

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

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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 12/12/2024
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 - 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** 50445 Based on observation, interview, and record review the facility failed to ensure residents received adequate supervision to prevent incidents and accidents for one resident (Resident #1) of five residents reviewed for possible accident hazards and incidents. The facility failed to provide adequate supervision for Resident #1 on 07/23/2024 when he slid out of the sling during a mechanical lift transfer from wheelchair to bed. The noncompliance was identified as past noncompliance (PNC). The PNC began on 07/23/24 and ended on 07/28/24. The facility had corrected the noncompliance before the state's survey began. This failure could place residents at risk for possible injuries due to lack of adequate supervision. Findings included: Review of Resident #1's Face Sheet reflected Resident #1 was a [AGE] year-old male admitted to the facility on [DATE]. Record review of Resident #1's Quarterly MDS dated [DATE] reflected diagnoses including dementia, hypertension (elevated blood pressure), diabetes mellitus (alteration in blood sugar), aphasia (communication disorder resulting from a brain injury and may include inability to speak well), and stroke. The MDS reflected Resident #1 required substantial/maximal assistance for transfers to and from the bed and wheelchair. Record review of Resident #1's Care Plan dated 03/15/2022 and effective at the time of the incident (07/23/2024) reflected Resident #1 was dependent with activities of daily living and required the use of a mechanical lift for transfers. Review of Provider Investigation Report reflected the facility reported to Health and Human Services on 07/24/2024 at 05:15 p.m. that on 07/23/24 at 07:45 p.m. an incident occurred in which Resident #1 fell out of a sling during a mechanical lift transfer as reported to the charge nurse on duty by CNA A and CNA B. (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of written witness statement obtained by the facility and signed by CNA B dated 07/23/24 were reviewed and stated, sling never detached from hoyer and As I along with another staff were preparing to transfer 405 we hooked and secured the sling to the hoyer lift. As he started to push the button to go up everything seem to be ok. Then patient slipped out legs first head cushioned by a pillow that was on the wheelchair. We checked on his wellbeing immediately and then transferred by hand to the bed.(unable to read) arranged and checked again verbalize to make sure patient was ok. No concern of pain. Nurse Notified. Review of written witness statement obtained by the facility, signed by CNA A, and dated 07/23/24 stated, As we were transferring the resident in room [ROOM NUMBER] with another CNA, the sling was properly hooked on the hoyer but along the line the patient slipped. We notified the nurse, picked him up and got him situated. The patient, when asked said he did not feel any pain. Review of records- Clinical Note dated 07/23/24 and entered by LVN H for Resident #1 stated, 1945 (07:45 p. m.) the CNAs reported to this nurse that during transfer the resident from the wheelchair to bed by use of the mechanical lift, the resident slipped out of the Sling and fell down. The sling never detached from the Hoyer. The clinical note reflected that the nurse completed a head-to-toe assessment of Resident #1, notified the nurse practitioner, the hospice company, the ADON, and the family. LVN H reported he received orders for x-rays, and initiated neuro checks. The clinical note did not indicate that Resident #1 experienced any injury or any pain. Review of records reflected that on 07/24/2024 that x-rays revealed compression fracture of the T11 vertebral body that was of indeterminate age. The physician was notified, and Resident #1 was sent to emergency room for follow up. Record review of hospital records reflected that Resident #1 had no acute injuries: Hospitalist Progress Note dated 07/24/24 and written by MD A was reviewed and revealed that Resident #1 cat scan of the brain and x-rays showed no acute bleed or fractures or dislocations and that T-spine showed chronic T3 and T11 compression fractures. In an interview and observation on 12/10/24 at 11:00 a.m. Resident #1 was observed laying in bed. The bed was in low position and the call light was in reach. He denied remembering any incident of falling from a lift. His answers to questions did not always correspond appropriately to the questions. A wheelchair was noted at the bedside and a sling was on the back of the chair. The sling was noted in good condition. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 12/10/24 at 12:46 pm, LVN H reported he was the nurse for Resident #1 on 7/23/24 and that CNA A and CNA B reported to him in the evening that Resident #1 had slid out of the sling when they were transferring him from the wheelchair to the bed. He stated, I went to the room and the resident was on the floor. The CNAs reported they assisted the resident to the floor when he began to fall. They did not state that he hit his head or anything else. I looked and the Hoyer lift was okay, the sling was okay. LVN H reported he immediately went to Resident #1's room and noted Resident #1 lying on his back on the floor with his legs pulled up in a fashion typical for the resident, and that his hands were laying across his chest. LVN H stated the sling was under the resident but that he did not note the positioning of the sling. He reported that the resident was within one or two feet of the bed and was not contacting any object. He stated, I'm not sure what might have caused the slide, they did not mention anything. I assessed the resident, and he denied any pain. The facility policy to do neuro checks, we notified the hospice, management (unit manager), an x-ray was ordered, the family was contacted. The resident was not transferred on my shift, but I think maybe the next day. He also stated, A resident could slip out of a Hoyer lift if the resident was not properly positioned and that a resident who fell from a mechanical lift, could have a fracture or other injury. He reported that, Since the incident, the facility continues training on Hoyer lifts, but also nurses now monitor transfers with the Hoyer lift, when possible, to monitor for safe technique. In a telephone interview on 12/10/24 at 02:00 p.m., CNA A reported that on 7/23/24 he was working on evening shift when, the aide that was working that hall called me to help with Resident (Resident #1) to put him to bed. When we lifted him off of his chair, we noticed that his butt was almost off the sling, we lowered him to the floor with our arms and called the nurse to come and assess him. There was a pillow behind him on the neck area when he was in the chair and when we brought him down, we used the pillow as well to bring him down. He did not hit his head. He did not hit anything that we were aware of. When he was lifted from bed to chair, because of the way his legs are wide open, it may have created a wrinkle in the sling that made it not positioned well when we tried to transfer him. CNA A reported he received mechanical lift training about two weeks prior to the incident and again following the incident which including the need for two persons, locking the lift, manual controls, and the safe use of the lift. He stated he felt safe with the use of the mechanical lift at the time of the incident. He reported that the nurses are now more likely to check on the CNAs who are using mechanical lifts. In an interview on 12/10/24 at 12:50 p.m., the ADM reported that CNA B recently quit working at the facility, and they do not have an active contact number for her. The only phone number available for CNA B was noted as a non-working number. In a telephone interview on 12/10/24 at 04:04 p.m., NP A reported that Resident #1 did not have any injuries related to the fall from the mechanical lift in July. She denied any knowledge of any other residents at this facility having an injury related to a mechanical lift. She stated she has frequently seen Resident #1 and has had no concerns related to abuse or neglect in relation to this resident or the use of the mechanical lift by the facility staff. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/10/24 at 11:46 a.m., the ADM reported she had worked at this facility for 8 months. She reported she did the investigation related to the fall from the mechanical lift by Resident #1. She stated that based on the investigation at that time, When they were doing the transfer, the patient slipped out of the sling when going from wheelchair to the bed. They guided him as much as they could. He hit his back on the floor. They notified the charge nurse and the Hospice nurse and notified the family. X-rays were ordered and done 7/23/24 on the 2-10 shift. The x-ray came back negative through the hospice company, and we ordered a second x-ray through our company. The second x-ray done the next morning showed a possible compression fracture. The patient had no pain. The patient was sent out to the emergency room for a cat scan on 7/24/24. The cat scan showed the fractures were chronic and no new fractures were noted. The patient was kept for a urinary tract infection, but he returned to the facility after 4 days. ADM reported that the positioning of the patient on the sling was indicated as possible cause of the fall as CNA reported that the sling may have been mispositioned on the resident. She stated, If I remember correctly the patient wasn't up far enough on the sling. She reported there are 5 mechanical lifts at the facility. She reported that if a resident falls out of the mechanical lift, they could sustain a trauma or a fracture. In an interview on 12/10/24 at 12:00 p.m., LVN I stated she was here on 7/23/24 but that she was not here on the evening shift when the incident occurred. She reported that she was notified by CNA A and CNA B who were transferring resident #1 from the wheelchair to the bed, and they said he slid out of the sling, that basically Resident #1 was moving and that they guided him to the floor. The CNAs stated that the positioning of the resident on the sling may have and the resident moving, may have resulted in him sliding down, and they guided him down to the floor. LVN I reported the accident/injury assessment was done, the family and hospice were notified, the resident received an x-ray, and the facility did an x-ray as well. The resident was sent out to the hospital the next day for a cat scan which was negative. Review of Employee Coaching and Counseling Record dated 07/24/24 and signed by CNA B revealed, Employee in-service and re-evaluated on transferring and procedures when using lift with residents. The facility training records for CNA B were reviewed and noted to include signed Fall prevention competency testing dated 07-09-24 as well as a signed mechanical Lift Competency Skills Checklist dated 07/09/24 and a Transfer Skills Checklist signed and dated 07/09/24. Employee Coaching and Counseling Record dated 07/24/24 and signed by CNA A revealed, Employee inserviced and re-evaluated on transferring and procedures when using lift with residents. The facility training records for CNA A were reviewed and noted to include signed Fall prevention competency testing dated 07-09-24 as well as a signed mechanical Lift Competency Skills Checklist dated 07/09/24 and a Transfer Skills Checklist signed and dated 07/09/24. Review of Facility Accident/Incident Reports dated from 07/07/24 to 12/05/24 were reviewed with no incidents indicating the involvement of a mechanical lift. In an observation on 12/11/24 at 09:00 a.m., CNA C and CNA D were observed transferring Resident #1 from the bed to the chair using the mechanical lift. Proper technique including the proper positioning of the sling was utilized, and no safety concerns were identified. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 12/10/24 at 09:30 a.m., CNA E and CNA C were observed transferring Resident #2 from her electric wheelchair to her bed using the mechanical lift, providing incontinence care, and then transferring Resident #2 back to her wheelchair using the mechanical lift. The CNAs utilized the mechanical lift safely. The CNAs positioned the sling beneath the resident and attached it to the lift appropriately. The resident tolerated well, and no safety concerns identified. In an interview on 12/10/24 at 09:45, Resident #2 reported she has received assistance with mechanical lift transfers three to four times a day for months due to incontinence. She stated she has never been injured, fallen, or slipped during the use of the mechanical lift and that many different CNAs have assisted her. Review of facility Mechanical Lift Protocol (undated) reflected, 7. Complete return demonstration with all nursing staff with the Hoyer Lift transfer checklist. Review of the facility Full Mechanical Lift Competency Skills Checklist dated May 2024, reflected, 17. Ensure the patient is centered in the lift sling before raising the lift to transfer. The facility took the following actions to correct the noncompliance prior to the investigation: In an interview on 12/10/24 at 11:23 a.m., the DON reported he has worked at this facility for 9 months. He stated that he was not here and had been on leave during the time surrounding Resident #1's fall from the mechanical lift. He stated he was aware that post-incident training was completed with staff and that the unit manager for long-term, LVN I, was responsible for that. He stated that since the incident what the facility does differently is that he himself and LVN I often walk in to see if a resident being transferred is being transferred appropriately. He also stated that LVN I reinforces in-service trainings with the staff. He reported that staff receive mechanical lift training annually and prn and that mechanical lift training had been done within 8 months prior to the incident. The DON reported he did not know how Resident #1 might have fallen out of the sling. Review of facility Employee In-Service Training Report dated 07/24/2024 and titled, Abuse and Neglect in Skilled nursing Facilities: An Overview was reviewed and noted to include staff signatures. The Inservice Training Report dated 07/24/2024 and Titled Sling Care was reviewed and included the content, This sling must be inspected prior to each use for any rips, tears, frayed, or bleached areas which are unsafe and could result in injury. Do not exceed max. weight specified. Refer to Owner's manual for operation of your lift. The in-service training included staff signatures. In-service Training Report dated 07/24/2024 and titled, Mechanical Lift/Hoyer Training included topics of Hoyer lift storage, Battery Charging, and Procedure and Correct Use and was noted to include signatures of nurses and CNAs. Staff return demonstration checklists date 07/24/24 through 07/28/24 titled, Mechanical Lift Competency Skills Checklist were reviewed. Training record for CNA B revealed a Transfer Skills Checklist and a Mechanical Lift Competency Skills Checklist and Fall Prevention Competency Test were completed and signed by CNA B on 07/24/24. Fall Prevention Competency Test, Mechanical Lift Competency Skills Checklist, and Transfer Skills Checklist were completed and signed by CNA A on 07/06/22 and on 07/03/24, and these were repeated and signed post-incident on 7/24/24. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/10/24 at 12:00, LVN I reported she did one on one training with the two aides involved in the incident and all the nursing staff beginning the next day following the incident. She was assisted in training by the therapy department. She reported all staff have received training including the proper use of the mechanical lift and transferring, including the need for two people. She reported mechanical lift training will be done upon hire and quarterly and with annual training and that the staff will be required to do a return demonstration. She reported that in-services will be done as needed between the trainings. She reported that since the incident, the facility does more spot checking to go in and see that mechanical transfers are being done correctly. This is done by the unit managers, nurses, the DON, and staffing coordinator. The frequency of these checks can vary but are often done when it is noted a mechanical lift is being used. Mechanical lift training was reported as completed fully on 7/28/24 after the weekend staff received training. In an interview and review of records on 12/10/24 at 11:46 a.m., the ADM reported that retraining on mechanical lift transfers were done with the two CNAs involved as well as all nursing staff throughout facility beginning 07/24/24. The training completed on 07/28/24 in order to include the weekend staff. She reported that mechanical training continues to occur with all staff upon hire, quarterly and prn. The ADM reported that during the training staff were required to give return demonstration to assure competency and that nursing staff are conducting periodic random checks on mechanical lift transfers to monitor for proper technique. The ADM reported that an emergency QAPI meeting was called on 07/25/24. The QAPI cover sheet dated 07/25/24 titled, Emergency QAPI Plan. System Identified: Transfer Techniques was noted with Participants listed as the executive director, DON, Medical Director, Unit Managers, and Director of Rehab. In an interview on 12/10/24 at 03:34 p.m., DOR reported she began assisting with mechanical lift training for nursing staff including the safe use, safe procedures, including sling placement on 07/24/24. She reported that she required staff to provide a return demonstration of mechanical lift use. She stated she is aware that managers, RN's and LVN's are also checking in during mechanical lift transfers with residents. She reported she believed all staff were trained in mechanical lift transfers and that this was completed within a few days of the incident with Resident #1. A record review of the facility's Hoyer Transfer Audit revealed that Hoyer transfer audits were conducted on a weekly basis from 07/25/24 through 08/29/24 and then bi-weekly from 09/25/24 until 10/31/24. These audits included a sample of six residents each week and no concerns were identified. In an interview on 12/10/24 at 09:50 a.m., CNA E reported she has worked at this facility for about 3 years. She reported she last received mechanical lift training at this facility about 3 months ago and that this included the CNAs transferring each other from chair to bed using the mechanical lift. She denied having ever witnessed any resident falling out or sliding out of a mechanical lift sling. She stated that this would only occur if, the CNA did the transfer by themselves, or they positioned the sling wrong. In an interview on 12/10/34 at 09:55 a.m., CNA F reported she has worked at this facility about 6 years. She stated she received mechanical lift training about 3 weeks ago and that this involved demonstrating the transfer of a fell ow CNA using the lift. She stated she has not witnessed or experienced a resident injured or fall during a mechanical lift. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an in an interview on 12/10/24 at 03:15 p.m., CNA G reported he has worked at this facility for about 7 months and that he last received mechanical lift training including the safe use of the mechanical lift including placement of the sling in July 2024. He stated that this occurred a day or two after an incident involving a resident in a mechanical lift. He stated that immediately following that training and since the nurses have been going around making sure we are doing Hoyer transfers right. In an interview on 12/10/24 at 03:18 p.m., RN I reported he has worked at this facility for five months (since August) and was not here at the time of the incident with Resident #1. He reported he last received mechanical lift training a few weeks ago. He stated that this included the safe use of the lift and sling placement as well as return demonstration. He reported that when he hired on, he was informed by his unit manager that nurses are expected to randomly pop in to monitor for the safety of residents receiving mechanical transfer. He stated that he assists and watches to ensure resident safety with mechanical transfers. In an interview on 12/10/24 at 03:20 p.m., LVN K reported he has worked at this facility for five months (since August) and was not here at the time of the incident with Resident #1. He reported he last received mechanical lift training a few weeks ago. He stated that this included the safe use of the life and sling placement as well as return demonstration. He reported that when he hired on, he was informed by his unit manager that nurses are expected to randomly pop in to monitor for the safety of residents receiving mechanical transfer. He stated that he assists and watches to ensure resident safety with mechanical lift transfers. In an interview on 12/10/24 at 03:45 p.m., LVN L reported he has worked at this facility for 6 or 7 years and that he received mechanical lift training in July. He reported the training included a return demonstration of the safe use of the mechanical lift including the positioning of the sling. He stated he was informed that nurses must always make sure that 2 CNAs are used when a resident is transferred and that he was told during training that nurses must check in on mechanical lift transfers periodically to ensure safety and he does this. In an interview on 12/10/24 at 09:00 a.m., CNA D (staffing coordinator) reported he often does random drop-ins to monitor mechanical lifts for proper techniques and safety, and that this began following the mechanical lift incident in July 2024.		