STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676128	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Madison on Marsh	2245 Marsh LN Carrollton, TX 75006

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268 Based on observation, interview, and record review the facility failed to ensure residents had a right to personal privacy for one of three residents (Resident #3) reviewed for personal privacy in that: CNA C failed to ensure the door to Resident #3's room was closed while she assisted in dressing Resident #3. This failure could place residents at risk for low self-esteem, loss of dignity, and decreased quality of life due to a lack of privacy during their care. Findings included: Review of Resident #3's face sheet, printed 01/17/2025, revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnosis that included but not limited to hypokalemia (high levels of potassium). Review of Resident #3's baseline care plan dated 1/10/2025 revealed Resident #3 was a fall risk, required 1 person assist and was incontinent in bladder. Review of Resident #3's electronic file revealed a MDS had not been completed. Observation on 01/17/2025 at 5:05 AM revealed CNA C was assisting with incontinent care of Resident#3 while the curtain was not drawn, and the door was open. Resident #3 was seen undressed from waist down and turned on her side exposed to the hallway. CNA B walked out of the room to get supplies leaving the door open and Resident #3 turned on her side undressed from waist down. Resident #3 did not have a roommate, and no one was observed on the hall. Attempted interview on 01/17/2025 at 2:00 PM with Resident#3 was unsuccessful. Resident #3 was observed laying in bed and would not respond to questions. Interview on 01/17/2025 at 5:54 AM with CNA C revealed when assisting with incontinent care, she should always close the curtains and resident door to ensure privacy. CNA B stated she did not pull the curtain and close the door due to rushing because she had to go get another resident up and ready for dialysis. CNA C stated the risk leaving the door open and not pulling the curtain would be that the resident would not have privacy. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/17/2025 at 12:29 PM with the Administrator revealed staff were aware that the privacy curtain and door should be closed when assisting with incontinent care. The Administrator stated she would have a discussion with Caregiver B regarding her leaving the door open. The Administrator stated the risk of leaving the door open would be the resident privacy could be violated. Interview on 1/17/2025 at 2:45 PM with the Director of Nursing revealed staff were aware of closing the door and privacy curtain during incontinent care. The Director of Nursing stated the Surveyor completed observation at a busy time and staff were trying to change residents before the shift change and had a lot of things to do during that time. The Director of Nursing stated she had 5 CNAs scheduled for the night shift and felt there was enough staff to provide proper care to residents. The Director of Nursing did not acknowledge any risk due to not pulling the privacy curtain and closing the door. Review of the facility policy titled Resident rights- abuse, neglect exploitation undated did not address resident rights to privacy.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268 Based on interview and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive assessment and quarterly review assessments for two (Resident #1 and Resident #2) of four residents were reviewed for comprehensive care plans. The facility failed to ensure the interdisciplinary team revised and reviewed the care plan after each assessment for Resident #1 and Resident #2. This failure could affect residents by placing them at risk for not having their individual needs met. Findings included: Record review of Resident #1's face Sheet printed 01/17/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included but not limited to acute chronic diastolic heart failure (causes a stiff left ventricle that prevents the heart from relaxing between beats),type 2 diabetes (a chronic condition characterized by insulin resistance and high blood sugar levels.) and high blood pressure. Record review of Resident #1's quarterly MDS, dated [DATE], reflected a BIMS score of 15 which indicated Resident#1 was cognitively intact. Review of section GG indicated Resident #1 was independent with eating, oral hygiene, and upper dressing. Review of Resident #1's care plan dated effective 8/8/2024 revealed Resident #1 was at risk for hyper/hypoglycemic episodes secondary to diabetes. Interventions included: diet as ordered, meds as ordered, lab as ordered. Resident #1 received pain management with intervention to include review medication, frequency, and side effects. Review of Resident #1's care plan conference revealed the last care plan was held 09/18/2024. Review of Resident #2's face sheet printed 07/17/2025, reflected an [AGE] year-old female admitted to the facility 04/27/2022 with diagnoses that included stroke (occurs when the blood supply to part of the brain is blocked or reduced.) and dementia (diseases that affect memory, thinking, and the ability to perform daily activities.) Review of Resident#2's care plan dated effective 4/27/2022 revealed Resident #2 was incontinent with bowel and bladder. Interventions included monitor signs symptoms, document refusals and encourage fluid intake. Review of the quarterly MDS undated revealed a BIMS score of 10 which indicated Resident #2 was mildly cognitively impaired. Review of Resident #2's care plan conference notes revealed the last care plan was 07/16/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/17/2025 at 11:39 AM with the Social Worker revealed care plans were completed within 48 hours of admission and quarterly. The Social worker stated she checked the MDS calendar once a month to determine when care plan conferences were due. The Social Worker stated care plans should be updated quarterly however she was not sure of there was a risk if they were not updated quarterly. The Social Worker stated she was not sure why the care plan conferences had not been done timely stating it was likely an oversight due to her being busy with other task. Interview on 01/17/2025 at 12:29 PM with the Administrator revealed the Social Worker was responsible for ensuring care plans were completed timely. The administrator stated she would have to speak with the Social Worker to determine why care plans conference were not completed timely however stated he was sure that staff had been in continuous contact with residents and their responsible parties frequently however may not have documented the conversations. The Administrator did not acknowledge any risk associated with not completing care plan conferences timely. Review of the policy Care Plans, Comprehensive person- Centered revised September 2010 The Interdisciplinary Team must review and update the care plan at least quarterly,

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for 1(Resident #4) of 5 reviewed for pharmaceutical services The facility failed to ensure Residents #4's medication administration was administered according to the physician order. This failure placed residents at risk of not having accurate clinical records completed to indicate if a medication was administered, resulting in potential medical errors and a decline in health. Findings included: Review of Resident #4's electronic face sheet printed 01/17/2025 revealed a 65- year -old male admitted to the facility on [DATE] with diagnosis that included but not limited to diabetes (body does not make enough insulin) and high blood pressure. Review of Resident #4's care plan effective 11/01/2024 revealed Resident #4 was hypo or hyperglycemic secondary to diabetes with interventions which included diet as ordered and medication as ordered. Review of Resident #4's admission MDS dated [DATE] revealed a BIMS score of 10 which indicated Resident #4 was mildly cognitively impaired. Review of Resident #4's order physician order revealed HumuLIN 70/30 U-100 Insulin 100 unit/mL subcutaneous suspension (40 units) VIAL (ML) Subcutaneous One Time Daily Starting 12/13/2024. Order Date: 12/13/2024 TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS Notes: Do not give insulin if EQUAL/less than (110). Alert MD if Blood Sugar greater than:(400) PR aware Review of the MAR dated 12/01/2024-12/31/2024 revealed on 12/18/2024 Resident #4 was recorded as 86 and documented that insulin was given by LVN C. On 12/19/2024 Resident #4 blood sugar was documented at 96 and insulin given by LVN C. Review of the document titled non prn medication notes for Resident #4 dated 12/01/2024-12/31/2024 revealed no documentation of medication not being given on 12/18/2024 or 12/19/2024. Attempted call on 01/17/2025 at 2: 00PM to LVN C was unsuccessful. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/17/2025 11:50 AM with the Director of Nursing revealed she was not sure if LVN C had given Resident #4 the medication or not however nursing staff were aware that orders should have been followed. The Director of Nursing stated staff still had to put their initials on the MAR and she was not sure of how staff indicated that medication was not given. Interview on 01/17/2025 at 12:29PM with the Administrator revealed he was not sure why the MAR would show the medication was given if it should not have been given and stated he would have to speak with the Director of Nursing for clarification. Interview on 01/17/2025 at 1:45PM with the Regional Director of Clinical Services revealed the Director of Nursing was not pulling the correct document which showed when a medication was not given. The Director of Clinical Services revealed the non- prn medication notes would revealed if a medication was not provided. The Director of Clinical Services reviewed the non - prn medication notes along with the surveyor and confirmed that there was no documentation on 12/18/2024 or 12/19/2024 of Humulin not being given. The Regional Director of Clinical services stated the risk of Humulin being given outside of the order would be the residents blood sugar could drop. The Regional Director of Clinical Services stated all nursing staff would be in- serviced today (01/17/2025) regarding administering medication according to physician orders. The Regional Director of Clinical Services stated moving forward the Director of Nursing would be responsible for ensure MAR's were completed correctly and medication was being given as prescribed. The policy dated Medication labeling and storage did not discuss medication administration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45268 Based on observation, interview and record review, the facility failed to store all drugs and biologicals in locked compartments for four (treatment cart #1 and medication cart #2, Medication cart #3 and Medication cart 4) of 4 carts reviewed for locked drugs and biologicals. The facility failed to lock treatment Medication Cart #1, Medication Cart #2, Medication Cart #3, and Medication Cart #4 when not in use. This failures could affect residents at risk of drug diversion or misuse of medications. Findings included: Observation on 01/17/2025 at 5:25 AM revealed Medication Cart #1 and Medication Cart #2 unlocked on the hall while LVN A was in a Resident's room. LVN A walked out of the Resident room and down to the nurse's station leaving the Medication Cart #1 and Medication Cart #2 unlocked. Medication Cart #1 and Medication Cart #2 drawers were able to be pulled open and exposed routine medications. Medication Cart #1 and Medication Cart #2 continued to remain unlocked during an observation of LVN A passing medication to four different residents. Observation on 01/17/2025 at 5:30 AM LVN A walked back to the Medication Cart #1 and proceeded to pass medication entering a Resident room without locking the Medication Cart #1 or Medication Cart #2 Observation on 01/17/2025 at 5:53 AM revealed Medication Cart #3 and Medication Cart #4 on the hall with no staff members present or residents were present. The drawers to Medication Cart #3 and Medication Cart #4 were able to be pulled open and exposed routine medications. Medication Cart #3 and Medication Cart # 4 remained unlocked for approximately 10 minutes. Interview and Observation with LVN A on 01/17/2025 at 5:30 AM revealed she was using Medication Cart #1 and Medication Cart #2 because one cart contained routine medication and one cart contained overflow routine medication as well as PRN medication. LVN A stated she was aware that the Medication Cart should have been locked when not in eyesight however she was disorganized due to her being new to working this hall. LVN A stated the risk of leaving the medication carts unlocked would be someone could access the medication. During an observation of medication pass to 4 residents, LVN A continued to leave Medication Cart #1 and Medication Cart #2 unlocked when entering resident rooms. Interview on 01/17/2025 at 6:05 AM with LVN B revealed Medication Cart#3 and Medication Cart #4 should have been locked however she had just begun her shift at 6:00AM and the nurse before her would have been responsible for ensuring the medication cart was locked. Interview on 01/17/025 at 1:45 PM with the Regional Director of Clinical Services and the Director of Nursing revealed medication carts were expected to be locked when not within eyesight of the nursing. The Regional Director of Clinical Services and the Director of Nursing both agreed the risk of leaving the cart unlocked would be someone would be able to access the medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy Medication labeling and storage dated revised February 2023 revealed Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.