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	02/20/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 2 (Resident #1 and Resident #2) of 5 residents reviewed for resident rights. The facility failed to ensure LVN A introduced herself and spoke to Resident #1 while administering pain medication. The facility failed to ensure LVN A introduced herself and spoke to Resident #2 while moving his call light. These failures could place residents at risk of not being treated with respect and dignity.Findings included: Review of Resident #1's admission MDS Assessment, dated 02/20/26, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her BIMS score was 14, which indicated she was cognitively intact. Her diagnoses included arthritis and pelvic fracture. An observation and interview on 02/19/26 at 11:15 AM with Resident #1 revealed she was lying in bed. She was groaning, grimacing and said she was in pain. LVN A walked into the room. She had a cup of water and a cup with a pill in it. She handed it to Resident #1. LVN A did not speak to the resident. She did not introduce herself or explain what medication she was giving to the resident. Resident #1 said she was used to the nurse not introducing herself. An interview on 02/19/26 at 11:25 AM, LVN A revealed she had been trained to introduce herself to residents and explain the medication she was giving, but this time she just did not. She said it was important to introduce herself and explain medication to residents for assessment. Review of Resident #2's admission MDS Assessment, dated 11/09/25, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His cognitive skills were severely impaired. His diagnoses included non-Alzheimer's dementia and Parkinson's disease. An observation and interview on 02/19/26 at 11:35 AM, Resident #2 did not answer questions. He was lying in bed awake and alert. His call light was at the end of the bed. LVN A was asked about the call light being out of reach. LVN A walked into the room and did not speak or introduce herself. LVN A went to the resident, picked up the call light and tossed it up to the resident. The resident was looking at the LVN. The LVN straightened the resident's blanket and walked away from the resident. Resident #2 did not reach for the call light. An interview on 02/19/26 at 11:40 AM with LVN A, Resident #2 would move around a lot and the call light would be moved. She said she did not speak to the resident because she was just in her head. She said she had been trained to introduce herself and interact with residents. She said it was important to interact with residents because it was their right. An interview on 02/19/26 at 11:30 AM, the DON revealed nurses were supposed to introduce themselves and explain the medication they were administering to the residents. She said failure to do so could keep the residents from having the right to be informed. Record review of the facility policy, Resident Rights, revised 12/01/25, reflected: .10. All residents will be treated equally.11. The facility will ensure that all direct care.are educated on the rights of residents and the responsibility (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
	676429	A. Building B. Wing	02/20/2026

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Carrara	4501 Tradition Trail Plano, TX 75093

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the facility to properly care for its residents.

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	02/20/2026

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 (Resident #1) of 3 residents reviewed for pain management. The facility failed to ensure LVN A assessed the pain level for Resident #1. This failure could place residents at risk of not having their pain managed.Findings included: Review of Resident #1's admission MDS Assessment, dated 02/20/26, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her cognitive skills for daily decision making were not impaired. Her BIMS score was 14. Her diagnoses included arthritis and pelvic fracture. Review of Resident #1's Comprehensive Care Plans, dated 02/16/26, reflected:The resident was on pain medication therapy.Facility interventions included: Monitor/document/report adverse reactions to analgesic therapy: altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritus, respiratory distress/decreased respirations, sedation, urinaryretention. Review of Resident #1's Physician Orders for February 2026 reflected:02/16/26: Oxycodone 15 milligrams every 6 hours as needed for pain02/16/26: Methocarbamol (muscle relaxer) 1000 milligrams four times [NAME] scheduled Review of Resident #1's Medication Administration Record reflected:02/19/26 - Oxycodone 15 milligrams administered by LVN A at 11:18 AM. Pain Scale Score: 5 02/19/26 Methocarbamol administered as ordered. An observation and interview on 02/19/26 at 11:15 AM, Resident #1 was lying in bed. She was groaning, grimacing and said she was in pain. Resident #1 said her pain level was a 12 on a scale of 1-10. It hurts so bad if I move around. LVN A walked into the room. She had a cup of water and a cup with a pill in it. She handed it to Resident #1. LVN A did not introduce herself. LVN A did not ask Resident #1 what her pain level was. LVN A walked back out of the room. An interview on 02/19/26 at 11:25 AM, LVN A gave Resident #1 oxycodone for her pain. LVN A said she did not assess Resident #1's pain level because she just did not. She said she did not know Resident #1 had a pain level of 12. LVN A said the resident would ask for the pain medicine every six hours and the nurses would administer it to her. She said she was supposed to ask what the pain level was to see if the medicine was working. She said she would call the physician because Resident #1 said her pain level was a 12. A follow-up interview on 02/20/26 at 4:15 PM, Resident #1 was lying in bed. She said her pain was at a good level. She said staff offered additional pain medicine (Tylenol), but she did not want to take it. An interview on 02/19/26 at 11:30 AM, DON said nurses were supposed to assess the pain level of residents to see if pain medicine was working. Record review of the facility policy, Pain Management, dated 12/01/25, reflected: .Pain Assessment.Asking the patient to rate the intensity of his/her pain using a numerical scale, a verbal or visual descriptor that is appropriate and preferred by the resident.