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	05/06/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections for three of five residents (Residents #1, #2, and #3) reviewed for catheters. The facility failed to ensure Resident #1, #2, and #3's urinary catheters were anchored/secured to protect the resident's urethral openings and maintain proper urine flow.This failure could place residents with urinary catheters at risk of pulling/tension, kinks, and accidental dislodgment which could result in trauma and increase the risk of urinary tract infections.Findings included:Record review of Resident #1's MDS, dated [DATE], reflected she was a [AGE] year-old female who admitted on [DATE]. The resident's diagnoses included stroke affecting her speech and ability to swallow, diabetes, and pressure ulcers. The resident's BIMS score was not calculated due to her medical conditions. Her Functional Ability assessment reflected that she was totally dependent on staff for all her ADLs. Record review of Resident #1's care plan, dated 02/18/26, reflected she was incontinent of bowel and bladder, requiring the use of briefs and a urinary catheter. Record review of Resident #1's physician orders, dated 04/14/26, reflected: Foley catheter, change catheter anchor as needed. During observations on 05/06/26 at 10:59 AM and 3:10 PM, Resident #1's urinary catheter collection bag hung on the resident's bed frame. The urinary catheter was not anchored to the resident's leg. Record review of Resident #2's quarterly MDS, dated [DATE], reflected he was admitted to the facility on [DATE] with diagnoses which included traumatic brain injury, diabetes, and seizures. His BIMS score was 3, indicating severe cognitive impairment. His Functional Ability assessment reflected he was totally dependent on staff for his ADLs. Record review of Resident #2's care plan, dated 05/05/26, reflected he had an indwelling urinary catheter. During observations on 05/06/26 at 11:23 AM and 1:10 PM, Resident #2's urinary catheter collection bag hung from the resident's bed frame. The catheter was not secured to the resident's leg. Record review of Resident #3's admission MDS, dated [DATE], reflected he was a [AGE] year-old male who admitted on [DATE]. The resident's diagnoses included low oxygen levels due to poor breathing, high blood pressure, and pneumonia. His BIMS score was 14, indicating he was cognitively intact. His Functional Assessment revealed he required minimal assistance with his ADLs. Record review of Resident #3's care plan, dated 03/02/26, reflected he had a urinary catheter related to and enlarged prostate. During observations on 05/06/26 at 10:10 AM and 12:28 PM, Resident #3's urinary catheter collection bag hung from the resident's bed frame. The catheter was not secured to the resident's leg. During an interview on 05/06/26 at 1:40 PM, LVN A stated the nurse was responsible for ensuring the urinary catheter was secured to the resident's upper leg. She stated the risk if it was not secured could be the catheter being pulled out accidentally. During an interview on 05/06/26 at 1:53 PM, LVN B stated it was ultimately the nurse's responsibility to ensure the urinary catheter was properly secured to the resident's leg. She stated there was a risk of the catheter being pulled out if it wasn't anchored properly. During an interview on 05/06/26 at 2:00 PM, LVN C stated the nurse had the ultimate responsibility to ensure the catheter was secured to the resident's upper leg. Often the CNAs would let them know they had replaced the anchoring (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	device. She stated the biggest risk was the catheter being pulled out and causing trauma if it was not anchored properly. During an interview on 05/06/26 at 2:15 PM, the ADON stated the CNAs and nurses were responsible for ensuring urinary catheters were properly secured to the resident's legs. He stated the obvious risk was the catheter being pulled out accidentally, causing severe trauma to the urethra (tube from the bladder out of the body). The balloon that secured the catheter in the bladder was much larger than the urethra and pulling the catheter out before deflating the balloon would cause severe trauma to the urethra. During an interview on 05/06/26 at 4:00 PM, the Administrator stated the DON had been hired but was currently in training. Record review of the facility's Catheter Care policy, dated 12/01/25, reflected it did not address anchoring the catheter to the resident's leg. Record review of the CDC's Healthcare Infection Control Practices Advisory Committee's Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2009 reflected: .II. Proper Techniques for Urinary Catheter Insertion.E. Properly secure indwelling catheters after insertion to prevent movement and urethral traction.