

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER The Madison on Marsh		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 (Resident #1) of 5 residents reviewed for ADLs.</p> <p>The facility failed to ensure Resident #1 had his fingernails cleaned and trimmed.</p> <p>This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections, and a decreased quality of life.</p> <p>Findings include:</p> <p>A record review of Resident #1's Quarterly MDS assessment dated [DATE] reflected Resident #1 was a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including type 2 diabetes mellitus, muscle weakness, and cerebrovascular accident (CVA). Resident #1 had a BIMS score of 02 out of 15 which indicated Resident #1's cognition was severely impaired. She required extensive assistance of two-persons for physical assistance with personal hygiene.</p> <p>A record review of Resident #1's Comprehensive Care Plan, dated 04/29/21 to present, reflected the following: problem: Resident#1's ADL function are impaired related to Hx CVA . weakness/debility, Hand Contractures, . depends on staff with ADLs. Goal: will maintain a sense of dignity by being clean, dry, odor free, and well-groomed over next 90 days. Interventions: assist, give . nail care schedule and prn .Assist with all ADL's as needed.</p> <p>An observation on 04/16/25 at 09:55 AM revealed Resident #1 was laying in her bed. The nails on both hands were approximately 0.3 centimeter in length extending from the tip of her fingers. The nails were discolored tan and the underside had a dark brown colored residue. Resident #1 was unable to answer questions.</p> <p>Interview on 04/16/25 at 10:08 AM, CNA A stated CNAs were allowed to cut the residents' nails if they were not diabetic. CNA A stated he would talk to the nurse about Resident #1's long nails because she was diabetic.</p> <p>Interview on 04/16/25 at 10:14 PM, RN B stated CNAs were responsible to clean and trim residents' nails as needed. RN B stated only nurses cut residents' nails if they were diabetic. RN B stated no one notified her Resident #1's nails were long and dirty, and she had not noticed the nails himself. RN B stated Resident #1 was diabetic, and he would clean and trim his nails.</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/16/25 at 2:33 PM, the DON stated nail care should be completed as needed and every time aides washed the residents' hands. The DON stated nails should be observed daily. The DON stated nurses were responsible for trimming the nails of residents who were diabetic, and CNAs could trim other residents' nails. The DON stated she expected CNAs to offer to cut and clean nails if they were long and dirty. The DON stated residents having long and dirty nails could be an infection control issue.</p> <p>Record review of the facility's policy titled, Bath-Bed dated, March 2013, reflected, Purpose. To cleanse, refresh, and soothe the Patient; to stimulate circulation; and to inspect the body. Care for fingernails . is a part of the bath. Be sure nails are clean. Fingernails .of diabetic Patients are cut by the licensed nurses .</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure residents received adequate supervision to prevent accidents for 1 (Resident #2) of 4 residents reviewed for elopement.</p> <p>The facility failed to provide adequate supervision to Resident #2 and as a result, the resident eloped from the facility and was found by a passerby between 12:00 pm and 2:00 pm in front of a local store (8.9 miles) away from the facility. Resident # 2 was gone from the facility for over five and a half hours and last seen on 02/22/25 at 1:41 AM. Resident #2 was taken to a hospital on [DATE] at 2:00 PM, and a nurse from the hospital notified the facility.</p> <p>The above noncompliance was determined to be a past non-compliance Immediate Jeopardy that existed from 02/22/25 at 01:41 AM, and the Immediate Jeopardy was determined to have been removed on 03/01/25 due to the facility's implemented actions that corrected the non-compliance of re-educating staff about assessing and identifying wandering residents, elopement risks, and alarm management prior to the beginning of the HHSC investigation on 04/16/25.</p> <p>This failure could place residents at risk for accidents, falls and serious injury resulting in a decreased psycho-social well-being, physical decline, or death.</p> <p>Findings included:</p> <p>Review of Resident #2's Face Sheet dated 04/16/25 revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses: Cirrhosis of liver (chronic liver damage from a variety of causes leading to liver failure), Hepatic encephalopathy (the loss of brain function when a damaged liver does not remove toxins from the blood) , restlessness, and agitation.</p> <p>Review on Resident #2's Elopement risk assessment dated 01/25/25 revealed 1. No risk. Patient is able to make decisions regarding tasks of daily living e.g. decisions are consistent and reasonable .</p> <p>Review of Resident #2's admission MDS assessment dated [DATE] revealed Resident #1's BIMS score was 10/15 (moderate cognitive impairment), and the resident had no wandering behavior, was independent with locomotion off unit, with setup only, not steady, but able to stabilize without staff assistance with balance during transitions.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's Care Plan dated 02/17/25 revealed, Problem. Potential for elopement as evidenced by: Exit seeking. Goal. Maintaining the least restrictive environment while providing for Resident #2 safety for 90 days. Intervention. Frequent monitoring. Have activities involved with favorite pastime. Photo in MARS and Elopement risk book. Further review revealed, Problem. Resident #2 demonstrates movement behavior that may be interpreted as wandering, pacing, or roaming r/t the diagnosis (es) of Hepatic Encephalopathy and problem understanding the immediate environment. Goal. Resident #2 will respond to staff direction to redirect attention from a potentially problematic situation (such as elopement or entering a peers' room) when any difficult behavior occurs by the next 90 days. Intervention. Implement preventative intervention strategies: Assess for potential elopement/unauthorized departure risk. Implement preventative intervention strategies: Make rounds/room checks per facility protocol to minimize chance of unauthorized leave. Implement preventative intervention strategies: Provide simple, clear directions to help the resident know what is expected. Review of ADL self-care performance revealed Resident #2 is capable of increased independence in at least some ADLs.</p> <p>Review of Resident #2's Nurse Progress dated 02/17/25 at 2:31 PM written by RN D revealed, [Resident#2] is attempting to exit through back doors & states he needs to go home. Management notified. Upcoming charge nurse notified. [Resident#2] . has been walking around back & forth from his room to dining area & halls. Resident#2 to be monitored for elopement.</p> <p>Review of Resident #2's Nurse Progress Note dated 02/17/25 at 8:46 PM written by RN C revealed, Patient attempting to exit the building.</p> <p>Review of Resident #2's Nurse Progress Note dated 02/23/25 at 7:53 PM, reflected the DON stated on 02/22/25 at 07:20 AM This nurse was notified by CN the [Resident#2] was not present in his room while rounding and that he had left AMA. This writer asked the CN to immediately do a facility door-to-door search with the team. Administrator and MD notified. Son of the resident called and notified that he had left AMA, and a search was initiated to ensure resident safety.</p> <p>Review of NP progress note dated 02/24/25 at 01:32 AM, reflected she saw Resident#2 on 02/20/25 at 01:32 AM .Subject: Patient seen today in room. Patient unable to answer questions clearly, confused. No pain or distress at this time. Spoke to nursing and therapy and they state that patient was exit seeking and with thrive in a memory care unit.</p> <p>Review of the Facility's Provider Investigative Report dated 03/01/25 revealed on 02/22/25 Resident #2 left the facility at 04:00 AM. At some point between 12:00 PM and 2:00 PM, the resident was located at nearby Wal-Mart and taken to a local hospital, where a nurse's note documented his presence shortly after 2:00 pm. The resident was found safe, without injuries, and expressed a desire to return home. notifications to [Resident #2] 's Doctor, Family member and Ombudsman was done. The Facility conducted several Staff and Resident interviews and could not figure out how [Resident #2] opened the door and exited the facility without anyone hearing the alarm, or if the alarm went off at the opening of the door. This incident prompted a comprehensive facility-wide response, staff training, and policy reinforcement to prevent future occurrences. The investigation remains ongoing, with continued audits, training, and elopement drills in place to strengthen security and resident safety. Life satisfaction rounds and interviews with the residents and education with staff about the elopement, elopement risks, alarm system and elopement were conducted, and staff statements were collected. The nurse assigned to Resident#2 on 02/22/25 shift 10 PM to 6 AM terminated. Findings: unconfirmed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's Physician medication order Recap Report dated 03/04/25 revealed the following medications orders:</p> <ul style="list-style-type: none"> -Folic acid tab 1000 mcg given 1 tablet orally one time a day for vitamin deficiency. -Pantoprazole tab 40 mg give 1 tablet orally two times a day for GERD (a digestive disease in which stomach acid or bile irritates the food pipe lining). -Divalproex tab 125 mg given 1 tablet orally two times a day for restlessness and agitation. -Lactulose sol 10 gm/15ml give 60 milliliters orally four times a day for Cirrhosis of liver. <p>Doxycycl HYC cap 100 mg give 1 capsule orally one time a day for bacterial peritonitis (a severe bacterial infection of abnormal accumulation of fluid in the abdomen).</p> <ul style="list-style-type: none"> -Tamsulosin cap 0.4 mg give 1 capsule orally one time a day for BPH (non-cancerous enlargement of the prostate gland). -Finasteride tab 5 mg give 1 tablet orally one time a day for BPH. -Miralax oral packet 17 gm give 17 gm by mouth one time a day for constipation. -Thiamine HCL oral tablet 100 mg give 1 tablet by mouth one time a day for Thiamine deficiency. -There was no order for a Wander Guard. <p>Review of the facility's Camera footage titled Video for the front door, revealed Resident #2 on 02/22/25 at 04:00 AM from inside pushed the door electric latch retraction, walked steadily via the front door, wearing beige shirt pants, beige long sleeve jacket, and outdoor shoes. Resident #2 was seen leaving the facility. The Camera was facing outside, and there was no camera facing inside the facility. The door had oval glass at the middle. The Video did not have any sound.</p> <p>Interview on 04/16/25 at 2:38 PM, CNA D stated she was working the 300 hall the day of the incident. She stated the staff searched for Resident #2 everywhere in the facility, and they could not find him. She stated she was thinking Resident#2 left sometime during the night shift. She stated she was trained to round every 2 hours or more frequent to check on residents. She stated she did not notice Resident#2 exit seeking behaviors to exit the facility. She stated Resident#2 was independent, used to walk around inside the facility, but she did not see him trying to leave until the incident happened.</p> <p>Interview on 04/16/25 at 3:09 PM, LVN I stated Resident #2 was last on 300 Hall. She stated she used to take care of him when he was in 100 Hall, and at that time, Resident#2 was most of the time, in bed. LVN I stated she rounded every two hours on the residents. LVN I stated the CNAs were in and out of the residents' rooms all the time. She stated when she was working during the night shift, she had some residents that would roam the facility and go to other halls and the staff would bring them back to their rooms.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 04/16/25 at 4:10 PM, the Administrator stated Resident #2 was there for short term. He stated the staff were trained to round on the residents every 2 hours. He stated Resident#2 was in the library when the 10 PM-6 AM shift staff came in for their shift. He stated the CMA for 2 PM-10 PM gave Resident#2 his medications, and the 2 PM-10 PM nurse saw the resident around 7 PM. He stated the nursing progress note from the night shift for RN R was done at 1:41 AM on 02/22/25. The Administrator stated CNA P was sent to the hospital to identify Resident#2. The Administrator stated Resident#2 was found by a passerby in front of Local store door, and the passerby called the paramedics who took Resident#2 to the hospital. The Administrator stated Resident#2 may have the code for the door, because if the person exiting the door had the code, the alarm would not go off. He stated after the incident, the facility changed the code. He stated the alarm sound was louder in the nursing station, and the facility increased the volume by the main facility exit door. The Administrator stated, per the staff at the time of the incident, the alarm did not go off. He stated the Resident#2 did not follow anyone. Interview revealed the Administrator, DON and Maintenance Supervisor reviewed the Video for the front door and saw the resident exiting the front door by himself. He stated Resident#2 may have observed the staff entering in the key code and got the code. The Administrator stated the housekeeping staff did not work at night; they started their shift at 5 AM and went home at 4 PM. He denied any other resident had eloped from the facility before or after the incident.</p> <p>Interview on 04/17/25 at 06:11 AM, Housekeeper Q stated he started his shift at 5 AM all the time, except if he had to shampoo the carpet, then he comes in at 4 AM . He stated whenever he came in to work, the alarm was always on, and when the alarm goes off, he walked around and check if there was someone outside the door. He stated there were no supplies delivery early in the morning.</p> <p>Interview on 04/17/25 at 06:58 AM, the Administrator stated the door alarms engaged automatically, they were doing weekly checks, before the incident, by the Maintenance Supervisor. When the Administrator was asked if there was a power outage the night of the incident that can affect the alarm system, he replied he did not know, and did not know if the alarm system was connected to the generator. The Administrator stated the Maintenance Supervisor would have that information. He stated the facility sent LVN L to the hospital to assess and speak to Resident#2. He stated the Corporate Marketer and the Maintenance supervisor tried also to talk to Resident#2, but the local PD did not allow them to talk to Resident#2 because of the ongoing investigation. He stated he did not get the police report from the local police department. The Administrator stated the facility asked for it, and the local police department wanted \$1000 to release the report, and it would take up to 6 months to get the full report. He stated Resident#2 wanted to leave the facility and go home. He stated the Resident lived near the Local store he was found in. When asked about the elopement risk to the residents, the Administrator stated they would contact the family, put the resident on one-to-one monitoring, and start the process of discharge to a safer facility. The Administrator mentioned that the facility did not have a secured unit and did not have wander guards for elopement risk residents.</p> <p>Interview on 04/17/25 at 07:28 AM, LVN D stated she was familiar with Resident #2, and he was not having exit seeking behavior. She stated he wanted to go home, and the family had known about it. LVN D stated the facility was trying to discharge him.</p> <p>Interview on 04/17/25 at 07:33 AM, RN M stated she did not work with Resident #2 and denied seeing him try to go out.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 04/17/25 at 07:47 AM, LVN L stated, she was familiar with Resident#2 and he was not trying to go out of the facility. She stated she did not see him wandering. She stated after the incident, she went to the hospital to identify and assess Resident#2. She stated she went to his room in the hospital and talked to him but did not ask him how he got out of the facility. She stated Resident#2 was not in distress during the hospital visit and he was sitting at the edge of the bed.</p> <p>Interview on 04/17/25 at 07:57 AM, the Maintenance Supervisor stated he went with LVN L to the hospital to talk to Resident#2, but he could not talk to him. He stated Resident#2 was seen in a Video walking out the front door, the Camera was facing outside, and there was no sound. He stated after the incident, he had the local fire department come to the facility and check the alarms. Interview revealed the alarm testing showed all alarms were working. He stated the alarm should go off whenever the door opened from during the time from 6 PM to 6 AM. He stated the camera was situated outside the door, on the keypad side, and he did not know if the camera could capture the resident key in the code from inside. He stated he was not aware of any power outage at the time, and even if there was a power outage the alarm, would still go off and sound. He stated the alarm was automatically set to engage at 6 PM and disengage at 6 AM. He stated the alarm would go off at the nursing station and by the front door area. He stated the door alarm cannot be disarmed by anyone unless they have the code to disarm it, and no one in the facility had that code. He stated the facility did not get any citation for the door's alarms during the last survey. He stated his guess was that someone entered the code at the nursing station to silence the alarm in the nursing station and did not enter the code at the front door to silence the alarm by the front door. He stated at that time the alarm by the door was not too loud. He stated after the incident, the local fire department came to the facility and tested the alarms. Interview revealed the alarm sound by the front door was set to a louder volume.</p> <p>Interview on 04/17/25 at 08:47 AM, the DON stated at first Resident#2 was ready to go home after he was done with rehabilitation, then his ascites (abnormal accumulation of fluid in the abdomen) was worsening, was sent to hospital. She stated after he came back from the hospital, he was A&O x4, stable, and wanted to go home. She stated the Resident#2 called his family and spoke to them, one or two days before the incident, about going home. Interview revealed the resident would walk around the facility without a walker. She stated a resident family member visited him the day before the incident and the resident told the family member that he wanted to go home but the son wanted him to stay in the facility. She stated the management informed the family that the resident had a desire to leave the facility. She stated the discharge protocol was initiated for his safety. The DON stated the resident had a cell phone, but the phone service was disconnected due to a lack of payment. Interview revealed the resident used the facility land line to call his cousin. When asked about the elopement risk to Resident#2, she stated the resident was not at risk for elopement prior to the incident. She stated it was a resident right to leave the facility and the facility could not hold the resident against his wishes to leave as per the facility policy. She stated the resident was appropriately dressed and had shoes on when he left the facility. She further stated the resident was fine and no alcohol or drugs were found on him when he taken to the hospital. She stated LVN L went to the hospital to see the resident. The DON stated the resident told LVN L that he walked out of the facility main door. The resident walked to Local store. The DON stated she did not speak to him face to face at the hospital and the facility wanted to ensure that he was safe. She stated after the incident the facility conducted elopement prevention drill, and all the staff were in service trained on the residents elopement prevention. She stated the night of the incident the staff denied hearing the alarm going off at any time.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An attempt was made on 04/17/25 at 09:55 AM to interview Resident#2, but his Family Member answered the phone call. The family member stated Resident #2 did not have a cell phone and he moved to another facility after he was discharged from the hospital. He stated he did not recall the exact date of the incident, and what he know about the incident was that the resident walked through the facility front door and was found in local store parking lot by the local police and was taken to a hospital. He denied the resident was having any issues from the elopement.</p> <p>Interview over the phone on 04/17/25 at 10:29 AM, CNA S stated she was working the 300 hall the night of the incident. She stated the resident was on her assigned hall. She stated the resident walked around all the time. She said she laid eyes on him before she started her rounds. She stated she doesn't remember the exact time, but she rounds every 2 hours. She said the resident was present up until her last round around 3 AM or 4 AM. She said she didn't hear the door alarm, it's very sensitive, even when the wind blows, it goes off. She said staff ran to the door when the alarm went off to see if a resident tried to elope. She said she could hear the alarm from 300 hall. She said the resident was dressed in street clothes while lying in his bed that night because she changed his roommate. She said the resident may have eloped because he may have been watching staff, because around 3 AM, CNAs conducted rounds and nurses were giving medications. She said the resident was smart and may have been watching staff to see if they were preoccupied. She stated resident never voiced to her he wanted to leave. She said the resident would walk around in the middle of the night, some nights, but he was never go to the door. She stated she believed the nurse, can't remember her name, noticed he was gone. She stated she was contacted once she left and was told the resident eloped.</p> <p>Interview over the phone on 04/17/25 at 10:33 AM, LVN N stated, he worked with Resident#2 another night. He stated Resident#2 had the habit of wearing daytime attire even at night, walking around between his room, nursing station and dining area. He stated Resident#2 sometime would ask to call his wife and wanted his wife here at the facility. He stated, he did not see the Resident#2 wife or family member visiting at night. LVN N stated, he did not hear the door alarm going off during the night of the incident. He stated to enter or exit the facility after 6 PM, someone must key in the code from inside otherwise, the alarm would go off whenever the door opened. LVN N stated the facility was non-smoking and none of the staff went outside to smoke.</p> <p>Interview over the phone on 04/17/25 at 10:45 AM, CNA P stated she was not working on hall 300 the night of the incident. She said the resident was independent. She said she would see him walking around; he would go to the ice machine or come through the dining room. She said she never heard the alarm go off that night. She said when the alarm went off, staff would check at the nursing station to identify which alarm was going off, rush there and check to see if a resident eloped. She said all staff would check which door was alarming and go and check. She said the alarm was working that night because she stood at the door until someone let her in the building to start her shift.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview over the phone on 04/17/25 at 12:02 PM, RN R stated, she knew Resident#2, and worked with him a couple of times. She stated the Resident spend most of his time up and walking around independently. She stated the day of the incident, she went in to work late at 10:20 PM. She stated, she rung the bell, and nobody came in to open the door for her. She stated when she put the code from outside and open the door, the alarm did not go off. She stated usually at night, the alarm would go off whenever the door was open without keying in the code from the inside, but that did not happen that night. When asked if she notified someone about the alarm not going off, RN R stated she voiced to the staff at the nursing station the door alarm did not go off when she was coming in. She stated she rounded on her residents at 11:30 PM, and went on with her usual shift rounding, assessing residents, giving medication, etc. She said she could not remember the last time she saw Resident#2 that night, and per her documents, she did his physical assessment at 01:41 AM. She stated she was contacted once she left and was told the resident eloped. She stated she was suspended pending the investigation and was let go afterwards.</p> <p>Review of the directions reflected the location the paramedics picked Resident#2 from was 8.9 miles from the nursing facility via the website https://www.mapquest.com.</p> <p>Observation on 04/17/25 at 05:05 AM revealed two surveyors entered the facility at 05:05 AM, using the four-digit code provided by the Administrator the day before (04/17/25), the alarm went off. Observation revealed RN O walked to the front door and saw the surveyors entering the facility. RN O entered the key code and turned off the alarm. Housekeeper Q walked to the lobby area too. The staff left the lobby area. One surveyor stayed in the front lobby and the other surveyor went to the nursing station. The surveyor opened the front door and heard the alarm in the lobby. The surveyor at the nursing station heard the alarm. Observation revealed staff going to the front lobby to see what was happening and saw the surveyor at the front door with the alarm going off. Observation revealed the door alarm would go off when the surveyor pulled or pushed the front door. Observation revealed RN O turning off the door alarm when she determined it was the surveyor who opened the door and set off the alarm.</p> <p>Observation on 04/17/25 at 12:20 PM, revealed the street facing this facility was a busy 2-lane street.</p> <p>Interview on 04/16/25 at 2:38 PM, CNA D stated she was working the 300 hall the day of the incident. She stated she received training on resident elopement prevention.</p> <p>Interview on 04/16/25 at 3:09 PM, LVN I stated Resident #2 was last on 300 Hall. She stated she had training on resident elopement, the steps to take with exit seeking residents, including, immediately informing the management.</p> <p>Interview on 04/17/25 at 05:27 AM, RN O stated he started working in the facility after the incident. He stated he was trained on the resident elopement prevention before starting to work with the residents. He stated when the alarm went off, staff would check at the nursing station which door alarm was going off, where, then go there and check, including outside, and see if a resident had eloped. He said all staff would check which door and go and check. He stated at night the staff round on the residents every hour. He stated at that time there was one resident wandering around and exit seeking, and all the staff had to keep an eye on him.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Madison on Marsh		STREET ADDRESS, CITY, STATE, ZIP CODE 2245 Marsh LN Carrollton, TX 75006	
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 04/17/25 at 05:36 AM, CNA K stated she did not remember Resident#2. She stated was in serviced on preventing resident elopement. She stated the door alarm would go off, if the door was open from outside, and there is no code to get into the facility. She stated, then, whoever enter had to punch the code to silence the alarm, or ring the bell for someone to open the door from inside after punching the code in.</p> <p>Interview on 04/17/25 at 05:48 AM, LVN G stated she started working with the facility after the incident. She stated she received training on residents' elopement prevention during orientation. She stated at the start of her shift, she did rounds on the residents and check the residents' presence before she get the report from the outgoing nurses.</p> <p>Interview on 04/17/25 at 06:11 AM, Housekeeper Q stated he was in-serviced on residents' elopement prevention including to check all the rooms, look around the building, and notify the Administrator, and DON immediately.</p> <p>Interview on 04/17/25 at 7:17 AM, CNA F stated her first day working in the facility was last Saturday (04/12/25). She stated before she started working on the floor with the residents, she received training on residents' elopement prevention. She stated she was trained to pay attention to doors alarm and to answer as soon as she heard the alarm going off. She stated she was trained to do rounds on residents at the start of her shift, and at least every 2 hours.</p> <p>Interview on 04/17/25 at 07:22 AM, LVN H stated she returned to work three weeks ago and was not there during the resident elopement incident. She stated was trained on residents' elopement prevention. LVN H stated she was to follow the facility policy, that included doing a head count at change of shift, total facility resident head count if there was a missing resident and alert the Administrator . She stated for the residents with exit seeking behaviors she was to notify the administrator. LVN H stated she was to check the doors and put a plan in place; notify the family, the MD, and constantly do visual check on the resident. She stated the risk to resident, safety issue, and possible injury. LVN H stated there was a busy street by the facility.</p> <p>Interview on 04/17/25 at 07:28 AM, LVN D stated to prevent residents from eloping, the staff must look for the resident, do rounds and count the residents every shift; notify the Administrator, DON, and family if a resident left the facility.</p> <p>Interview on 04/17/25 at 07:33 AM, RN M stated she received an in-service on resident elopement prevention that included for the staff to do a head count, and see all the residents during their shift, and notify the Administrator if any resident was missing. RN M stated the staff must round on residents every two hours. She stated for any resident with exit seeking behavior, she notified the Administrator, the family, and the MD. She stated she would follow physician ordered for lab work to see if something was wrong with the resident. She stated the risks to residents were endanger their life and safety issues.</p> <p>Interview on 04/17/25 at 07:47 AM, LVN L stated she was trained on residents' elopement prevention. LVN L stated when she hears the alarm, she had to check outside, and inside for the resident before turning the alarm off. She stated for the resident with exit seeking behaviors, she would immediately notify the charge nurse, and the Administrator. She stated, she would make sure the resident was away from the front door, notify the MD, and the family.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 04/17/25 at 08:47 AM, the DON stated after the incident the facility conducted elopement prevention drill, and all the staff were in service trained on the residents elopement prevention.</p> <p>Interview over the phone on 04/17/25 at 10:33 AM, LVN N stated he was in-serviced on preventing resident elopements.</p> <p>Review of the facility's Inservice trainings revealed on 02/22/25 the facility conducted the following trainings across all the three-shifts with staff in-person and over the phone: elopement drill; elopement policy; abuse and neglect prevention; Elopement policy a. alarms checks b. if Resident is missing notify within 15 minutes to DON/Administrator; shift to shift report: for all CNAs and nurses. Walking rounds verifying with census. Every 2 hours visually account for each resident; check elopement resident who is high risk. Do elopement assessment on admission; Elopement Drill and information about the electronic monitoring system to ensure the doors worked properly and securely and the staff were provided the door access code.</p> <p>Review of Daily Doors Alarms, Wandering System and Storage Area log Maintenance forms for the month of February 2025 did not reveal any problems with the exit door mechanisms prior to 02/22/25 and after.</p> <p>Review of the facility's Maintenance Front Door daily check log between 02/21/25 and 04/16/25(entrance date) revealed no issue with the front door alarm system.</p> <p>Review of the facility's Provider Investigation Report dated 03/01/25 revealed Elopement Drills initiated on 2/22/25 will be completed on 3 shifts in the next 24 hours. The Administrator and DON were educated by the Regional Director of Clinical Services on abuse prevention policy, resident rights, elopement policy; Timely Reporting/Recognizing Abuse, Neglect: Change in Condition; Documentation; Physician Notification and family and clinical rounds for assistance, supervision, and needs. The facility had a QAPI meeting on 02/22/25 at 2:00 PM , and on 03/19/25 at 11:00 AM to address the facility elopement prevention protocol.</p> <p>Review of the local weather history for the area near the facility, on February 02/22/2025, revealed the temperature at the time was 43 degrees Fahrenheit, and foggy.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen.</p> <p>The facility failed to ensure food items in the facility walk-in refrigerator were covered, labeled, and dated.</p> <p>These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness, and food contamination.</p> <p>Findings included:</p> <p>Observation on 04/16/25 at 11:40 AM of the facility's walk-in refrigerator revealed:</p> <ol style="list-style-type: none"> 1. A plastic container had food that looked like sausage was not labeled. 2. A plastic container had some kind of red sauce was not labeled or dated. 3. A gallon sized Ziplock bag had cooked Brownies that were not dated or labeled. 4. A gallon sized Ziplock bag had about 8-10 Bread slices with butter that were not dated or labeled 5. A quart sized Ziplock bag had 4-5 pieces of cooked Corn bread that were not dated or labeled 6. A plastic bag that had about 10-12 pieces of Danish bread were not dated, labeled, or covered. 7. A used block of unknown kind of cheese , wrapped loosely in a plastic wrap was not dated, labeled, or covered. 8. A quart sized Ziplock bag had about 7-8 slices of cooked meat that were not dated or labeled. 9. A bag of Grated Cheese that was not dated or labeled. <p>In an interview on 04/16/25 at 01:33 PM with [NAME] C revealed he was working in the facility kitchen as an morning [NAME] since November 2024. He stated that all food items in the kitchen should be labeled, dated, and covered. He stated that the foods that were cooked should have a use-by date of three days after cooking. Other food items like ready-to-eat/serve items should have an expiry date on them. He stated everyone in the kitchen, including the cooks, dietary aides, and dietary manager, were responsible for dating, labeling, and covering all food items. He stated not covering, labeling, and dating food items could cause cross contamination and potentially cause illness in residents.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 04/16/25 at 01:45 PM, the Dietary Manager stated everyone, including the cooks and himself, were responsible for covering, dating, and labeling all food items in the kitchen. He stated that he had been working in the facility for last two years and ensured that all staff received multiple in-services about food labeling, dating, and covering appropriately. He stated her expectation was all food items in the kitchen should be marked with a cooked date once the food item was cooked and stored for use later and a use-by date for leftovers and opened food items. He stated it was his expectation that all foods should be properly sealed in Ziplock bags or containers with tight fitting lids. He stated the risk of not dating, labeling, covering food items could cause cross contamination resulting in food borne illness or food contamination. He added that he had thrown away the food items in the refrigerator that were not dated or labeled appropriately.</p> <p>Review of facility's policy titled Food Storage revised 3/2019 reflected, .13. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 2-3 days or discarded 15. Refrigeration .e. All foods should be covered, labeled, and dated .</p> <p>Review of the Food and Drug Administration Food Code, dated 2022, reflected, .3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food 3-305.11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety</p>		