STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676429	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrara	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 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. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Resident #1) of four residents reviewed for respiratory care.The facility failed to ensure Resident #1's nebulizer mask (device used to deliver medication in a mist form through the nose and mouth) was properly stored, in a plastic bag with the resident's name and date on it, when not in use on 08/13/2025.This failure could place residents at risk for respiratory infection and not having their respiratory needs met.Findings included: Record review of Resident #1's Face Sheet, dated 08/13/2025, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #1 had diagnoses which included COPD (disease of the lungs and airway that affects breathing), diabetes (the body does not use insulin effectively), and chronic kidney disease (reduced kidney function). Record review of Resident #1's MDS (tool used to measure health status) Quarterly Assessment, dated 06/16/2025, reflected moderate impaired cognition with a BIMS (tool used to assess cognitive function) score of 12. Section I (active diagnoses) reflected Resident #1 was treated for COPD and asthma (lung disease that causes the airway to narrow and can make breathing difficult).Record review of Resident #1's Comprehensive Care Plan, dated 07/14/2025, reflected the resident had COPD and the approaches were to monitor for shortness of breath and administer medication as ordered.Record review of Resident #1's Physician's Order, dated 08/13/2025, reflected to administer Ipratropium Albuterol Solution 0. 5-2.5 (3) mg/3ml - inhale 1 vial orally three times a day for shortness of breath. During an observation and interview on 08/13/2025 at 9:30 AM, Resident #1 was lying in bed. A nebulizer was on top of Resident #1's night stand next to the bed. A nebulizer mask and tubing was connected to the nebulizer. The nebulizer mask was in the top drawer of the night stand with Resident #1's personal items. The mask was not bagged. Resident #1 stated she had a breathing treatment earlier that day. In an interview on 08/13/2025 at 9:42 AM, the RN stated the nebulizer mask should have been in a bag. She stated nebulizer masks and tubing were changed weekly for all respiratory care items. She stated it was important to keep them covered to prevent contamination and infection. During an interview on 08/13/2025 10:05 AM, the CNA stated she also looked at nebulizer masks. She stated nebulizer masks should always be in a bag when the resident was not using it. She stated if a nebulizer mask were not in a bag, she reported it to the nurse so the nurse could get a new mask and put in a bag. She stated she had not noticed the nebulizer mask was not in a bag. She stated if it was not kept in a bag, it was exposed to whatever was in the air. She stated if the resident put the mask back on her face, the risk could be infection. During an interview on 08/13/2025 at 10:12 AM, the ADON stated staff members changed oxygen tubing and nebulizer masks weekly on Sunday night. She stated items should be dated and stored in bags when not being used by residents. She stated this was a risk for infection to residents.During an interview on 08/13/2025 at 1:25 PM, the facility's Regional Nurse Consultant stated in-service training for staff was in progress. He stated there were dust particles in the air and it was important to keep respiratory items in bag to prevent the risk of infection to residents. Record review of the facility's policy Administration Through a Small Volume (Handheld) Nebulizer, undated, reflected 29 . store in a plastic bag with the resident's name and the date on it.