interaction. It reflected the care plan for Self-administration of medication, with intervention to: Evaluate resident could appropriately follow directions and tell time to know when the medication needed to be taken and evaluated the residents ability to ensure the medication was stored safely and securely. Record review of Resident #5's current physician order for June 2026 did not reflect an order for Vicks Vapor Stick. Record review on 06/24/2026 of Resident #9's Clinical Assessment List reflected the resident had no assessment for self-administration of medications, an assessment that the resident was competent to apply the barrier cream, or an assessment that the resident could store medications inside her room. During an observation and interview on 06/23/26 at 10:15 a.m., Resident #9 was lying in bed inside her room. It was observed there was a bottle of Vicks Vapor Stick on top of the resident's overbed table. She stated she used it to clear her sinuses; she stated the nurses knew she used it and had not told her she was not allowed to keep it. 3. Record review of Resident #40's face sheet, dated 06/23/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #40 had diagnoses which included: Type 2 Diabetes (high blood sugar levels), Cellulitis of Right Lower Limb (a common bacterial infection of the deeper layers of your skin and the tissues just beneath it). Record review of Resident #40's Comprehensive MDS Assessment, dated 05/28/26, reflected the resident had a BIMS score of 11 (moderate cognitive impairment). Resident #40 was at risk for pressure-ulcer. Record review of Resident #40's current physicians order reflected an order, dated 06/17/26, for Peri-area and inner groin: cleanse area and apply calmoseptine / nystatin mixture three times a day and as needed due to MASD three times a day for MASD. Record review of Resident #40's care plan, dated 10/05/25, reflected the resident was at risk for impaired cognitive function/dementia (a condition characterized by loss of memory and ability to reason)or impaired thought processes r/t psychoactive medication use. During an observation and interview on 06/23/26 at 10:20 a.m. with Resident #40, revealed she was in bed awake, a sachet of peri-guard wipe and a tub which contained a pink paste was noted on her bed side table. She stated the staff used it when she performed peri-care on her. She stated the items were left on the bedside table after she was cleaned. During an interview on 06/23/26 at 10:25 a.m. with LVN S, she stated the items, Peri Guard and Vicks, should not be in the resident rooms per the facility policy. She stated the nurse and all care staff were responsible for making sure these items were not in the resident's room. She stated confused residents who wandered could get a hold of them and swallow them causing them to be sick since those items could contain toxins and alcohol the resident could react to. During an interview on 06/23/26 at 10:30 a.m. with MA C, he stated he was not sure of what the facility policy was, but Peri Guard and Vicks should not be in the resident's possession for safety reasons. He stated he should tell the nurse if he noticed those items in the residents' rooms. He stated the items could harm residents who were confused and cause them to be hospitalized if swallowed. During an interview on 06/23/26 at 10:34 a.m. with CNA R, she stated the Peri Guard, Vicks and Sani wipes should not be in the residents' rooms. She stated every staff member was responsible for making sure those items were not in the residents' room. She stated it would endanger residents who were confused, they could have an allergic reaction to the items and cause serious harm to themselves or others During an interview on 06/25/26 at 11:49 a.m. with the DON, she stated the residents were not supposed to have any unauthorized items in their rooms, unless they were carefully assessed and care planned to self-administer medications. She stated they started and Inservice right away with the staff. She stated for safety reasons and for residents' who wandered, it could cause harm if they got a hold of those items. She stated they could swallow and cause harm to themselves if they got a hold of them. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy Medication Administration Policy/Procedure – Nursing Clinical, revised May 2025, reflected POLICY: It is the policy of this Facility, medication shall be administered as prescribed by the resident's physician, nurse practitioner, or physician's assistant . procedure . 1. Only licensed medical and nursing personnel or other lawfully authorized staff members may prepare, administer, and record medication administration. Record review of the facility's policy titled, Medication Storage in the Facility P & P, dated March 2025 reflected, Policy: Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations . 2. Only licensed nurses, the Consultant Pharmacist, and those lawfully authorized to administer medications. Record review of the facility's, undated, policy, Residents' Rights Safety, Resident, reflected the following; Avoid Leaving in the Resident's room any medication or equipment that might cause harm. Ensure all medications, chemicals, cleaning supplies and any potential hazardous materials are kept locked / secure when staff has completed their use and is no longer in attendance. Conduct a room search should there be concern that prohibited /unsafe items are being stored in the room.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's kitchen reviewed for food and nutrition services. The facility failed to ensure all food items in the facility's kitchen were dated, discarded prior to their use-by date and were properly sealed. This failure could place residents at risk of food contamination and food-borne illness. Findings include: During an observation on 06/23/26 between 9:10 A.M. and 9:45 A.M. in the facility's kitchen revealed: One gallon bag which contained pasta egg noodles were dated 06/12/2026 had no visible expiration date. One gallon bag which contained spaghetti noodles was dated 05/11/2026 had no visible expiration date. One gallon bag which contained white cake mix was dated 05/12/2026 had no visible expiration date. One gallon bag which contained sliced cheese was dated 06/21/2026 had no visible expiration date. One gallon bag which contained shredded cheese was dated 06/21/2026 had no visible expiration date. One gallon plastic jug which contained purred fruit was dated 06/18/2026 had no visible expiration date. One gallon bag which contained shredded carrots had a brownish spots. During an interview on 06/25/2026 at 1:36 PM, DM stated all staff were responsible for labeling. DM stated the items would be corrected. It could make residents sick and could get a food borne illness. DM stated he and the kitchen aides were responsible for labeling and making sure the items were labeled properly. DM stated the risk of serving foods that were past the use-by date, or serving food that was not labeled or dated could cause food borne illness. DM stated the risk to residents if the policy was not followed was a health risk to the residents. DM stated the items should be labeled, and the risk of the concerns not being addressed could result in food-borne illnesses. DM stated if food items were not dated when opened, then they would not know how long the item would last. DM stated once items were opened, they should be properly sealed and dated. DM stated she encouraged staff to use it or throw it away, there was no reason to keep a small portion if the facility didn't need to keep it. During an interview on 06/25/2026 at 12:45 PM, ADMIN stated she oversaw all departments, and ensured residents were taken care of. ADMIN stated the DM made her aware of the concerns observed in the kitchen. ADMIN stated if items were expired, the risk of serving foods that were past the use-by date, or serving food that was not labeled or dated could cause food borne illness. ADMIN stated the issues could cause food contamination. The ADMIN stated the risk of all those concerns observed in the kitchen could result in residents getting sick. ADMIN stated she would expect the DM to ensure the kitchen followed all guidelines, which included ensuring the food items were labeled properly in the kitchen. She said the risk to residents if the policy was not followed, was they could get sick from food borne illnesses. The ADMIN stated she expected staff to ensure they were following policies and procedures of the facility kitchen policy, to protect residents and to deliver good care. Record review of the facility's Food Storage Policy, Food and Nutrition Services, revised 01/2022, reflected Policy It is the policy of this facility that food storage areas shall be maintained in a clean, safe, and sanitary manner. Procedure 1. Food storage areas shall be clean at all times. 3. All foods shall be labeled and dated prior to being stored. Review of TITLE 21--FOOD AND DRUGS CHAPTER I--FOOD AND DRUG ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICESSUBCHAPTER B - FOOD FOR HUMAN CONSUMPTION PART 110 -- CURRENT GOOD MANUFACTURING PRACTICE IN MANUFACTURING, PACKING, OR HOLDING HUMAN FOOD.

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	06/25/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **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 six of eighteen residents (Residents #39, #40, #46, #50, #70 and #81) and for six of ten direct care staff (LVN E, CNA F, CNA G, CNA H, CNA I, and CNA J) reviewed for infection control. 1.The facility failed to ensure CNA J would not assist Resident #39 and Resident #50 at the same time during lunchtime on 06/23/2026. 2.The facility failed to ensure CNA J did not place Resident #39 in her geri-chair without any brief on, with the perineal area touching the seat of the geri-chair directly, after a shower on 06/23/2026. 3.The facility failed to ensure Resident #46's kerlix dressings were not touching the floor on 06/23/2026. 4.The facility failed to ensure CNA H wore a gown when she emptied Resident #70's catheter bag on 06/24/2026. 5.The facility failed to ensure CNA H and CNA I wore gowns when they transferred Resident #70 to her wheelchair on 06/24/2026. 6.The facility failed to ensure CNA F performed hand hygiene and wore a gown during Resident #81's incontinent care, when he repositioned the resident, and when he changed the resident's clothes on 06/23/2026. 7.The facility failed to ensure CNA F and CNA G wore gowns when Resident #81 was transferred to his wheelchair on 06/23/2026. 8.The facility failed to ensure CNA G wore a gown when she stripped Resident #81's beddings on 06/23/2026. 9.The facility failed to ensure LVN E would not place her lunch bag inside the medication room's refrigerator on 06/24/2026. 10.The facility failed to ensure RN S sanitized her hands after removing dirty gloves and before putting on clean gloves while providing wound care for Resident #40 on 06/24/2026. These failures could place residents at risk of cross-contamination and development of infections. Findings included: 1.Record review of Resident #39's face sheet, dated 06/24/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with weakness and muscle wasting. Record review of Resident #39's Comprehensive MDS Assessment, dated 04/11/2026, reflected the resident was unable to complete the interview to determine the BIMS score. The staff assessment for mental status denoted the resident had a memory problem. The resident was dependent on staff for eating. Record review of Resident #39's Comprehensive Care Plan, dated 06/02/2026, reflected the resident had an ADL self-care performance deficit and one of the interventions was to spoon feed with meals. Record review of Resident #50's face sheet, dated 06/24/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with weakness and physical debility (weakness). Record review of Resident #50's Comprehensive MDS Assessment, dated 04/13/2026, reflected the resident was unable to complete the interview to determine the BIMS score. The staff assessment for mental status denoted the resident had a memory problem. The resident needed assistance during meals. Record review of Resident #50's Comprehensive Care Plan, dated 06/10/2026, reflected the resident had an ADL self-care performance deficit and one of the interventions was to assist with meals. During an observation on 06/23/2026 at 12:16 p.m., CNA J was sitting between Resident #39 and Resident #50, assisting both residents with lunch at the same time. She first assisted Resident #39 by taking her spoon with her right hand and gave Resident #39 a spoonful of food. She then turned towards Resident #50, picked up her spoon with her right hand, and gave Resident #50's a spoonful of food. CNA J continued to feed the residents with alternating assistance without sanitizing her hands between the residents. During an observation and interview on 06/23/2026 at 12:25 p.m., LVN D said CNA J should not assist two residents at the same time because it could result in cross contamination. LVN D approached CNA J and talked to CNA J. It was observed after LVN D spoke with CNA J, CNA J went on to assist Resident #50 only. During an interview on 06/23/2026 at 1:42 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p.m., CNA J said she was supposed to assist one resident only during feeding for infection control. She said she usually assisted only one resident during mealtime and she did not know why she started assisting two residents at the same time. 2.Record review of Resident #39's face sheet, dated 06/24/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with weakness. Record review of Resident #39's Comprehensive MDS Assessment, dated 04/11/2026, reflected the resident was unable to complete the interview to determine the BIMS score. The staff assessment for mental status denoted the resident had a memory problem. The Comprehensive MDS Assessment indicated the resident was dependent on staff for shower and transfer. Record review of Resident #39's Comprehensive Care Plan, dated 06/02/2026, reflected the resident had an ADL self-care performance deficit and one of the interventions was to assist with bathing and transfer. During an observation on 06/24/2026 at 1:31 p.m., CNA J was about to transfer Resident #39 from the geri-chair to her bed. It was observed the resident's pants was halfway on her legs, the resident did not have a brief on, and the geri-chair did not have any clean towel or blanket to cover the seat. It was observed the resident's bare perineal area touched the seat directly. During an interview on 06/24/2026 at 1:42 p.m., CNA J said she had just finished Resident #39's shower and she was about to transfer the resident to her bed. She said she would raise the resident's pants once she was transferred to her bed. When asked why the resident did not have any brief on or why the seat did not have any cover, CNA J did not answer. She said the risk of the resident's perineal area directly touching the seat of the geri-chair could be cross contamination that could lead to infection. She said she did not know if the seat of the geri-chair was clean. During an interview on 06/24/2026 at 1:47 p.m., LVN D said there should be a clean barrier between Resident #39 and the seat of the geri-chair, either a brief or a clean towel because the seat could be dirty. She said putting the resident directly to the seat, with her bare perineal area touching the seat, could cause infection. She said she would talk to CNA J to educate her. 3.Record review of Resident #46's face sheet, dated 06/24/2026, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with fluid overload. Record review of Resident #46's Comprehensive MDS Assessment, dated 06/08/2026, reflected the resident had moderate impairment in cognition with a BIMS score of 09. The Comprehensive MDS Assessment indicated the resident had an edema. Record review of Resident #46's Comprehensive Care Plan, dated 06/11/2026, reflected the resident had actual impairment to skin integrity r/t edema to BLE with weeping areas and one of the interventions was to cover with kerlix daily and PRN due to weeping legs. Record review of Resident #46's Physician Order, dated 06/13/2026, reflected Left foot: Cleanse area with wound cleanser, cover with xeroform, apply abd pad, kerlix and secure with tape to dressing not skin. Change daily and prn if leaking every day shift for weeping. Record review of Resident #46's Physician Order, dated 06/13/2026, reflected Right lower extremity: Cleanse area with wound cleanser, cover areas with xeroform apply ABD pad, kerlix and secure with tape to dressing not skin. Change daily and PRN if leaking every day shift for weeping. During an observation on 06/23/2026 at 8:56 a.m., Resident #46 was sitting in his wheelchair in the hallway. It was observed both his feet were wrapped in a wet, white dressing. Both of the resident's feet were on the floor, thus the dressings on both feet were touching the floor. During an interview on 06/23/2026 at 11:31 a.m., RN A said she had already changed Resident #46's dressings to both feet. She said she was not aware the resident's dressings to both feet were touching the floor. She said the dressing should not be touching the floor because kerlix dressings were permeable and could absorb dirt and fluid from the floor. She said if the kerlix dressings were wet, the more dirt from the floor could be attached to them and could eventually enter into the breaks in the skin to both feet, which could lead to infection. 4. Record review of Resident #70's face sheet, dated 06/24/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with neuromuscular dysfunction. Record review of Resident #70's Comprehensive MDS Assessment, dated 05/04/2026, reflected the resident had moderate impairment in cognition with a BIMS score of 08. The resident had (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an indwelling catheter. Record review of Resident #70's Comprehensive Care Plan, dated 05/31/2026, reflected the resident had a suprapubic catheter and one of the interventions was to position the catheter bag and the tubing below the bladder. During an observation on interview on 06/23/2026 at 9:13 a.m., Resident #70 was in her bed, awake. It was observed that the resident had a catheter bag hanging at the side of the bed. The resident said she had a catheter because her bladder was not working. During an observation on 06/24/2026 at 10:29 a.m., CNA H emptied Resident #70's catheter bag without wearing a gown. It was observed that there was a sign on the resident's door that specified a gown was required for catheter care and folded gowns were hanging on the door of the bathroom. 5.During an observation on 06/24/2026 at 10:34 a.m., CNA H and CNA I were about to transfer Resident #70 to her motorized wheelchair via Hoyer lift. Both CNAs hooked the Hoyer sling to the Hoyer lift and prepared to lift the resident. It was observed when they were hooking the Hoyer sling, both CNAs were leaning on the resident's bed, with CNA I directly leaning on the catheter bag. After hooking the Hoyer sling, they transferred the resident. Both CNAs did not have a gown. It was observed there was a sign on the resident's door that specified a gown was required when transferring a resident with a catheter and folded gowns were hanging on the bathroom's door. During an interview on 06/24/2026 at 10:43 a.m., CNA I said he should have worn a gown when they transferred Resident #70 because she had a catheter. He said the gown was to protect the residents from any contaminants the staff could transfer that could eventually lead to infections. During an interview on 06/24/2026 at 10:54 a.m., CNA H said she forgot to wear a gown when she emptied Resident #70's catheter bag and when they transferred her because she was in a hurry. She said the gown was used in addition to the gloves to prevent cross contamination between the staff and the residents. She said gowns were required for residents with indwelling devices like the catheter. 6.Record review of Resident #81's face sheet, dated 06/24/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing). Record review of Resident #81's Comprehensive MDS Assessment, dated 05/04/2026, reflected the resident had severe impairment in cognition with a BIMS score of 00 The resident had a feeding tube. Record review of Resident #81's Comprehensive Care Plan, dated 05/30/2026, reflected the resident required tube feeding and one of the interventions was to use enhanced barrier precautions. Record review of Resident #81's Physician Order, dated 01/10/2026, reflected Enhanced Barrier Precautions (infection control strategy to reduce the spread of resistant organisms): PPE required for high resident contact care activities. Indication: Indwelling Medical Device (a device or tube left inside the body for a period to provide treatment) every shift for monitoring. During an observation on 06/23/2026 at 9:15 a.m., CNA F was about to perform Resident #81's incontinent care, who had a g-tube. He went inside the room, washed his hands, put on a pair of gloves, but did not put on a gown. He pulled the resident's pants down, unfastened the soiled brief, tucked it between the resident's legs, and started to clean the perineal area. After cleaning the perineal area, he changed his gloves without sanitizing his hands. He then assisted the resident to roll, pulled the soiled brief, threw it to the trash can, and cleaned the resident's bottom. After cleaning the resident's bottom, he pulled the draw sheet and threw it in the trash can. He changed his gloves without doing hand hygiene. He then took the new brief, put it under the resident, and fixed it. After fixing the brief, he pulled the pants up, took off the resident's shirt, and put on a new shirt. He then repositioned the resident from a lying position to a sitting position by pivoting the resident to the side of the bed. It was observed that when he pivoted the resident, his upper body was in direct contact with the resident's upper body. There was a sign inside the resident's room that stated a resident with g-tube was on EBP, and a gown was required when changing the brief and clothing. It was also observed there was no sanitizer inside the room. 7.During an observation on 06/23/2026 at 9:34 a.m., CNA F and CNA G were about to transfer Resident #81 to his wheelchair. Both CNAs washed their hands and put on pairs of gloves. CNA F put on the gait belt around the resident's waist and prepared him for transfer. CNA G was assisting CNA F in putting the gait belt and at the same time fixing the resident's shirt. After putting (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the gait belt around the resident's waist, they both transferred the resident to his wheelchair. Bothe CNAs did not wear gowns during the transfer. There was a sign inside the resident's room that stated a resident with g-tube was on EBP, and a gown was required when transferring the resident. Folded gowns were observed hanging on the bathroom's door. 8.During an observation on 06/23/2026 at 9:38 a.m., after Resident #81 was transferred to his wheelchair, CNA G started to strip the resident's beddings. It was observed she leaned on the resident's bed while removing the bedding. She did not have a gown. There was a sign inside the resident's room that stated a resident with a g-tube was on EBP, and a gown was required when changing the linens of the resident. During an interview on 06/23/2026 at 9:40 a.m., CNA F said he should have sanitized his hands when he changed his gloves, especially after touching the soiled brief to prevent cross contamination. He said, since Resident #81 had a g-tube, then PPE was required during incontinent care, when he changed his t-shirt, when he repositioned him, and when they transferred the resident. He said he knew there was a sign on the resident's door and gowns were available, but he still forgot to wear a gown. He said not wearing a gown could result in the transfer of any microorganism from his scrubs to the resident. During an interview on 06/23/2026 at 9:43 a.m., CNA G said if a resident had a g-tube, the resident required EBP and a gown should be worn even when they transferred the resident and when she removed the linens because it was a high contact activity. She said a gown should have been worn to prevent cross contamination. 9. During an observation on 06/24/2026 at 11:49 a.m., a lunch bag was observed inside the refrigerator inside the medication room. It was observed that thee were several bottles of medications inside the refrigerator. During an observation and interview on 06/24/2026 at 11:50 a.m., RN C said the refrigerator inside the medication room was solely for medications and should not have any food in it. She opened the lunch bag and saw there were several kinds of food inside the lunch bag. She said it could be an infection control issue because it was not known where the lunch bag was last placed. She said the lunch bag, food particles, and spills could contaminate the fridge, thus affecting the containers of the medications. She said there was a refrigerator inside the staff break room for the personal foods and drinks of the staff. She said medications could not be placed where food was stored. She said she would look for the owner of the lunch bag. During an interview on 06/24/2026 at 11:53 a.m., LVN E said the lunch bag inside the refrigerator inside the medication room was hers. She said the refrigerator inside the breakroom was sometimes full so she would put her lunch bag inside the medication room. She said nobody told her she could not put her lunch bag inside the refrigerator of the medication room. She said she would ask around if they were allowed to put their personal food inside the medication room. During an interview on 06/24/2026 at 1:07 p.m., LVN E said she asked another nurse and was told she could not put her lunch bag inside the refrigerator designated for medications due to infection control. She said she had already put her lunch bag in the break room. During an interview on 06/25/2926 at 6:28 a.m., the DON said she was already made aware about the infection control issues and already started the in-services for them, except a resident's catheter bag was emptied and a resident with a catheter was transferred without a gown. She said residents should be assisted with meals one at a time. She said aside from cross contamination, the staff should focus on the resident to see if the resident was choking or was pocketing the food. She said hands should be sanitized before putting on a new pair of gloves; gowns should be worn when a resident had a g-tube and a catheter for activities such as incontinent care, change of clothing, linen change, emptying the catheter, and transfer. She said Resident #46's kerlix should not be touching the floor because the feet could get infected. She said staff should not put the residents in their chairs with bare perineal area because it could also cause infection. She said the expectation was for the staff to practice the policy and procedure of infection control. During an interview on 06/25/2026 at 6:59 a.m., the Administrator said the expectation was for the staff to understand the importance of following the policies and procedure of infection control. She said she would coordinate with the DON about the issues. During an interview on 06/25/2026 at 11:49 a.m., the DON said the lunch box should not have been placed in the refrigerator, she stated it's the policy not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to have any personal items in the refrigerator that was used for the resident's nutrition or medication storage. She said the staff had a refrigerator for their use in the breakroom. She said it could be an infection control issue. During an interview on 06/25/2026 at 12:51 a.m., the Administrator said the expectation was for foods and beverages the staff brought were to be in the breakroom fridge. She said for infection control purposes, the staff should not have any personal items in the fridge inside the medication room. She said it was not known what kind of food was in the lunch box and if it was mistakenly given to a resident, it could cause them harm. 10 . Record review of Resident #40's face sheet, dated 06/23/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #40 had diagnoses which included: Type 2 Diabetes (high blood sugar levels) and Cellulitis of Right Lower Limb (a common bacterial infection of the deeper layers of your skin and the tissues just beneath it). Record review of Resident #40's Comprehensive MDS, dated [DATE], reflected the resident had a BIMS score of 11 (moderate cognitive impairment). Resident #40 was at risk for pressure-ulcer. Record review of Resident #40's current physicians order reflected an order, dated 05/21/26, for the right shin wound care: Cleanse wound with wound cleanser and pat dry. Apply thin layer of Iododorb to Calcium Alginate Sheet, then apply to open wound. Cover with dry dressing. Change daily and as needed for soilage or dislodgement. Record review of Resident #40's care plan, dated 03/20/26, reflected the resident Has arterial/ischemic ulcers (poor circulation sores or blocked blood flow wounds) of the Right Shin, Right Anteromedial Shin (the front-inside part of your lower leg, running along your shinbone) related to History of ulcers, Peripheral Arterial Disease (poor circulation in the legs), Vascular insufficiency (poor blood circulation). With goal of: Will be free from infection or complications related to arterial ulcer through review date and intervention to treat wound per order. Use non-occlusive wound dressings. During an observation on 06/24/26 at 10:25 a.m., RN S was observed for wound care on Resident #40, she did not to sanitize her hands after removing dirty gloves and put on clean gloves 6 times during the wound care. During an interview on 06/24/26 at 10:50 a.m. with RN S, she stated per proper hand hygiene protocol she should sanitize her hands every time she changed gloves to prevent cross contamination. She stated the possibility existed that her hands could come in contact with the outside of dirty gloves and picking up a clean glove without sanitizing would contaminate it. She stated not sanitizing her hands after removing dirty gloves and putting on a clean gloves could cause the resident's wound to be contaminated after it had been cleaned and could make the wound worse or delay healing. During an interview on 06/25/26 at 11:49 a.m. with the DON, she stated the protocol was that hands should be washed or sanitized whenever gloves were changed or going from dirty to clean task. She stated it was an infection control issue if the protocol was not followed. She stated it could lead to an infection and the wound could get worse if proper hand hygiene was not followed. Record review of the facility's policy Infection Control IPCP Standard and Transmission-Based Precautions revised March 2024 reflected Policy: It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions . Enhanced Barrier Protection (EBP) . used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs (Multi-Drug Resistant Organisms: refers to microorganisms that are resistant to one or more antibiotics) to staff hands and clothing then indirectly transferred to residents or from resident-to-resident . PPE . for nursing home residents with . urinary catheter . feeding tubes . high-contact resident care activities requiring gown . dressing . transferring . changing linens . changing briefs . device use . urinary catheter . feeding tube. Record review of the facility's policy Hand Hygiene Policy & Procedure, revised April 2025, reflected Policy: It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene, which is one of the most effective measures to prevent the spread of infection, based on accepted standards . Use an alcohol-based hand rub . Before moving from a contaminated body site to a clean body site during resident care . After contact with blood or bodily fluids . After removing gloves . Before and after assisting a resident with meals. Record review (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the facility's policy Skin and Wound Monitoring and Management Policy & Procedure, revised April 2024, reflected Policy: It is the policy of this facility that . 2. A resident having pressure injury(s) receives necessary treatment and services to . prevent infection. Record review of the facility's policy Food Storage Policy & Procedure, revised January 2022, reflected Policy: It is the policy of this facility that food storage areas shall be maintained in a clean . 7 . drugs are not to be stored in the kitchen area or in storerooms for food. Record review of the facility's policy Resident/Personal Food Storage Policy/Procedure revised November 2016 reflected Policy: Food or beverage brought in from outside sources for storage in facility pantries, refrigeration units, or personal/resident room refrigeration units will be monitored by designated facility staff for food safety . 2. Outside foods brought in to residents by visitors will be stored in personal refrigerator or facility refrigerator designated for resident use . Resident and individuals bringing food in from outside sources will be educated on safe food handling.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for one of eight (Resident #12) reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #12's room was in a position that was accessible to the resident on 06/23/26. 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 #12's Face Sheet, dated 06/23/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #12 had diagnoses of Dementia (A progressive loss of memory, reasoning and communication skills), History of falling, need for assistance with personal care and age-related physical debility. Record review of Resident #12's MDS Assessment, dated 05/13/26, revealed the resident had a BIMS score of 99 (indicating unable to complete BIMS assessment). The MDS Assessment revealed the Resident had active diagnoses of History of falling, need for assistance with personal care. Record review of Resident #12's Comprehensive Care Plan, dated 06/19/25, revealed the resident was a fall risk and an intervention included ensuring call light was within reach of the resident and encourage Resident to use it. During an observation on 06/23/26 at 9:44 a.m. and 10:55 a.m., Resident #12 was observed lying in his bed and his call light was located on the floor, under his bedside table and out of his reach. During an interview on 06/23/26 at 10:55 a.m., Housekeeper G was shown Resident #12's call light being on the floor, under the bedside table out of the resident's reach. She stated that the call bell should not be on the floor but should be clipped to the Resident's bed and within reach. She stated that everyone is responsible for making sure the call bell is within reach of the residents. She stated that she should have picked it up after cleaning the floor in Resident #12's room and put it within reach of the resident and report the missing clip to the maintenance personnel. She stated that if the call bell is not within reach the resident could fall. During an interview on 06/23/26 at 11:00 a.m. with CNA E, she stated that according to the facility policy, the call bell should always be within reach of the Resident. She stated that everyone is responsible for making sure the call bell is within reach of the resident. She stated that if the call bell is not within reach of the resident and they try to get out of bed, they could fall or could go a long time without help. During an interview on 06/23/26 at 11:05 a.m. with LVN S, she stated that the facility policy is that the call bell should be within reach of the resident at all times. She stated that it is important that it is to prevent delays in providing care or if the resident is having an emergency without the call bell within reach they could be dangerous for the Resident #12 and cause him harm. She stated that it could also affect them emotionally if they wet themselves and are unable to call for help. During an interview on 06/25/26 at 11:49 a.m. with the DON, she stated that it was care planned after the surveyor observation that Resident #12 takes the call light off his bed and throws it on the floor. Now they hook it to the back of the bed but within reach. She stated that it is expected that the call light should be within reach at all times. She stated that it should be within reach for him to call for assistance. She stated that he would not be able to get help when he needs it if the call light is not within reach. She stated that all staff are responsible for making sure the call light is within reach. During an interview on 06/25/26 at 12:51 p.m. with the Administrator, she stated that the expectation is that the call light should be within reach and frequent rounding to make sure it is in place. She stated that the call bell should be within reach so the residents can call for help when needed. She stated that if they are a fall risk it is an added risk if the call bell is not within reach. She stated that Resident #12 is a fall risk and due to that he is kept in the room across from DON's office. Record Review of the facility's undated policy on Resident Rights revealed The resident has the right ?To be encouraged and assisted throughout his or her stay in the Center to exercise these Resident Rights as well as those which Residents are entitled as a U.S. citizen'.

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	675972	A. Building B. Wing	06/25/2026

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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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure assessments accurately reflected the resident's status for one of eight residents (Residents #8) reviewed for accuracy of assessments. The facility failed to ensure Resident #8's Comprehensive MDS Assessment, dated 03/24/2026, accurately reflected that the resident was receiving oxygen therapy. This failure could place the residents at risk for not receiving care and services to meet their needs, diminished function of health, and regression in their overall health. Record review of Resident #8's Face Sheet, dated 06/24/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #8's Comprehensive MDS Assessment, dated 03/24/2026, reflected that the resident had a severe impairment in cognition with a BIMS score of 07. The Comprehensive MDS Assessment did not indicate that the resident was receiving oxygen. Record review of Resident #8's Comprehensive Care Plan, dated 06/22/2026, reflected that the resident did not have a care plan for oxygen use. Record review of Resident #8's Physician Order, dated 02/17/2026, reflected O2 AT 2 L/MIN CONTINUOUS PER nasal cannula. every shift for SOB related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED. During an observation on 06/23/2026 at 11:44 a.m., Resident #8 was in her bed with eyes closed. It was observed that the resident was on oxygen therapy. During an observation and interview on 06/24/2026 at 12:06 p.m., the MDS Nurse said if Resident #8 was using oxygen continuously, then the resident should be coded that she was on oxygen therapy. She opened the resident's physician order for oxygen and saw that the resident was using the oxygen every day. She then checked on the resident's MDS and saw that the resident was not coded for oxygen therapy. She then changed the code, so the MDS would reflect that the resident was using oxygen. She said it was an oversight on her part. She said the MDS was a form of a clinical assessment to capture the needs of the residents that needed to be addressed. She said if the assessment was not accurate, then there could be a probability that the needs would not be met. She said she would also audit the MDS of the other residents. During an interview on 06/25/2926 at 6:28 a.m., the DON said she was made aware that Resident #8 was not coded for the oxygen use. She said the MDS Nurse had already modified it. She said the MDS should reflect the current status of the residents to provide the necessary care needed by the residents. During an interview on 06/25/2026 at 6:59 a.m., the Administrator said the MDS must be updated to capture the diagnoses of the residents to provide the appropriate interventions. She said she would coordinate with the MDS Nurse and the DON regarding the MDS of the residents. Record review of the facility's policy Resident Assessment and Associated Processes Policy & Procedure revised December 2023 reflected Policy: It is the policy of this facility that resident's will be assessed and the findings documented in their clinical health record . comprehensive, accurate, standardized reproducible assessment of each resident and will be conducted initially and periodically as part of an ongoing process through which each resident's preferences and goals of care, functional and health status, and strengths and needs will be identified.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for one of eight residents (Resident #8) reviewed for care plans. The facility failed to ensure that Resident #8 had a care plan for her oxygen use on 06/23/2026. This failure could place the residents at risk of not receiving the necessary care and services.Findings included: Record review of Resident #8's Face Sheet, dated 06/24/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #8's Comprehensive MDS Assessment, dated 03/24/2026, reflected that the resident had a severe impairment in cognition with a BIMS score of 07. The Comprehensive MDS Assessment did not indicate that the resident was receiving oxygen. Record review of Resident #8's Comprehensive Care Plan, dated 06/22/2026, reflected that the resident did not have a care plan for oxygen use. Record review of Resident #8's Physician Order, dated 02/17/2026, reflected O2 AT 2 L/MIN CONTINUOUS PER nasal cannula. every shift for SOB related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED. During an observation on 06/23/2026 at 11:44 a.m., Resident #8 was in her bed with eyes closed. It was observed that the resident was on oxygen therapy. During an observation and interview on 06/24/2026 at 12:06 p.m., the MDS Nurse said if Resident #8 was using oxygen continuously, then there should be a care plan for oxygen use so that everybody taking care of the resident would be aware of how to manage it. She said the care plan should reflect the potential issues of the residents and provide interventions for such issues. She went to Resident #8's care plan and saw that the resident was not care planned for oxygen therapy. She then updated the resident's care plan to reflect that the resident was using some oxygen. She said she would also audit the care plans of the other residents. During an interview on 06/25/2926 at 6:28 a.m., the DON said the MDS Nurse had already updated Resident #8's care plan to reflect her oxygen use. She said care plans should be in place to reflect the realistic goals and interventions, to gauge if the expectations were being met, so that the staff could provide the best care needed. She said the expectation was for all the issues of the residents were care planned appropriately. During an interview on 06/25/2026 at 6:59 a.m., the Administrator said the expectation was that all the residents were care planned specific to their needs so the staff taking care of the residents could provide the care and services needed. She said care plans should be in place so that the individuals providing care for the residents would be on the same page. She said she would coordinate with the MDS Nurse and the DON regarding the care plans of the residents. Record review of the facility's policy Care Planning Policy/Procedure - Nursing Administration reviewed July 2020 reflected POLICY: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident . 9. The resident's plan of care - focus, goals, and interventions - are communicated and implemented by the members of the health care continuum accordingly.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 the residents' environment remained free of hazards as was possible for two of eight Residents (Resident #65 and #12) reviewed for accident hazard. The facility failed to ensure that Resident #65 did not have a container of germicidal wipes on her shelf on 06/23/2026. The facility failed to ensure that Resident #12 did not have scissors in his room on 06/23/26. These deficient practices placed the residents at risk for accidental injury, exposure to hazardous chemicals and misuse of sharp objects.Findings included: Record review of Resident #65's Face Sheet, dated 06/24/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with Dementia (A progressive loss of memory, reasoning, and communication skills) and need for assistance with personal care. Record review of Resident #65's Quarterly MDS Assessment, dated 05/06/26 did not reveal any BIMS score. The Quarterly MDS Assessment indicated that the resident required Substantial / Maximal assistance with eating and dependent with oral hygiene, toileting hygiene, shower / bath self, upper body dressing, lower body dressing, putting on / taking off footwear and personal hygiene. Record review of Resident #65's Comprehensive Care Plan, dated 05/02/18 last revised 05/25/26 revealed the resident is at risk for impaired cognitive function and thought processes related to dementia- recent diagnosis metabolic encephalopathy (a temporary, generalized malfunction of the brain caused by a chemical imbalance in the body), with intervention: Needs supervision/assistance with all decision making-has good family support. During an observation on 06/23/26 at 10:10 a.m. it was observed that Resident #65 had a can of Sani-cloth germicidal disposable wipes on her shelf. During an interview on 06/23/26 at 10:25 a.m. with LVN S, she stated that the Sani wipes should not be in the residents' rooms per the facility policy. She stated that the nurse and all care staff are responsible for making sure that the items are not in the residents' rooms. She stated that confused residents who wander could get a hold of it and swallow them causing them to be sick since those items could contain toxins and alcohol that the resident could react to. During an interview on 06/23/26 at 10:30 a.m. with MA C, he stated he was not sure of what the facility policy was, but that Sani wipes should not be in the resident's possession for safety reasons. He stated that he should tell the nurse if he notices those items in the residents' rooms. He stated that the items can harm residents who are confused and cause them to be hospitalized if swallowed. During an interview on 06/23/26 at 10:34 a.m. with CNA R, she stated that the Sani wipes should not be in the residents' rooms. She stated that every staff member is responsible for making sure those items are not in the residents' rooms. She stated that it will endanger residents who are confused, they could have an allergic reaction to the items and cause serious harm to themselves or others. During an interview on 06/25/26 at 11:49 a.m. with the DON, she stated the residents are not supposed to have Sani-wipes in their rooms, she stated that they started and in-service right away with the staff. She stated that for safety reasons and for residents that wander, it could cause harm if they get a hold of those items. She stated that they can swallow and cause harm to themselves if they get a hold of them. Record review of Resident #12's Face Sheet, dated 06/23/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #12 had diagnoses of Dementia (A progressive loss of memory, reasoning, and communication skills), History of falling, need for assistance with personal care and age-related physical debility. Record review of Resident #12's MDS Assessment, dated 05/13/26, revealed the resident had a BIMS score of 99 (indicating unable to complete BIMS assessment). The MDS Assessment revealed the Resident had active diagnoses of History of falling and need for assistance with personal care. Record review of Resident #12's Comprehensive Care Plan, dated 06/19/25, revealed the resident was at risk for impaired cognitive function or impaired thought processes r/t dementia, needs redirection and assist to find his (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room and time related activities such asMealtimes, with intervention to Communicate with family/caregivers regarding resident's capabilities and needs. During an observation on 06/23/26 at 1:10 p.m., Resident #12 was observed holding scissors in his hands. The Administrator was called into the room immediately and retrieved the scissors. When she asked the resident how he obtained the scissors, he stated that his daughter gave them to him. During an interview on 06/23/26 at 1:43 p.m. with CNA E who worked in the 200 hall, she stated that the scissors should not be allowed in Resident #12's room for safety reasons, especially since the resident was confused. She stated that if she comes across any dangerous items in the residents' rooms, she will report them to the nurse immediately to have it removed. She stated that she has not noticed the scissors in the Resident's room. She stated that if the scissors remain in the resident's room, he could harm himself or others. During an interview on 06/25/26 at 10:12 a.m. with RN C, she stated that the residents should not have anything sharp in their rooms, they remove the item and notify the DON / Administrator and access if there are any injuries and notify the residents' responsible party. She stated that having any dangerous items can cause injuries to the residents and staff members. She stated that the injury can cause the resident to be sent to the hospital and if it is serous can even cause death. During an interview on 06/25/26 at 11:49 a.m. with the DON, she stated that when residents are admitted and they do care plans, the families are reminded not to bring in items that could cause harm like scissors. She stated that during rounds, the staff checks for such items and remove them, educate the family to not bring such items in the facility. She stated the residents can injure themselves or others if they have possession of dangerous items. During an interview on 06/25/26 at 12:51 p.m. with the Administrator, she stated that the expectation is that all department heads do rounds in addition to the rounds done by the floor staff to make sure the environment is safe for all residents. She stated that if the environment is not safe and they have scissors, they could hurt themselves or their roommates. Record review of the facility's policy, Residents' Rights Safety, Resident undated, revealed the following; Ensure all medications, chemicals, cleaning supplies and any potential hazardous materials are kept locked / secure when staff has completed their use and is no longer in attendance. Conduct a room search should there be concern that prohibited /unsafe items are being stored in the room.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview, and record review the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infection for one of five residents (Resident #70) reviewed for incontinent care. The facility failed to ensure that CNA H did not place Resident #70's catheter bag on top of the resident, rendering the catheter bag and its tubing to above the bladder during transfer on 06/24/2026 This failure could place the residents at risk of urinary tract infection.Findings included: Record review of Resident #70's Face Sheet, dated 06/24/2026, reflected a 67-year- old female admitted to the facility on [DATE]. The resident was diagnosed with neuromuscular dysfunction of the bladder (the muscles and nerves that control the bladder do not work properly due to illness). Record review of Resident #70's Comprehensive MDS Assessment, dated 05/04/2026, reflected that the resident had moderate impairment in cognition with a BIMS score of 08. The Comprehensive MDS Assessment indicated that the resident had an indwelling catheter (device that drains urine from the urinary bladder). Record review of Resident #70's Comprehensive Care Plan, dated 05/31/2026, reflected that the resident had a suprapubic catheter (device inserted into the stomach to the bladder to drain urine) and one of the interventions was to position the catheter bag (collects urine from the urinary bladder) and the tubing below the bladder. During an observation and interview on 06/23/2026 at 9:13 a.m., Resident #70 was in her bed, awake. It was observed that the resident had a catheter bag hanging at the side of the bed. The resident said she had a catheter because her bladder was not working. During an observation on 06/24/2026 at 10:34 a.m., CNA H and CNA I were about to transfer Resident #70 to her motorized wheelchair via mechanical lift. Both CNAs hooked the mechanical lift sling to the mechanical lift and prepared to lift the resident. Before raising the mechanical lift, CNA H placed the catheter bag on top of the resident where it remained until the resident was lowered to her motorized wheelchair. When the resident was already in her wheelchair, CNA H started to figure out how to extend the leg rest of the wheelchair. While she was figuring out what to do with the leg rest, the resident's catheter was still on top of the resident. During an interview on 06/24/2026 at 10:43 a.m. CNA I said he saw Resident #70's catheter bag on top of the resident but it did not occur to him to remind CNA H that the catheter bag should always be below the bladder so that the urine, if there was any, would not go back inside the resident's bladder that could result in a UTI. During an observation on 06/24/2026 at 10:47 a.m., Resident #70's catheter bag was still on top of the resident and CNA H was still trying to fix the motorized wheelchair until she said she would just call maintenance to help with the wheelchair. After saying that she would call maintenance she hooked the catheter bag at the side of the wheelchair. During an interview on 06/24/2026 at 10:54 a.m., CNA H said she was busy fixing the wheelchair that she forgot to hook the catheter bag at the side of the motorized wheelchair. She said she was not even supposed to put it on top of the resident because the catheter bag should always be below the bladder to prevent backflow of urine that could cause a UTI. During an interview on 06/25/2926 at 6:28 a.m., the DON said catheter bags should always be below the bladder to prevent backflow of urine from the catheter bag to the bladder. She said if there was a backflow, it could result in a urinary tract infection. She said she already started an in-service to re-educate the staff about catheter care. During an interview on 06/25/2026 at 6:59 a.m., the Administrator said she was not a clinician and would let the DON take the lead about the issue. Record review of the facility's policy Catheter Care, Indwelling Infection Control Policy/Procedure reviewed January 2025 reflected POLICY: It is the policy of this facility that each resident with an indwelling catheter will receive catheter care every shift and PRN . PURPOSE: To promote hygiene, comfort and decrease risk of infection for catheterized residents . PROCEDURES . 12. Keep tubing below level of bladder.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two of ten residents (Resident #1 and Resident #14) reviewed for respiratory care. 1.The facility failed to ensure Resident #1's oxygen nasal canula was properly stored on 06/23/26. 2.The facility failed to ensure Resident #14's spirometer was properly stored when not in use on 06/23/2026. These failures could place residents at risk of respiratory infection, respiratory complications, and not having their respiratory needs met.Findings Include 1. Record review of Resident #1's face sheet, dated 06/23/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with the following: Chronic Obstructive Pulmonary Disease - COPD (a progressive, long-term lung disease that makes it hard to breathe), Chronic Respiratory Failure (your lungs or breathing system have long-term damage, making it hard to get enough oxygen into your blood or push out waste gases), Congestive Heart Failure (chronic, progressive condition in which the heart cannot pump blood efficiently enough to meet the body's needs). Record review of Resident #1's Quarterly MDS Assessment, dated 04/07/26, reflected moderately impaired cognition with a BIMS of 10. The Quarterly MDS Assessment indicated the resident was on oxygen therapy. Record review of Resident #1's Comprehensive Care Plan, dated 01/10/25, reflected the resident had oxygen therapy and one of the interventions was to give oxygen at 2 lpm per nasal cannula. Record review of Resident #1's Physician Order, dated 11/08/25, reflected oxygen at 2-4 l/m, continuous, per nasal canula every shift related to COPD, chronic respiratory failure; Change Oxygen Tubing and Humidifier Bottle, Clean filter and pat dry with paper towel on concentrator with weekly tubing change every night shift every Wed. During an observation and interview on 06/23/26 at 1:25 p.m., reflected after Resident #1 was transferred from her wheelchair to her bed by CNA R. CNA R removed the nasal canula connected to the wheelchair oxygen tank, it was exposed and not bagged, per the facility policy. Resident #1 stated CNA R put her in bed after lunch and did not know if the nasal canula should be bagged or not. During an interview on 06/23/26 at 1:30 p.m. with LVN S, she stated the facility policy required oxygen tubing to be bagged when not in use. She stated it was important to have the tubing in a bag to prevent bacteria from contaminating the tubing which could predispose the resident to infection or exacerbate the current medical condition. She stated she would have to discard the old tube, replace it with a new one and provide a bag for it. She stated everyone who cared for the resident was responsible for making sure the tube was bagged when not in use. During an interview on 06/23/25 at 1:35 p.m. with CNA R, she stated the oxygen tube should be bagged when not in use. She stated leaving the tubes exposed would contaminate them and would need to be changed. She stated after she put Resident #1 in bed she should have put the tube in a bag or let the nurse know to provide a bag if there was none. She stated if the tube was exposed to contamination, it could make the resident sick. During an interview on 06/23/26 at 11:49 a.m. with the DON, she stated the tubing should be bagged after the resident was transferred from her wheelchair to the bed if the oxygen was not in use. She stated it should be bagged for infection control. She stated the resident could get some kind of illness if the tube was not bagged. She stated all care staff were responsible for making sure the oxygen nasal canula was bagged per facility policy. 2. Record review of Resident #14's face sheet, dated 06/23/2026, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with atelectasis (collapse of the lungs) and asthma (lung disorder caused by narrowing of the airways). Record review of Resident #14's Comprehensive MDS Assessment, dated 05/04/2026, reflected the resident had severe impairment with a BIMS score of 06. The Comprehensive MDS (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assessment indicated the resident had atelectasis and asthma. Record review of Resident #14's Comprehensive Care Plan, dated 04/07/2026, reflected the resident had asthma and one of the interventions was to monitor airway functioning which may indicate hypoxia (insufficient amount of oxygen in the body). Record review on 06/23/2026 of Resident #6's Physician Order reflected the resident did not have an order to use a spirometer (medical device that measures the flow of air inhaled and exhaled by the lungs). During an observation on 06/23/2026 at 9:07 a.m., Resident #14 was in his bed with his eyes closed. It was observed that an unbagged spirometer was on top of the resident's dresser. The mouthpiece of the spirometer was touching the wall. During an observation and interview on 06/23/2026 at 11:31 a.m., RN A said she was not sure if Resident #14 was using the spirometer or if there was an order to use a spirometer. She said, nevertheless, the spirometer should be bagged because it was still inside the resident's room, and it should be kept clean in case the resident needed to use it. She went to her cart, took a plastic bag from one of her drawers, and bagged the resident's spirometer. During an interview on 06/25/2926 at 6:28 a.m., the DON said the spirometer should be bagged even though Resident #14 was not using it to keep it clean. She said the resident did not have a discharge order for the spirometer, that was why the resident did not have an order for the spirometer, but nevertheless, it should still be kept clean. She said she already started an in-service about respiratory care. During an interview on 06/25/2026 at 6:59 a.m., the Administrator said the expectation was for the spirometer to be bagged to keep them clean. She said she would coordinate with the DON about the issue. Record review of the facility's policy Incentive Spirometry Policy & Procedure, revised April 2025, reflected Policy: It is the policy of this facility that an incentive spirometry device may be used by a resident to assist with maximal lung ventilation . 12. Place the mouthpiece in a plastic storage bag between exercises. Record review of the facility's, undated, policy / procedure titled, Oxygen Equipment reflected: Oxygen masks, nasal cannulas, and tubing will be used for one resident only. When used continuously or intermittently, tubing will be routinely changed to prevent the build-up of respiratory secretions, mucous, and bacterial growth. When mask or cannula is temporarily not being used, it will be covered loosely to prevent contamination from airborne microorganisms. It will not be covered tightly.

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	06/25/2026

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain an effective pest control program so the facility was free of pests and rodents for one of 8 residents' rooms (Resident #69) reviewed for pest control. The facility failed to ensure Resident #69's room was free from gnats. This failure could place residents at risk for the potential spread of infection, cross-contamination, food-borne illness, and a diminished quality of life.Findings include: Record review of Resident #69's face sheet, dated 06/24/26, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with dementia (a condition characterized by loss of memory and ability to reason) and Type 2 Diabetes with hyperglycemia (adult-onset diabetes with consistently high blood sugar). Record review of Resident #69's Comprehensive MDS Assessment, dated 05/22/26, revealed the resident had a severe impairment with cognition with a BIMS score of 06. The resident was diagnosed with Diabetes mellitus and Dementia Record review of Resident #69's Comprehensive Care Plan, dated 06/22/25, revealed the resident had potential for altered endocrine status r/t Diabetes Mellitus with intervention: Diabetes medication as ordered by doctor. Monitor/document for side effects andeffectiveness. Observation on 06/24/26 at 8:04 a.m. revealed a gnat observed flying and perching on Resident #69's breakfast, MA C noticed and stated the resident should not have gnats on her breakfast tray while she was eating. During an interview on 06/25/26 at 9:47 a.m. with MA C, he stated when he noticed any pest, he reported to the nurse and maintenance. He stated they had a log book to put down any complaints of bugs. He stated the gnats were in and out, they tried to have the food covered. He stated he made a report in the past. He stated it was important for the residents to have a pest free environment, he stated the bottom line was that they should not have pests around them. He stated the bugs could bite the residents and infect their skin, get into their food, it could make them sick if they ate food that a bug landed on. During an interview on 06/25/26 at 10:07 a.m. with CNA M, he stated he should get a new tray if he noticed a bug on the resident's tray. He stated he would let the nurse know and the maintenance director as well. He stated the insects could carry bacteria and make them sick. He stated the residents might not want to eat the food. He stated no one wanted to live in an environment that had bugs. During an interview on 06/25/26 at 10:12 a.m. with RN C, she stated if she noticed any pest, she put in a request in the log and let them know verbally as well. She stated it was part of infection control, it made the environment unclean, could affect their skin if the bug bit them. During an interview on 06/25/26 at 10:23 a.m. with Housekeeper A, she stated she would correct the situation and clean it up. She stated she reported to maintenance as well. She stated that it was important to have a pest free environment for sanitation and safety. She stated it's the residents home and they should feel comfortable. She stated the residents could feel upset if they had pests in the environment. During an interview on 06/25/26 at 10:30 a.m. with the Maintenance Director, he stated they had a pest control company that came in when they had a pest issue. He stated as housekeeping cleaned and made rounds, they got rid of any open food source and discarded as directed by the pest control company. He stated the residents families brought in food from outside and sometimes came in with pests. He stated the expectation was that the environment should be safe for the residents to live in, he stated they tried the best they could to keep the facility clean. He stated the pest control company came in once a month for a full sweep pest service and spot treated when they called for other pests. He stated pests could be dangerous to health and life and could be annoying to the residents. He stated they could pass disease and bite the residents. During an interview on 06/25/26 at 11:49 a.m. with the DON, she stated the facility had a logbook and verbally let maintenance know and the pest control company came out as needed. She stated it had been reported that there were gnats in the building. She stated due to the demographics of the facility, on Fridays the families of some residents brought in Kimchi that increased the population of the gnats. She stated it was important to have a pest free (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	environment to make the facility feel like home.She stated the residents might not eat their meals or not go to the dining if they saw pests on their trays and that could lead to social isolation. During an interview on 06/25/26 at 12:51 p.m. with the Administrator, she stated she noticed gnats in the building, she stated a report was made to maintenance. She stated it got worse with the recent rain fall in the area. She stated the rooms should be cleaned properly and they did as much cleaning as possible and removed uncovered food to reduce the gnat problems. She stated any staff member who noticed pests should report to a department manager or the maintenance director and put it in the pest logbook. She stated the facility was the residents' home and that it should be made comfortable for them, she stated no one wanted pests in their homes. She stated residents would not feel at home if they noticed pests in the environment and felt it's not clean place to live.