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	12/03/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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 0628 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 record review and interviews, the facility failed to ensure completion of a discharge summary including a recapitulation of the resident's stay, and final status at discharge for 1 of 3 residents (Resident #1) reviewed for discharge summary. The facility failed to complete a recapitulation of stay for Resident #1, who discharged to the community on 10/07/25. This failure could place residents at risk of a recapitulation of their stay being unavailable to help ensure continuity of care once they are discharged from the facility.Findings included: Record review of Resident #1's face sheet dated 10/21/25, indicated a 55yo female who admitted to the facility on [DATE] with diagnoses which included anxiety (excessive worry, fear, and nervousness), chronic kidney disease (kidneys unable to filter waste products from the blood), fibromyalgia (widespread body pain and fatigue), displaced trimalleolar fracture of left lower leg (severe injury to the ankle joint where three of the bones are broken and displaced) and muscle weakness (muscles lose their strength and tone). Resident #1 discharged from the facility on 10/07/25. Record review of Resident #1's discharge MDS assessment dated [DATE], indicated Resident #1's cognition was intact with a BIMS score of 15. Resident #1 was discharged to the community with a discharge assessment-return not anticipated. Record review of Resident #1's comprehensive care plan dated 08/01/25, indicated Resident #1 expressed a desire to return to the community. The care plan interventions included make arrangements with required community resources to support independencepost-discharge. Record review of Resident #1's Discharge Instruction Form, with an effective date of 10/01/2025, reflected it was not complete nor signed. The areas of Follow-up Appointment, Dietary Recommendations, Skin Issues and Patient Instructions/Teaching were all missing required information. Record review of Resident #1's IDT - Recapitulation of Stay, with an effective date of 10/08/2025, revealed the document was not complete nor signed. The areas of Nursing Services, Activities, Dietary Services, and Rehabilitation Services were all missing required information. The only completed section was Social Services. Record review of Resident #1's nursing progress note dated 10/07/25 at 15:21 (3:21 PM) and signed by RN A, revealed . [Resident #1 was discharged today accompanied by his [sic] [family member] with take home meds and discharge instructions. Review of Resident #1's EMR reflected no discharge summary was completed or uploaded. During an interview on 10/21/25 at 2:00 PM, RN A stated when a resident discharged from the facility the discharge summary was completed. RN A said the nurse was responsible for ensuring the nursing summary section was completed. RN A said the discharge summary included the list of medications the resident was taking, home health company, any equipment needed, the summary of their care, and any upcoming doctor appointments. RN A stated the SW informed her on the morning of 10/07/25, that Resident #1 would be discharged the same day. RN A stated she gathered all of Resident #1's medications, recorded her routine vitals and printed the discharge paperwork. RN A stated she completed the recapitulation of the medications and had Resident #1 sign it. RN A stated she failed to make a copy as Resident #1 was in a rush to leave. RN A stated she was supposed to make a copy and place it in the discharge paperwork tray to be scanned into Resident #1's EMR by Medical Records. RN A stated she was supposed to create a Progress Note and enter the details of Resident #1's discharge including when and whom she left with, discharged location, observation, etc. RN A stated she completed discharges before and made copies, except this time Resident #1 was in a hurry. RN A stated she was trained on how to complete discharges by the ADON. RN A stated she never had issues with discharges before. RN A stated she should have copied the discharged paperwork. RN A stated Resident #1's physical and mental health could be jeopardized without the list of medications and details of her stay properly documented. RN A stated it was important for Resident #1 to have a copy of her Discharge Summary completed in case there was an emergency. During an interview on 10/21/25 at 2:35 PM, the ADON stated the SW alerted the nurses which residents were being discharged , the date and time, and the mode of transportation. The ADON stated the nurse gathered all medications and completed the discharge paperwork. The ADON stated the nurse confirmed the discharge with the resident. The ADON stated on the day of discharge, the nurse gathered all medications and informed the resident of the discharge time. The ADON stated the nurse confirmed all medications in the resident's room with the resident and/or family and educated them. The ADON stated the nurse should have printed the discharge form because it included the medication list including the discharged date and had the resident sign it. The ADON stated she instructed the nurses to print two copies to be signed by the resident. The ADON stated you were supposed to enter

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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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 0656 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 interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan interventions for each resident consistent with the resident rights that included measurable objectives and time frames to meet the resident's medical needs identified in the comprehensive assessment for 1 (Resident #1) of 6 residents reviewed for care planning. The facility failed to care plan Resident #1's wound care order that reflected the following: Allow Pico dressing to stay 1 week, then remove and let doctor know what underlying wound look like. Text picture to [number] in the morning until 10/08/2025. This failure could affect resident care/services and may cause a delay in treatment and/or complications, infection, and poor wound healing. Record review of Resident #1's admission Record, dated 10/16/25, reflected an [AGE] year old-female initially admitted on [DATE] with diagnoses to include Spontaneous Rupture of Extensor Tendons (unexpected and without apparent cause tear of the tendons that extend the fingers and thumb) Left Lower Leg, Strain of Left Quadriceps Muscle, Fascia and Tendon (tear or overstretching of muscle fibers, fascia (connective tissue that wraps around, supports, and separates muscles, organs, blood vessels, and nerves), or tendons in the thigh), Postprocedural Seroma of a Musculoskeletal Structure Following a Musculoskeletal System Procedure (collection of serous fluid that forms after a musculoskeletal system procedure), Difficulty in Walking, and Lack of Coordination (uncoordinated movement due to a muscle control problem). Record review of Resident #1's admission MDS assessment, dated 09/15/25, revealed the resident had a BIMS score of 15 out of 15, which indicated cognition was intact. The MDS assessment under Section GG-Functional Abilities also revealed resident required assistance with walking. The MDS assessment under Section M-Skin Conditions revealed resident was at risk of developing pressure ulcers/injuries. Record review of Resident #1 Comprehensive Care Plan, dated 09/15/25, revealed the care plan did not include focus, goals, and interventions of wounds. Record review of Resident #1's prescription, signed and dated 10/01/25 by [MD] reflected the following: Please allow PICO dressing to stay on for 1 week. Then remove and let us know what underlying wound looks like. Text picture to [number]. Record review of Resident #1's order summary report, dated 10/17/25, reflected the following: Allow Pico dressing to stay 1 week, then remove and let doctor know what underlying wound look like. Text picture to [number] in the morning until 10/08/2025 11:46. Start date: 10/01/2025 and End date: 10/08/2025. In an interview on 10/16/25 at 4:51 PM with DON, she stated Resident #1 came into the facility post-surgery for her knee. DON stated Resident #1 had sutures on her knee. DON revealed the facility only monitored Resident #1's wound. In an interview on 10/17/25 at 2:00PM, LVN B revealed she did not deal with wounds. She stated if there were any changes, she reported it to the nurse. She stated she looked at the treatment and admission report to find the residents' needs. LVN B stated some care plans were important. She stated if there were any changes with the resident, she had to look at the care plan. She also stated if there were no changes or a resident was a long-term care resident, she did not often look at the care plan. LVN B stated the risk of not looking at resident's care plan was not understanding what the resident's needs were. In an interview on 10/17/25 at 2:49 PM with MDS Coordinator, he stated he had worked at the facility for three months. He stated the ADON or Wound Care Nurse was responsible for adding any wound care to care plans. He also stated he had 21 days for the care plan. MDS Coordinator stated acute care plans were done by the ADON. He stated he would help with updating care plans if the Wound Care Nurse was behind. He also stated he could not update the care plan with wound care if the Wound Care Nurse did not tell him. The MDS Coordinator stated he was told on 10/16/25 by DON to add wound care into Resident #1 care plan. He stated not having wound care in the care plan could affect the resident's care. In an interview on 10/17/25 at 3:29 PM, the ADON revealed the facility monitored Resident #1's wound. She stated Resident #1's care plan should have been revised to include any wound care that was provided by the facility. The ADON also stated it was the MDS nurse's responsibility to update Resident #1's care plan. She stated sometimes MDS Nurse may not be in the facility upon a residents' admission but was still responsible. ADON stated the risk of not including the care plan was staff not knowing proper care for the resident In an interview on 10/17/25 at 5:14 PM, Wound Care Nurse stated her understanding was the MDS Nurse oversaw the care plans. The Wound Care Nurse revealed she had been performing wound care for Resident #1 although it was not in the care plan. She stated wound care goals and interventions were supposed to be included in Resident #1's care plan. She revealed the wound care for Resident #1 was not in the care plan due to an oversight. She stated