

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024
NAME OF PROVIDER OR SUPPLIER Carrara		STREET ADDRESS, CITY, STATE, ZIP CODE 4501 Tradition Trail Plano, TX 75093	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 27070 Based on observations, record reviews and interviews, the facility failed to ensure the resident environment remains as free of accident hazards as is possible and that residents received adequate supervision to prevent accidents for one (Resident #79) resident of three residents reviewed for elopement. RN A on 07/30/23 failed to report to the Administrator (at that time), the DON (at the time) or communicate to oncoming nursing staff when Resident #79 became agitated and stated he was going to leave the facility. On 08/02/23 Resident #79 became agitated and frustrated and told LVN B he was leaving the facility. LVN B redirected him and did not provide adequate supervision to prevent him from eloping from the facility on 08/02/23. Resident #79 was able to leave the building without staff being aware that he left the building on 08/02/23 sometime after 4:00 p.m. and was later found by the police approximately three miles from the facility. It was determined these failures placed Resident #79 in an Immediate Jeopardy(IJ) situation from 07/30/23-08/03/23. The facility corrected the noncompliance before the survey began. This failure placed residents at risk for harm and /or serious injury. Findings included: Record review of Resident #79's Admission MDS assessment, dated 07/10/2023 reflected the Resident was a [AGE] year-old-male who admitted to the facility on [DATE] and discharged on [DATE]. The resident had diagnosis which included: Parkinson's Disease (disease that affects the nervous system producing tremors and stiffness), left nephrectomy (removal of left kidney), spinal stenosis (disease of the spine causing difficulty in walking long distances), fall with head strike, functional decline, generalized weakness, and ETOH (alcohol abuse). The MDS reflected he had a BIMs score of 10, which indicated moderate cognitive impairment and the resident was ambulatory with an unsteady gait and required assist of one staff for activities of daily living. The MDS did not reflect any wandering behavior. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024
NAME OF PROVIDER OR SUPPLIER Carrara		STREET ADDRESS, CITY, STATE, ZIP CODE 4501 Tradition Trail Plano, TX 75093	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #79's care plan, dated with a review date of 07/14/2023, addressed the resident's impaired cognition due to short term memory loss (unable to remember after 5 minutes), risk for falls and assistance required for activities of daily living. Further review of the clinical record reflected, the resident's moderate risk for elopement was not addressed, until 08/03/2023. Record review of Resident #79's Elopement [NAME] Assessment completed 07/05/2023 scored Resident #79 as no risk for elopement. Review of the clinical record reflected no Elopement Risk Assessment completed on 07/30/2023. Record review of Resident #79's Elopement Risk Assessment completed on 08/02/2023 scored Resident #79 as high risk for elopement. This assessment was completed after the elopement. Record review of the Provider Investigation Report, dated 08/03/2023, revealed Resident #79 was independently ambulatory and was noted missing from the facility on 08/02/2023 at approximately 4:00 p.m. The resident was last seen at approximately 4:30 p.m. in his room. Facility staff searched the facility, the entire campus, and the surrounding neighborhood. Resident #79 was not located. The police were called, and the resident was located and taken to the hospital, where he was found to be in stable condition, under the influence of alcohol and drugs, for which the hospital provided care. The Provider Investigation Report reflected a finding of unconfirmed (for neglect). The hospital communicated they would assist in finding a secured unit SNF for the resident. The facility started in-service on the elopement policy and procedure with all staff and conducted an elopement drill with all staff. The facility changed all the door codes in the facility. Review of Provider Investigation Report dated 08/03/2023 reflected a finding of Unfounded for Neglect. Review of the External/Internal/Systemic Approach Investigation Summary dated 08/02/2023 completed on 08/08/2023 reflected: . an emergency QAPI meeting was held on 08/03/2023 with Medical Director in attendance . all residents had a new elopement assessment to identify any current patients that are imminent risk for elopement (no other residents were found to be at imminent risk of elopement) . (who was responsible: Nurse Management . who will monitor: Regional Director of Clinical Services/Director of Nursing. elopement assessment will be completed upon admission and quarterly by the charge nurse and/or nurse managers and for any resident that triggers an imminent risk for elopement, the elopement response protocol will be initiated Any patient that triggers elopement risk will be placed on 1:1 monitoring until no longer deemed necessary. DON will monitor for compliance for 3 weeks until 08/27/2023 and then monthly on an ongoing basis .Who will monitor: Regional Nurse of Clinical Services Until alternative and or safe living arrangements are made they will be placed on one-one-supervision with facility staff. The resident's picture and face sheet will be placed in an elopement binder. Resident care plans will also be updated. The Director of Nursing and/or Nurse Manager will monitor weekly for compliance by completing an audit of the elopement assessments and the elopement binders. Audits will be completed weekly for 3 weeks until 08/28/2023 and monthly on an ongoing basis Monitoring .Starting 08/02/2023 Director of Nursing and/or Nurse Managers will receive in hand, the resident monitoring/every 2-hour body check documentation at the end of each shift for the first 72 hours, each day for one week, then weekly for 4 weeks. The Regional Director of Clinical Services will review the documentation each week for compliance The Executive Director will monitor daily to ensure compliance for four weeks and will review . Further review of the Providers Investigation Report reflected monitoring and audits by the designated staff (DON Nurse Managers and Regional Nurse consultant) had occurred. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024
NAME OF PROVIDER OR SUPPLIER Carrara		STREET ADDRESS, CITY, STATE, ZIP CODE 4501 Tradition Trail Plano, TX 75093	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of progress notes reflected Resident #79 on 07/30/2023 had previously indicated he had reported to RN A stating he is leaving this place. Further review of the progress note reflected Resident #79 was agitated. Record review of progress notes reflected Resident #79 on 08/02/23 he was observed wandering in the hallway stating, I'm going home today The nurse redirected the resident back to his room, educated the resident his discharge date was not today, and he would be notified when his discharge date was. The resident indicated to the nurse he understood and he would stay in his room for a nap. The nurse when rounding later around 1800 it was noted the resident was not in his room, the nurse made rounds in the hallways and other residents rooms looking for resident #79 and he was unsuccessful in locating him. Review of In-service dated 08/03/2023 reflected all staff attended and the subject matter was regarding Facility policy on elopement and reducing the risk for elopement: initiating a frequent monitoring form and updating the care plan. In an interview on 04/02/2024 with LVN C at 1:30 p.m. revealed he did recall a resident leaving the facility but was not working when it happened. LVN C stated he did not recall Resident #79 or being told anything about the resident trying to leave. LVN C stated he did recall having an in-service given by the administrator (at the time) about elopement. LVN C knew what to do and who to report to if a resident was exit seeking, but he currently did not have any residents that were, but stated he would be telling the administrator and the DON. An observation on 04/02/24 at 4:00 p.m. revealed the surrounding outside area, parking lot, and streets adjacent to the facility. The facility was in an industrial area with multiple car lots, a concrete/gravel company, a large hospital, and multiple businesses. The street in front of the facility was very busy with cars parked on both sides of the street and large 18 wheelers were observed delivering cars. Dump trucks and container trucks were observed driving down the street. There was a popular highway less than a third of a mile away, as well as a very busy main four lane street that leads to residential areas, and large shopping centers, that has heavy traffic on the road all times of the day and night. Where the resident was found (in another city than the facility) is approximately three miles away through busy streets, the industrial areas, and residential areas. In an interview on 04/03/2024 with Social Worker at 8:45 a.m. revealed she had worked here since September 2023 there had not been any elopements. The Social Worker stated she had been in-served by the new Administrator. The staff is supposed to report any exit seeking behaviors, that would include a resident talking about leaving. The resident is immediately replaced on 1:1 until they can locate a safe place for them to reside. The Social Worker stated the facility is not equipped to handle wandering and exit seeking residents. In an interview on 04/03/2024 with the DON at 9:00 a.m. revealed he had only worked at the facility for less than two weeks. The DON stated he had been trained on the policy and procedure for elopement. The DON stated an elopement could be very serious, and the resident could get hurt while out of the facility. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024
NAME OF PROVIDER OR SUPPLIER Carrara		STREET ADDRESS, CITY, STATE, ZIP CODE 4501 Tradition Trail Plano, TX 75093	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 04/03/2024 with the Administrator at 10:00 a.m. revealed she had worked at the facility since September. The Administrator stated the staff had been in-serviced on elopement and her expectations. The Administrator stated even if the resident talks about leaving she must be notified immediately. She would then determine if they need 1:1 assist monitoring until they can safely find placement for the resident. She said this facility is not set up for any type of wandering residents. In an interview on 04/03/2024 with Regional Nurse Consultant (RNC) at 10:10 a.m. revealed he knew Resident #79 and he was involved with the occurrence. The RNC stated Resident #79 was alert and oriented and the resident knew he wanted to leave and wanted cigarettes, so he went to the store he was used to going to. RNC stated he did not think Resident #79 eloped, he just possibly forgot to sign out. RNC stated, he thought Resident #79 just wanted to go visit with his buddies. He said they have a lot of residents that talk about leaving, they talk with them and explain why they are here, and they do not leave. During the interview the RNC was given the opportunity to provide the sign in sheets for the in-services 07/2023 and 08/2023, but none were provided by the exit. In an interview on 04/03/2024 with LVN B at 10:45 a.m. revealed he recalled Resident #79; he had admitted to the facility for rehabilitation. LVN B stated Resident #79 was a wandering resident. LVN B said he thought he was new and needed to be redirected. LVN B stated Resident #79 was a very nice resident and he was not exit seeking. LVN B stated he just walked around all the time, but he did appear to be frustrated about being there. The LVN stated he had not been made aware that the resident had talked about leaving before. LVN B stated when he arrived for his shift, he received report and counted medications with the nurse that was leaving, then he made rounds and located all his residents. He stated Resident #79 was walking in the hallway, and he asked him if he needed anything; he stated, no. LVN B stated he took a break and then he came back in at 3:00 p.m. LVN B stated when he was performing finger sticks for blood sugars around 4:00 p.m. he asked Resident #79 if he needed anything and he stated he wanted to leave. LVN B said Resident #79 was getting agitated, so he spoke with him, and he agreed to go back to his room. LVN B said he showed him where it was and just thought he was still trying to acclimate to his room and the facility. LVN B said when he got Resident #79 to his room, he told him No buddy this is where you live now at least for a while. And he agreed to lie down. LVB stated he left him there and went to complete finger sticks and dinner and when he made his next rounds around 6:00 p.m. he was not in his room. LVN B stated he looked for him, and he was not walking in the hallway. LVN B said he told the staff he could not find him; they all begin to look. Someone notified the DON and the police. LVN B stated he called the family, the Physician, and the Nurse Practitioner. LVN B stated he was worried about the resident because he could get hurt out there. LVN B confirmed he had in-service training on the next day on elopement and could not return to work until he did. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024
NAME OF PROVIDER OR SUPPLIER Carrara		STREET ADDRESS, CITY, STATE, ZIP CODE 4501 Tradition Trail Plano, TX 75093	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 04/03/2024 at 1:00 p.m. with RN A revealed she was the weekend RN Supervisor on 07/30/2023. RN A stated Resident #79 was agitated and frustrated acting on that day and he kept walking around in the hallways. RN A said he was not exit seeking, just agitated. RN A stated Resident #79 approached her and stated, I am going to leave this place When she spoke to him, he wanted to talk to his family member, so she called the family member. RN A said after Resident #79 spoke to her, he went back to his room with the CNA (she could not recall her name). RN A said but later he came out of his room, and he was walking in the hallways again. She said he was not agitated just frustrated acting, and not exit seeking. RN A stated she did not report this to anyone, and she did not do an elopement risk assessment, because he had been easily redirected and he was no longer agitated, just walking and appearing frustrated. RN A stated she did not think she needed to report to anyone that Resident #79 was talking about leaving because he was redirectable. In an interview on 04/05/2024 at 10:00 a.m. with DOR (Director of Rehab) revealed she did recall Resident #79. The DOR stated she had treated him as a Speech Therapist when he was there. The DOR stated he was difficult to treat, he was not interested, and could not focus because he was not interested in what they were doing for his rehabilitation. The DOR said she completed a screening at the beginning, at the middle, and at the completion. His screening showed he had not made any progress, if very little during his therapy. He was just very basic in his thinking. She stated he was alert but not completely oriented and could not communicate effectively and make decisions for himself. The DOR stated that he did talk about where he was going when he left there, and he used to tell her he was leaving soon. The DOR stated she thought he was talking about when he went back to where he had come from. The DOR stated he was living in a group sobriety home. Attempts were made to contact the previous DON on 04/02/2024 at 11:00 a.m. and 1:45 p.m., and on 04/04/2024 at 3:00 p.m. Attempts were made to contact the previous Administrator on 04/03/2024 at 3:30 p.m., 04/04/2024 at 10:00 a.m. and 2:00 p.m., and 04/05/2024 at 2:15 p.m. Attempt was made to returen call to the Medical Director on 04/05/2024 at 11:30 a.m. without success and a message was left. The Medical Director did not return call prior exit. Review of the Facility's Policy titled Abuse protocol dated March 2012 reflected: 14. If patient begins to exhibit inappropriate behavior, the facility will assess the patient and take appropriate steps to both minimize further inappropriate behavior and to protect these steps will include, as appropriate, providing additional supervision .obtaining appropriate medical/psychiatric evaluation and treatment, adjusting facility practices to minimize the risk of further inappropriate behavior and using activities and interventions that redirect the energies of . patients Review of Facility's Policy titled Elopement Response Protocol dated January 2023 reflected the following Upon the occurrence of an elopement or a suspected elopement, the following steps must be immediately taken: 1. Conduct thorough search of the facility and its grounds. 2. If the Patient is not found within 30 minutes notify the Executive Director, DON, Regional [NAME] President Operations (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024
NAME OF PROVIDER OR SUPPLIER Carrara		STREET ADDRESS, CITY, STATE, ZIP CODE 4501 Tradition Trail Plano, TX 75093	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Notify the patient's responsible party and attending physician. 4. Notify the police department. 5. Organize search teams composed of facility staff to search the vicinity of the facility on a continuous basis. Search teams should conduct their searches in one-hour shifts and cover defined areas identified on a street map. Unless the specific circumstances dictate otherwise, searches should begin with an area that consists of a circle with a one-mile diameter with the facility at its center and then expand to incrementally broader areas. 6. Communicate updates frequently (i.e. every hour) to the Regional Director of Clinical Services, Regional [NAME] President of Operations and the [NAME] President of Clinical Operations until the patient is located or you are directed to report at a different frequency .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024
NAME OF PROVIDER OR SUPPLIER Carrara		STREET ADDRESS, CITY, STATE, ZIP CODE 4501 Tradition Trail Plano, TX 75093	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46486 Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 (Resident #80) of 5 residents reviewed for clinical records. 1. The facility failed to ensure staff kept copies of Resident #80's shower sheets from February and March 2024. 2. The facility failed to provide nurses notes on Resident #80's refusals to shower from February and March 2024. These failures could affect residents and place them at risk of inaccurate or incomplete clinical records. Findings included: Review of Resident #80's face sheet, dated 03/27/2024, reflected the resident was a [AGE] year-old woman who was admitted to the facility on [DATE] and discharged [DATE]. Her diagnoses included chronic obstructive pulmonary disease, unspecified infectious disease, unspecified fall, hemorrhage of left cerebrum without loss of consciousness, and urinary tract infection. Review of Resident 80's MDS assessment, dated 2/26/2024, reflected she had a BIMS score of a 3. Review of shower log provided by the facility for Resident #80 revealed there were no showers for the month of February 2024 and four showers the entire month of March 2024. Interview on 04/04/24 at 2:12 PM with CNA D revealed he cared for Resident #80 and provided her only four bed baths while she was at the facility. CNA D said Resident #80's shower days were Tuesdays, Thursdays, and Saturdays. CNA D said when a resident refused a shower he would notify LVN E and if Resident #80 continued to refuse he would fill out a shower sheet and give it to the LVN E. CNA D said he was not sure what happened to the shower sheets after that. Interview on 04/04/24 at 2:45 PM with the LVN E revealed he was not able to locate any shower sheets for Resident #80 or nurses notes documenting the refusal for February and March 2024. Interview on 04/04/24 at 3:08 PM with the DON revealed he was unable to locate any additional shower sheets for Resident #80 for the months of February and March 2024. The DON said the shower sheets were pulled and discarded at the end of each month. The DON said the CNA's were responsible for providing showers and filling out the shower sheet and then showing it to the Nurse and placing it in a specific place to be held until the end of the month. He revealed the purpose of keeping shower sheets was to prove that the resident was offered a shower on that date and if they refused it was annotated on the shower sheet. The DON revealed no nurse documented shower refusals of resident 80 and no notification to family. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024
NAME OF PROVIDER OR SUPPLIER Carrara		STREET ADDRESS, CITY, STATE, ZIP CODE 4501 Tradition Trail Plano, TX 75093	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy, revised July 2017, and titled Charting and Documentation reflected: Documentation in the medical record may be electronic, manual or a combination. The following information is to be documented in the resident medical record: Objective observations; Treatment or services performed; changes in resident's condition. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Documentation of procedures and treatments will include care specific details, including: the date and time the procedure/treatment was provided; the name and title of the individual who provided the care; the assessment data and/or any unusual findings obtained during the procedure/treatment; how the resident tolerated the procedure/treatment; whether the resident refused the procedure/treatment; notification of family, physician or other staff, if indicated; and the signature and title of the individual documenting.		