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	09/17/2025

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 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. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0842 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 interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 (Resident #1) of 5 residents reviewed for accuracy of medical records in that: The facility failed to document Resident #1's blood pressure before she was transported to dialysis on 08/13/25. This failure could place residents at risk of a change in condition and not receiving proper treatment and care in a timely manner.Findings included: Record review of Resident #1's face sheet, dated 09/17/25, reflected a [AGE] year-old female with an admission date of 01/24/23. Resident #1 had a diagnosis of Stage 5 Chronic Kidney Disease (the most advanced stage of kidney disease), Acute or Chronic Heart Failure (sudden life-threatening or worsening heart condition), Bacterial Infection (harmful bacteria enter the body and can cause damage), End Stage Renal Disease (kidneys have lost most of the function), Type 2 Diabetes Mellitus (body cannot regulate blood sugar levels), Fluid Overload (excessive amount of fluid in the body), Cardia Arrhythmia (abnormal heart rhythm), Presence of Heart Assist Device, Chest Pain, Unspecified Dementia (cognitive decline and memory loss), and Hypotension of Hemodialysis (a drop in blood pressure that occurs during dialysis). Record review of Resident #1's quarterly MDS assessment, dated 07/16/25, reflected she had a BIMS score of 11 in Section C, which indicated she was moderately impaired. Section N of the quarterly MDS assessment noted Resident #1 had anticoagulant, antibiotic, and hypoglycemic medications. Section O of the quarterly MDS assessment noted Resident #1 received dialysis while she was a resident. Record review of Resident #1's physician orders reflected the following orders: 04/21/25Dialysis MWF11:00 AM 04/21/25Vital Signs Every Shift Record review of Resident #1's Dialysis Communication Form, dated 08/13/25, reflected the following: Dialysis date: 08/13/25 Most Recent Blood Pressure Blood Pressure 102/65 Date 08/12/25 18:22 (6:22 PM) Record review of Resident #1's care plan with an initial date of 05/15/25 reflected the following: Resident #1 required hemodialysis 3 times per week due to ESRD Monitor vital signs. Notify MD of significant abnormalities Resident #1 has an implanted cardiac pacemaker Monitor vital signs. Notify MD of significant abnormalities Record review of the progress notes on Resident #1's electronic record reflected not vital listed for 08/13/25. Record review of the main page of the electronic record, dated 09/17/25, reflected the last blood pressure vital was taken on 08/12/25 at 18:22 (6:22 PM), and Resident #1's blood pressure was 102/65. Record review of the Vitals tab on Resident #1's electronic record reflected the last blood pressure recorded was on 08/12/25 at 18:22 (6:22 PM) by Nurse A. Record review of the August 2025 NAR reflected no blood pressure vitals documented on 08/13/25. Record review of the August 2025 MAR reflected no blood pressure vitals documented on 08/13/25. Record review of the August 2025 TAR reflected no blood pressure vitals documented on 08/13/25. During an interview on 09/17/25 at 11:10 AM, with the Director of Clinical Services, the DON, and the Administrator, Resident #1's Dialysis Binder was requested but not received prior to exit. In an interview on 09/17/25 at 11:40 AM, LVN B stated he prepped Resident #1 for dialysis on 08/13/25. He stated he took her to the transportation person and sent her dialysis folder with her. LVN B stated he checked all of her vitals before she left, and all were within the appropriate range. In an interview with the Director of Clinical Services and the ADON on 09/17/25 at 2:09 PM, The Director of Clinical Services stated he reviewed Resident #1's electronic record and did not locate documentation of Resident #1's blood pressure reading from 08/13/25. The ADON stated it could have been a coincidence that the blood pressure reading from 08/12/25 was the same reading for 08/13/25, and that LVN B probably just documented the wrong date for the blood pressure reading of 102/65. The Director of Clinical Services stated all staff were trained on quality of care, following physician's orders, and documentation. The Director of Clinical Services stated Resident #1's vitals would usually be checked before she left for dialysis. The Director of Clinical Services stated the risk of LVN B not possibly checking the blood pressure or recording the vitals of the patient could negatively affect the patient's care. In a follow-up interview on 09/17/25 at 2:26 PM, LVN B stated he recalled he manually checked Resident #1's blood pressure, but he could not remember what the reading was. LVN B stated he did remember that the blood pressure was within the normal range. LVN B stated vitals are checked on all dialysis residents before they leave for dialysis. He stated he must not have documented the blood pressure. He stated he thought he just wrote the wrong date on the dialysis communication form. LVN B stated the risk of not checking or not documenting the vital check was there could be a problem with the resident and staff would not be aware of