

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

Printed: 08/28/2024
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 05/22/2024
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49415 Based on observation, interview and record review, the facility failed to promote and maintain the residents' right to be treated with respect and dignity for 2 of 8 residents (Resident #2 and Resident #4) reviewed for dignity and respect in that: 1) The facility failed to provide Resident #2 with help using the toilet and was told by staff to wear an adult brief after her preference to use the toilet with help was voiced. 2) The facility failed to answer call lights in a timely manner for Resident #2 and Resident # 4's. These failures could place residents at risk of diminished quality of life and loss of dignity and self-worth. The findings were: 1) Record review of Resident #2's face sheet revealed a [AGE] year-old female, admitted on [DATE]. Diagnoses included: Right Arm Arthritis (swelling and tenderness causes joint pain or stiffness), Overactive Bladder (a problem with bladder function that causes the sudden need to urinate), Unspecified Osteoarthritis (a progressive joint disease that causes inflammation and pain in joints). Record review of Resident #2's admissions MDS dated [DATE] revealed a BIMS score of 15 which is cognitively intact. Record review of Resident #2's Care Plan revealed it was not completed. (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 05/22/2024
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 5/22/24 at 11:23 a.m. Resident #2 stated she was admitted last Thursday evening, 5/16/24 after having surgery on her shoulder. Resident #2 said she fell when she got on a treadmill and the speed was too high. She dislocated her shoulder and had to have surgery. Resident #2 stated she has had a pretty bad experience at the facility. She stated the night shift is scary and they did not want to take her to the bathroom. They told her to pee in her diaper instead of helping her use the restroom. Resident #2 stated a female on the night shift told her she had over 30 residents to take care of by herself. She stated this is why they wanted her to wear a diaper. Resident #2 stated she could walk but needed assistance to use the restroom. She had told the facility staff she wanted help using the bathroom instead of wearing a diaper but stated they take so long to come when she used her call light. She stated she would almost wet herself or would wet herself. Resident #2 said it was better to wear the diaper than wet herself. She stated last night, 5/21/24, she needed two changes and used her call light but got no response. 2) Record review of Resident #4's face sheet revealed a [AGE] year-old man who was admitted on [DATE]. Diagnoses included: Acute kidney failure (a condition in which the kidneys suddenly cannot filter waste from the blood), Cardiac arrhythmia (improper beating of the heart, whether irregular, too fast, or too slow), Hypertension/High Blood Pressure (a condition in which the force of the blood against the artery walls is too high), Long term use of anticoagulants (blood thinners which could increase the risk of bleeding, which can be fatal or affect critical organs), Pain, and Shortness of Breath. Record review of Resident #4's quarterly MDS dated [DATE] revealed a BIMS score of 09, which is moderately cognitively impaired. Resident #4's MDS revealed he needs partial/moderate assistance (helper does less than half) with eating. Also, Resident #4's MDS revealed he needed substantial/maximal assistance (helper does more than half the effort) with oral hygiene, toileting hygiene, dressing, and personal hygiene. Furthermore, Resident #4's MDS revealed he was dependent for chair/chair to bed transfer and uses a wheelchair and is incontinent. Record review of Resident #4's Care Plan revealed he was at risk for falls with interventions for staff to respond promptly to calls for assist to the toilet. Also, Resident #4's care plan stated he was always incontinent, and interventions were to check for incontinence; change if wet/soiled to keep skin intact. Furthermore, Resident #4's care plan stated he was at risk for pressure ulcer development with interventions for incontinent care provided every 2 hours and as needed. Interview and Observation on 5/22/24 at 11:56 a.m. with Resident #4 was in a wheelchair and was unable to speak but agreed to shake his head yes or no to questions. He shook his head yes and put his hands outstretched wide when asked if call lights took a long time to be answered. Resident #4 shook his head yes when asked if the night shift took longer to answer call lights. Interview on 5/22/24 at 12:01 p.m. with LVN B stated they do abuse/neglect training every week. He stated the call lights should be answered in 5 to 10 minutes. LVN B said residents should be checked on every two hours. Interview on 5/22/24 at 12:46 p.m. with CNA C stated they do abuse/neglect training weekly or bi-weekly at least. He stated call lights should be answered as soon as the call light went on. He said the call light beeps at the nurse's station also. CNA C stated resident should be checked on every 2 hours or more frequently if they are a fall risk or cannot use their call light. (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 05/22/2024
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 5/22/24 at 12:59 p.m. with CNA D stated they do abuse/neglect training weekly and as needed. She stated they are supposed to answer call lights promptly. CNA D stated if you were with a resident, you went to the next resident when you were done. CNA D said all the nurses help each other out answering call lights. She stated residents were to be checked on every 2 hours and as needed. CNA D said she would check on fall risk residents more often. Interview on 5/22/24 at 1:17 p.m. with CNA E stated they do abuse/neglect training every week and as needed. He said call lights should be answered as soon as possible. CNA E said residents are to be checked every two hours or if their call light was on. Interview on 5/22/24 at 4:04 p.m. with DON stated calls lights were expected to be answered within 5 - 10 minutes. He stated residents were to be checked on rounds every 2 hours and as needed. The DON said it was not ok to tell a resident to wear a brief instead of getting help to use the bathroom. The DON stated they had a staff meeting every morning and the nurses would go to each resident's room and ask the resident if they were getting the proper care. Record Review of Resident Council minutes from 3/18/24 showed weekend and night shift take longer for call lights. Also, on 5/21/24, call light need answered timelier. Record Review of the facility's Resident Rights Guidelines for All Nursing Procedures, dated October 2010, stated under Preparation: a. Preventing, recognizing, and reporting resident abuse. b. Resident dignity and respect. Record Review of the facility's Abuse Prohibition Protocol policy dated April 2019, stated under 7. The following definitions are provided to assist our Facility's staff members in recognizing incidents of Patient Abuse: and I. I. Neglect is the failure of the facility, it is employees or service providers to provide goods and services to a Patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Record Review of facility's Call Light policy, dated June 14, 2006, stated under Responsibility All Staff. Under Purpose To respond promptly to Patient's call for assistance and to ensure call system is in proper working order. Under Procedure Answer ALL call lights promptly whether or not you are assigned to the Patient. Answer all call lights in a prompt, calm, courteous manner. Never make the Patient feel you are too busy to give assistance; offer further assistance before you leave the room. Record Review of facility's Incontinent Care Protocol dated June 2013 stated under Goal: Maintain the Patient in a clean and dry state and prevent complications of incontinence by maintaining and providing incontinent care to the Patient at regular intervals. Under Procedure: Incontinent care will be provided after each incontinent episode. The incontinent product will be changed as indicated. Also, under Document/Review: Care plan and Daily Care Guide reflects every 2- hour checks, preventive skin care and turning/repositioning.		

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 05/22/2024
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49415 Based on observations, interviews and record reviews, the facility failed to ensure a resident who was unable to carry out activities of daily living received necessary services to maintain good personally hygiene for 3 out of 8 residents (#2, #5, and #6) reviewed for ADL care. The facility failed to provide timely incontinence care for every two hours or as needed for Resident #2, # 5 and # 6 from 5/17/24 through 5/21/24. The facility failed to provide timely incontinence care on a regular basis for residents #2, #5, and #6. This failure could place residents at risk of skin breakdown, urinary tract infections and loss of dignity. Findings included: 1) Record review of Resident #2's face sheet revealed a [AGE] year-old female, admitted on [DATE]. Diagnoses included: Right Arm Arthritis (swelling and tenderness causes joint pain or stiffness), Overactive Bladder (a problem with bladder function that causes the sudden need to urinate), Unspecified Osteoarthritis (a progressive joint disease that causes inflammation and pain in joints). Record review of Resident #2's admissions MDS dated [DATE] revealed a BIMS score of 15 which is cognitively intact. The MDS was not completed as Resident #2 was admitted on [DATE]. Record review of Resident #2's ADL care sheet showed incontinent care was documented on 5/17/24 at 1:10 p.m. and at 6:37 p.m., 5/18/24 at 1 a.m., 7:29 a.m. and at 5:42 p.m., 5/19/24 at 2:10 a.m., 6:59 a.m. and at 5:03 p.m., 5/20/24 at 7:44 a.m. and at 7:12 p.m., 5/21/24 at 12:28 a.m., 7:11 a.m., 7:44 p.m. and at 11:31 p.m., 5/22/24 at 9:19 a.m. Interview on 5/22/24 at 11:23 a.m. Resident #2 stated she was admitted last Thursday evening, 5/16/24 after having surgery on her shoulder. Resident #2 said she fell when she got on a treadmill and the speed was too high. She dislocated her shoulder and had to have surgery. Resident #2 stated she has had a pretty bad experience at the facility. She stated the night shift is scary and they did not want to take her to the bathroom. They told her to pee in her diaper instead. Resident #2 stated a female on the night shift told her she had over 30 residents to take care of by herself. She stated this is why they wanted her to wear a diaper. Resident #2 stated she could walk but needed assistance to use the restroom. She had told the facility staff she wanted help using the bathroom instead of wearing a diaper but said they take so long to come. She stated she would almost wet herself or would wet herself. Resident #2 said it was better to wear the diaper than wet herself. She stated last night, 5/21/24, she needed two changes and used her call light but got no response. (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 05/22/2024
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Record Review of Resident #5's face sheet revealed a [AGE] year-old female, who was admitted on [DATE]. Diagnoses included: Vascular Dementia (occurs when blood flow to brain is reduced which can lead to problems with memory, thinking and behavior), Presence of Right Arthritis (swelling and tenderness causes joint pain or stiffness), Insomnia (sleep disorder in which one has trouble falling asleep, staying asleep or getting quality sleep), Generalized Anxiety, Psychotic Disorder (a mental disorder characterized by a disconnection from reality), Depression and Shortness of Breath. Record Review of Resident #5's Quarterly MDS dated [DATE], revealed a BIMS score of 99 which revealed the resident was unable to complete interview. The MDS revealed Resident #5 was in a wheelchair and is dependent on ADL care provided by 2 or more staff. Furthermore, Resident #5's MDS revealed she was always incontinent. Record Review of Resident #5's Care Plan dated 4/18/24, revealed she required ADL care due to contracture and was incontinent of bowel and bladder. The care plan stated Resident #5 would remain clean, dry and odor free by being placed on a 2-hour toileting program. Resident #5 was also care planned as a fall risk, had dementia, and rejected care/medications at times. Record Review of Resident #5's ADL care sheet revealed incontinent care was documented as given on 5/17/24 at 3:27 a.m. and at 1:30 p.m., 5/18/24 at 1:15 a.m. and at 9:59 a.m., 5/19/24 at 12:58 p.m., 5/20/24 at 8:41 a.m., 9:58 p.m. and at 10:30 p.m., 5/21/24 at 9:58 p.m. 1:32 a.m. and at 11:16 a.m. Observation and attempted interview on 5/22/24 at 12:07 p.m. Resident #5 was watching television. Surveyor introduced herself, and asked if she could talk to her, but Resident #5 closed her eyes. Surveyor asked if she was all right, and she closed her eyes tighter. Surveyor left the room and less than a minute later, Resident #5 started moaning loudly. 3) Record Review of Resident #6's face sheet revealed an [AGE] year-old man who was admitted on [DATE]. Diagnoses Included: Unspecified Dementia (Dementia (loss of memory, language, problem solving and other thinking abilities that interfere with daily life) without a specific diagnoses), Unspecified Convulsions (fits or seizures), and Parkinsonism (disorder of central nervous system that affects movement, often including tremors). Record Review of Resident #6's Admission MDS on 4/19/24 revealed a BIMS of 03; significantly cognitively impaired. The MDS for Resident #6 revealed he was in a wheelchair, and he was totally dependent on staff for ADL care including incontinent care with 2 or more people assisting. Record Review of Resident #6's Care Plan dated 4/19/24 showed he was a fall risk and had dementia. Record Review of Resident #6's ADL care sheet revealed incontinent care was documented as given on 5/17/24 at 12:45 a.m., 5/18/24 at 1:04 a.m. and 9:47 a.m., 5/19/24 at 12:14 p.m., 5/20/24 at 8:45 a.m., 5/21/24 at 9:57 p.m. and on 5/22/24 at 1:39 a.m. and 11:14 a.m. Interview on 5/22/24 at 12:01 p.m. LVN B stated they do abuse/neglect training every week. LVN B said residents should be checked on every two hours. Observation and attempted interview on 5/22/24 at 12:09 p.m. Resident #6 was sitting in his wheelchair in his room watching television. He was unable to answer any questions and just smiled and laughed when Surveyor told him she would let him go. (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 05/22/2024
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 5/22/24 at 12:46 p.m. CNA C stated they do abuse/neglect training weekly or bi-weekly at least. CNA C stated resident should be checked on every 2 hours or more frequently if they are a fall risk or cannot use their call light. Interview on 5/22/24 at 12:59 p.m. CNA D stated they do abuse/neglect training weekly and as needed. She stated residents were to be checked on every 2 hours and as needed. CNA D said she would check on fall risk residents more often. Interview on 5/22/24 at 1:17 p.m. CNA E stated they do abuse/neglect training every week and as needed. CNA E said residents are to be checked every two hours or if their call light was on. Interview on 5/22/24 at 4:04 p.m. the DON stated residents were to be checked on rounds every 2 hours and as needed. The DON stated when incontinent care was done, the CNAs are to document it on the computer. The DON stated he would be concerned if an ADL dependent resident only had 2 documented incontinent care times documented in the computer in a day. The DON stated there were several risks to a resident such as a UTI, Neglect, and patient's rights as well if resident's ADL care was done in a timely manner. The DON stated it was not all right for staff to tell a resident to wear an adult brief instead of helping them use the restroom. The DON stated they had a staff meeting every morning and the nurses would go to each resident's room and ask the resident if they were getting the proper care. Record Review of the facility's Resident Rights Guidelines for All Nursing Procedures, dated October 2010, stated under Preparation: a. Preventing, recognizing, and reporting resident abuse. b. Resident dignity and respect. Record Review of the facility's Abuse Prohibition Protocol policy dated April 2019, stated under 7. The following definitions are provided to assist our Facility's staff members in recognizing incidents of Patient Abuse: and I. I. Neglect is the failure of the facility, it is employees or service providers to provide goods and services to a Patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Record Review of facility's Incontinent Care Protocol dated June 2013 stated under Goal: Maintain the Patient in a clean and dry state and prevent complications of incontinence by maintaining and providing incontinent care to the Patient at regular intervals. Under Procedure: Incontinent care will be provided after each incontinent episode. The incontinent product will be changed as indicated. Also, under Document/Review: Care plan and Daily Care Guide reflects every 2- hour checks, preventive skin care and turning/repositioning.		