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	11/20/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 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 each resident had the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility for 1 (Resident #1) of 5 residents reviewed for reasonable accommodations. The facility failed to ensure CNA A removed Resident #1's lunch tray from the bedside table to accommodate him when requested.The noncompliance was identified as past noncompliance (PNC) that began on 11/03/25 and ended on 11/03/25. The facility had corrected the noncompliance before the state's investigation began. This failure could place residents at risk of not being able to meet their needs. Findings included:During a record review of Resident #1's face sheet, dated 11/20/25, revealed an [AGE] year-old man admitted on [DATE] with anxiety disorder (mental health conditions characterized by excessive worry or fear that interferes with daily life). During a record review of Resident #1's quarterly MDS assessment, dated 09/18/2025, revealed Resident #1 had a BIMS score of 5, which indicated severe impairment. Resident #1's functional limitation in range of motion revealed he was impaired on both sides for his upper and lower extremities and required setup or clean-up assistance with eating.During an interview on 11/20/25 at 10:00 a.m., the ADM revealed that on 11/03/25 Resident #1's family member notified me that an aide entered Resident #1's room and Resident #1 wanted to use his iPad that was located under his lunch tray. Resident #1 requested that the lunch tray be removed, and the staff member refused to remove the tray. The ADM stated that he learned through his investigation that the staff member did not remove the lunch tray and it was confirmed that it was a customer service issue and unprofessional. The ADM stated that the aide was suspended for a week, upon return was in-serviced on customer service and resident rights and reassigned and no longer worked with Resident #1. During an interview on 11/20/25 at 12:30 p.m., CNA A revealed that she had cared for Resident #1 on 11/03/25. CNA A stated that she was on the hall and heard a loud beeping noise and had entered his room, saw that his IV treatment had finished. The nurse assigned to the hall had dining room duties so informed Resident #1 that she was unable to disconnect the IV treatment that a nurse had to disconnect him from treatment and that she was going to find a nurse and would be right back. CNA A found a nurse, but the nurse had just entered another resident's room to perform trach care and informed CNA A to go and stay with the resident until she was able to get there. CNA A went back to Resident #1 room and told him that the nurse would be there shortly. CNA A stated that she saw that his colostomy bag needed to be emptied so started to change Resident #1's colostomy bag and Resident #1 requested her to remove his tray. CNA A stated that she had asked Resident #1 if he could wait until she had finished due to hands being dirty. She said she did not refuse to take the tray just delayed. CNA A stated she just wanted to finish what she was doing and would remove the tray on her way out. CNA A stated that she could have moved the tray off the table but was under the impression Resident #1 wanted her to remove the tray from the room. CNA A stated that she was suspended for a week and when she returned to work, she was reeducated on customer service and resident rights. Verified via record review in-services for CNA A were completed on 11/11/2025 and they were conducted by the ADM, Director of nursing and staffing coordinator. During an interview on 11/20/25 at 1:01 p.m., Resident #1 stated that on 11/03/25 an aide came into his room, he asked her to take his lunch tray so that he could utilize his bedside table, but the aide refused. Resident #1 stated he had called his family member by accident and the interaction was recorded on voicemail and it was reported to the ADM. Resident #1 stated that the aide had emptied his colostomy bag and still refused to remove the tray. Resident #1 stated he wanted the lunch tray removed from the beside table not the room, she could have placed it on the counter or sink area. Resident #1 stated that the aide was suspended for about a week, but when the aide returned, she could not care for him. Resident #1 stated that it did not cause him any harm or mental anguish, he just could not understand why she would not take the tray.During record review of Resident #1's recording on 11/20/25 at 1:05 p.m., revealed the aide refused to remove Resident #1's tray as requested. During an interview on 11/20/25 at 1:47 p.m., LVN B revealed that she entered Resident #1's room to disconnect his IV treatment that had finished. LVN B stated that Resident #1 and the aide was talking back and forth but she was focused on the disconnection and then left Resident #1's room. LVN B stated that she believed his lunch tray was on his bedside table as lunch had just finished. LVN B stated she did not hear what Resident #1, and the aide was talking about. LVN B stated that no voices were raised and did not hear anything derogatory or would have intervened. LVN B stated that she