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	02/26/2026

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the residents had the right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to the right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care for 4 of 6 residents (Residents #2, #20, #27 and #73) reviewed for Resident Rights.The facility failed to ensure Residents #2, #20, #27 and #73, and/or the resident's representative were invited and given the opportunity to participate in the resident's care plan meetings.This failure could place residents at risk of a decline in physical health, psychosocial health, and quality of care.Findings include:1. In a record review of Resident #2's face sheet, dated 02/25/2026, reflected a [AGE] year-old female who was initially admitted to the facility on [DATE]. Resident #2 had diagnoses which included Acute Gastrojejunal Ulcer with Hemorrhage (a severe, potentially life-threatening complication where an ulcer at the surgical site between the stomach and jejunum [middle section of the small intestine] erodes into a blood vessel, causing significant bleeding), Nondisplaced Transverse Fracture of Shaft of Left Tibia (a break across the shinbone where the bones remain aligned), Chronic Atrial Fibrillation (irregular heart rhythm where the heart's upper chambers quiver instead of beating effectively), Major Depressive (persistent sadness), Anxiety Disorder (persistent fear or worry), Morbid (Severe) Obesity (very overweight), and Polyneuropathy (the widespread damage of multiple nerves, causing numbness, tingling, burning pain, and muscle weakness).In a record review of Resident #2's Quarterly MDS, dated [DATE], reflected Resident #2's BIMS score was 10/15, which indicated moderate cognitive impairment. Resident #2 required maximum to dependent assistance (which meant staff did all of the effort) with care. During an interview on 02/26/2026 at 11:36 a.m., Resident #2 revealed she had never received a letter or invitation for a care conference, had never attended a care conference meeting with the DON, the Administrator, the DOR, Dietary, or Activities, and had never received a copy of her plan of care.2. In a record review of Resident #20's face sheet, dated 02/25/2026, reflected the a [AGE] year-old male who was initially admitted to the facility on [DATE]. Resident #20 had diagnoses which included Osteomyelitis (a serious bone infection), Type 2 Diabetes (high blood sugar level), Paraplegia (is the impairment or loss of motor and sensory function in the lower extremities), and Obstructive and Reflux Uropathy (urinary tract disorder where urine flow is blocked or flows backward into the kidneys).In a record review of Resident #20's admission MDS, dated [DATE], reflected Resident #20's BIMS score was 15/15, which meant an individual had perfect or fully intact cognitive function. Resident #20 required partial to maximum assistance with care.During an interview on 02/25/2026 at 12:02 p.m., Resident #20 revealed he talked to therapy and nursing when he first got to the facility and there was no meeting with anyone else to discuss his care and had never received a copy of his plan of care.3. In a record review of Resident #27's face sheet, dated 02/25/2026, revealed a [AGE] year-old female who was initially admitted to the facility on [DATE]. Resident #27 had diagnoses which included a fracture of the unspecified part of the neck of the left femur (serious hip injury), Iron (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Deficiency, Moderate Protein-Calorie Malnutrition, Hyperlipidemia (high levels of lipids in the blood), Essential Hypertension (chronic, high blood pressure), Heart Failure (heart not pumping enough blood), Muscle Weakness (reduced muscle movement), and Chronic Kidney Disease (kidney function loss).In a record review of Resident #27's Quarterly MDS, dated [DATE], reflected Resident #27's BIMS score was 3/15, which meant severely impaired cognitive function. Resident #27 required partial to maximum assistance with care.During an interview on 02/25/2026 at 12:54 p.m., Resident #27's family member revealed she had never received a letter, invitation or phone call for a care conference, had never attended a care conference meeting with the DON, the Administrator, the DOR, Dietary, or Activities, and had never received a copy of Resident #27's plan of care.4. In a record review of Resident #73's face sheet, dated 02/25/2026, revealed an [AGE] year-old female who was initially admitted to the facility on [DATE]. Resident #73 had diagnoses which included Metabolic Encephalopathy (a broad term for acute brain dysfunction), Muscle Weakness, Difficulty in Walking, Dementia (memory loss), Schizoaffective Disorder (hallucination/delusions), Generalized Anxiety Disorder (chronic worrying), and Bipolar Disorder(extreme mood swings).In a record review of Resident #73's Quarterly MDS, dated [DATE], reflected Resident #73's BIMS score was 07/15, which meant significant challenges with recall and orientation. Resident #73 required mostly maximum assistance with care.During an interview on 02/24/2026 at 1:15 p.m. the Administrator stated the interdisciplinary team collectively handled social worker duties, which included conducting care conferences. He explained the DON, the DOR, and himself conducted care conferences with residents and/or their families. He also stated he wrote his notes on paper, as did the rest of the team, and the notes were later entered into the facility's electronic medical record.During an interview on 02/25/2026 at 12:23 p.m., the DON revealed newly admitted residents had a care conference completed immediately, within 24 hours of admission, she spoke directly with the resident or, when applicable, the responsible party. She further stated the dietary and activities departments also met with residents separately to obtain information relevant to their areas and when the resident was receiving therapy services, the DOR participated as well.During an interview on 02/25/2026 at 12:54 p.m. Resident #73's family member revealed she had never received a letter, invitation or phone call for a care conference, had never attended a care conference meeting with the DON, the Administrator, the DOR, Dietary, or Activities, and had never received a copy of Resident #73's plan of care.During an interview on 02/25/2026 at 1:30 p.m. the Administrator stated the DON, the MDS Coordinator, and himself were responsible for the 48-hour care conference. He also reported he was unsure whether the resident or responsible party was given a copy of the care plan.During an interview on 02/25/2026 at 1:46 p.m., the MDS Coordinator revealed the DON spoke with residents but did not provide a written letter to the residents or their responsible party about the time and date the care conference was being held. If a resident was alert, she would remind them of the meeting and its scheduled time; if the resident was not alert, she would contact the responsible party.During an interview on 02/26/2026 at 11:00 a.m., the DOR revealed the facility held care conferences with residents or their responsible party, and she participated in those meetings. She reported the DON and the Administrator also attended. She stated the three of the IDT communicated regularly and discussed these matters during their weekly interdisciplinary team meetings. She further stated written notices were not sent to the residents or their responsible parties and that meetings were held on an impromptu (without advance planning) basis. She said care conferences were essential for care planning, ensuring safe discharges, and meeting residents' needs, and added without them, residents would not have the opportunity to express their expectations.During an interview on 02/26/2026 at 11:08 a.m. the MDS Coordinator revealed care conferences were conducted with the residents and/or their responsible party or family members, along with the DON, the Assistant DON, and at times, representatives from dietary, activities, the Administrator, or the DOR. She reported these conferences were held to establish a baseline understanding of the residents, which included their diet, goals, medications, and code status. She added without these meetings, the interdisciplinary team might not fully understand (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the residents' needs.During an interview on 02/26/2026 at 11:14 a.m., the DON revealed written letters were not mailed or provided to residents to notify them of the date or time of a care conference. She explained care conferences were conducted to discuss the resident's plan of care, provide updates, and address any concerns raised by the resident or family. She added the only negative consequence she could think of if care conferences did not occur was that families might not receive updates on the residents' condition. During an interview on 02/26/2026 at 3:46 p.m., the Administrator revealed the purpose of the care conference was to update the family on the residents' status and to allow families to inform staff of any changes to the residents' physician or other important updates and explained failing to hold care conferences could result in negative outcomes, such as misinformation, missed or undocumented changes in the resident's condition, failure to update the plan of care, or missed medication changes.In a record review of the form the Administrator stated he had taken notes on during care conferences with residents and/or their responsible parties did not show who attended the conference and date the conference was held.In a record review of Resident #2's, Resident #20's, Resident #27's and Resident #73's progress notes in the facility's electronic medical record revealed there was no documentation of a care conference with the residents or a family member, no documentation of phone calls made to invite the resident's responsible party, and there was no documentation of a letter or invitation for the resident's or family members to attend a care conference.In a record review of the facility's Comprehensive Care Plan policy, dated October 1, 2025, reflected, 4. The comprehensive care plan will be prepared by an interdisciplinary team that includes but is not limited to.c. A nurse aide with responsibility for the resident. d. A member of the food and nutrition services staff. c. The resident and the resident's representative to the extent practicable. f. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by their resident. Examples include but are not limited to:.ii. Activity Director. iii. Social Services. v. Family members or others desired by the resident. 7. The physician other practitioner or professional will inform the resident and or resident representative of the risks and benefits of proposed care of treatment and treatment alternatives options the facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record including discussions with the resident or resident representative. 8. Qualified staff responsible for carrying out interventions certified in the care plan will be notified of their role and responsibilities for carrying out the interventions initially and when changes are made.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on interview and record reviews the facility failed to ensure a facility with more than 120 beds employed a qualified social worker on a full-time basis for 1 of 1 (facility) reviewed for social worker qualifications.The facility, licensed for 125 beds, failed to employ a full-time social worker.This failure could place residents at risk of social service and psychosocial needs not being met.Findings include:In a record review of the facility's daily census, dated 02/26/2026, revealed the facility had a total licensed bed capacity of 125. In a record review of the Facility Summary Report from TULIP noted the facility had a total licensed capacity of 125 beds.During an interview on 02/24/2026 at 1:15 p.m., the DON revealed the previous social worker left for better job opportunities, and the interdisciplinary team had been managing the social worker duties, which included sending referrals and conducting care conferences.During an interview on 02/24/2026 at 2:34 p.m., the Administrator revealed the facility did not have a social worker on staff and reported the position had been vacant for approximately three to four weeks. He further explained the interdisciplinary team, which included himself, had been covering the social worker duties.During an interview on 02/25/2026 at 12:23 p.m., the DON revealed the facility was in the process of hiring a social worker. She explained the facility did not have a corporate social worker assigned to the building; however, if needed, a social worker from a sister facility could provide assistance. She further stated there was no established schedule for when a social worker would come to the facility, as the Administrator was responsible for arranging those visits.During an interview on 02/25/2026 at 1:30 p.m., the Administrator revealed he was responsible for hiring a full time social worker but had not been successful in locating a licensed candidate. He added the facility did not have a corporate social worker, though a social worker from a sister facility could provide assistance if available and if he requested it. He further noted he had not sought such assistance since the departure of the full time social worker.During an interview on 02/25/2026 at 3:46 p.m., the Administrator revealed the Social Worker position had been posted on both the company website and on Indeed. In a record review of the facility's job advertisement for a Social Worker was requested for both the company website and other jobsite board. And the facility was able to provide the advertisement from the company website but not from the any jobsite boards. In a record review of the undated Social Worker job announcement reflected a licensed Social Worker was being hired at the facility.In a record review of the undated, staff roster, provided by the facility, revealed there was no Social Worker.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure before a resident was transferred or discharged , the facility must notify the resident and resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understood and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for 2 of 6 residents (Residents #2 and #12) reviewed for discharge planning.1. The facility failed to notify Resident #2 and Resident #12, or the residents' representative or POA of the transfer or discharge with the reasons for the move in writing in a language and manner they understood when they were transferred to the hospital.2. The facility failed to send a copy of the notice of transfer or discharge to the representative of the Office of the State LTC Ombudsman involving Resident #2 and Resident #12, when they were transferred to the hospital.These failures could place residents at risk of being discharged without alternative placement, discharge options, their rights to appeal and access to advocacy services.Findings included:1, A record review of Resident #2's face sheet, dated 02/25/2026, reflected a [AGE] year-old female who was initially admitted to the facility on [DATE] and was her own responsible party. Her diagnoses included Acute Gastrojejunal Ulcer with Hemorrhage (a potentially life-threatening complication where an ulcer at the surgical site between the stomach and jejunum (middle section of the small intestine) erodes into a blood vessel, causing significant bleeding), Nondisplaced Transverse Fracture of Shaft of Left Tibia (a break across the shinbone where the bones remain aligned), Chronic Atrial Fibrillation (irregular heart rhythm where the heart's upper chambers quiver instead of beating effectively), Major Depressive, Anxiety Disorder, Morbid (Severe) Obesity, and Polyneuropathy (the widespread damage of multiple nerves, causing numbness, tingling, burning pain, and muscle weakness).A record review of Resident #2's Quarterly MDS, dated [DATE] reflected Resident #2's BIMS score was 10/15, which indicated moderate cognitive impairment. Resident #2 required maximum to dependent assistance (which means staff does all the effort) with care. A record review of Resident #2's progress note, dated 12/15/2025, reflected the resident was sent to the emergency room on December 15, 2025, for abdominal pains. There was no evidence a transfer or discharge notice was provided to Resident #2 in writing or to the LTC Ombudsman. 2. A record review of Resident #12's face sheet, dated 02/25/2026, revealed a [AGE] year-old female who was initially admitted to the facility on [DATE] and was her own responsible party. Her diagnoses included Urinary Tract Infection, Muscle Weakness, Difficulty in Walking, Dysphagia (difficulty swallowing), Hyperlipidemia (is high levels of lipids in the blood), Essential Hypertension (chronic, high blood pressure), and Morbid Obesity.A record review of Resident #12's admission MDS dated [DATE], reflected Resident #12's BIMS score was 14/15, which indicated cognitively intact mental status. Resident #12 required moderate to maximum assistance with her care.A record review of Resident #12's progress notes, dated 01/09/2026, reflected she was sent to the emergency room. There was no evidence a transfer or discharge notice was provided to Resident #2 in writing or to the LTC Ombudsman. During an interview on 02/25/2026 at 11:28 a.m., the DON revealed the only time the Ombudsman was notified about discharges was if a resident left against medical advice or if it was an unsafe discharge to the community.During an interview on 02/26/2026 at 12:23 p.m. with the facility's Ombudsman, she said she received one discharge notice in December 2025 and one in January 2026 and neither one was for Resident #2 nor Resident #12.During an interview on 02/26/2026 at 4:23 p.m., the DON revealed residents never received a transfer or discharge notice in writing.During an interview on 02/26/2026 at 4:23 p.m., the Regional Operations revealed she's never heard of having to provide a written notice to residents when they were discharged to the hospital with the intention of returning to the facility.A record review of the facility's Transfer and Discharge policy, revised 12/01/2025, reflected: Policy Explanation and (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Compliance Guidelines:3. The facility's transfer/discharge notice will be provided to the resident and the resident's representatives in a language and manner in which they can understand. The notice will include all of the following at the time it is provided:a. The specific reason and basis for transfer or discharge.b. The effective date of transfer or discharge.c. The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged .d. An explanation of the right to appeal the transfer or discharge to the State.e. The name, address (mailing and email) and telephone number of the State entity which receives such appeal hearing requests.f. Information on how to obtain an appeal form.g Information on obtaining assistance in completing and submitting the appeal hearing request.h. The name, web address, and phone number of the representative of the Office of the State Long-Term Care Ombudsman.i. For nursing facility residents with intellectual and developmental disabilities (or related disabilities) or with mental illness (or related disabilities), the notice will include the name, web address and e-mail addresses and phone number of the state agency responsible for the protection and advocacy of these populations.4. Generally, the notice must be provided at least 30 days prior to a facility-initiated transfer or discharge of the resident. Exceptions to the 30-day requirement apply when the transfer or discharge is effected because: a. The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident; b. The resident's health improves sufficiently to allow a more immediate transfer or discharge; c. An immediate transfer or discharge is required by the resident's urgent medical needs; or d. A resident has not resided in the facility for 30 days. e. In these exceptional cases, the notice must be provided to the resident, resident's representative if appropriate, and LTC ombudsman as soon as practicable before the transfer or discharge.7. The facility will maintain evidence that the notice was sent to the Ombudsman.10. Emergency Transfers to Acute Care . f. Document assessment findings and other relevant information regarding the transfer in the medical record.g. Provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated.h. The Social Services Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirements for content of such notices.

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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. **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 for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 of 6 residents (Resident #1 and Resident #27) reviewed for care plans 1, The facility failed to ensure Resident #1's comprehensive care plan was developed to address the code status was changed from full code to DNR on 01/07/2026.2. The facility failed to ensure the care plan for Resident #11 was developed to address the code status was changed from full code to DNR on 01/12/26.3. The facility failed to ensure Resident #27's comprehensive care plan was developed to address the code status was changed from full code to DNR on 02/11/2026.These failures could place residents at risk of not receiving treatment aligned with their expressed wishes and physician orders.Findings included: 1.In a record review of Resident #1's face sheet, dated 02/25/2026, reflected an [AGE] year-old female who was initially admitted to the facility on [DATE]. Resident #1 had diagnoses which included Mild protein-calorie malnutrition (a decrease intake of protein often appearing as weight loss), Dysphagia (difficulty swallowing), Cognitive Communication deficit (often caused by brain injury [stroke, tumor, TBI] or neurological disease), Schizoaffective disorder (a chronic mental health condition which can include, hallucinations, delusions, disorganized speech with mania or depression), Bipolar disorder (a chronic mental health condition characterized by intense mood swings, ranging from extreme highs to severe lows), and Anxiety disorders (a persistent, excessive fear or worry that interferes with daily life).In a record review of Resident #1's MDS dated [DATE], reflected Resident #1's BIMS score was 07/15, which indicated severe impairment. Resident #1 was dependent on the staff to do all her activities of daily living.In a record review of Resident #1's physician orders, dated 01/07/2026, reflected she had a DNR order signed by her physician.In a record review of Resident #1's care plan, initiated on 01/01/2026, reflected: she had no care plan for her advanced directive. In a record review of the facility's DNR binder, Resident #1 had an OOH-DNR order that was filled out correctly. 2. Record Review of Resident #11's admission MDS assessment, dated 01/17/26, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE]. The resident's cognitive status was intact with a BIMS score of 15. Her diagnoses included heart failure. Record review of Resident #11's Order Summary Report, dated 01/12/26, reflected: DNR.Record review of Resident #11's Care Plans, dated 01/10/26, reflected: Resident requests code status of full codeFacility interventions included: Inform staff of code status and monitor for decrease in change of condition, report to physician, and responsible party.3. In a record review of Resident #27's face sheet, dated 02/25/2026, reflected a [AGE] year-old female initially admitted to the facility on [DATE]. Resident #27 had diagnoses which included a fracture of the unspecified part of the neck of the left femur (is a serious hip injury), Iron Deficiency, Moderate Protein-Calorie Malnutrition, Hyperlipidemia (high levels of lipids in the blood), Essential Hypertension (chronic, high blood pressure), Heart Failure, Muscle Weakness, and Chronic Kidney Disease.In a record review of Resident #27's MDS, dated [DATE], reflected Resident #27's BIMS score was 3/15, which meant severely impaired cognitive function. Resident #27 required partial to maximum assistance with care.In a record review of Resident #27's physician orders, dated 02/11/2026, reflected she had a DNR order signed by her physician.In a record review of Resident #27's care plan, initiated on 02/10/2026, reflected Resident requests code status of full code. Facility interventions included: Inform staff of code status and monitor for decrease in change of condition, report to physician, and responsible party.In a record review of the facility's DNR binder, reflected Resident #27 had an OOH-DNR order that was filled out correctly.During an interview on 02/25/2026 at 12:54 p.m., Resident #27's family member revealed (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #27 had a signed DNR order that was given to the facility.During an interview on 02/24/2026 at 2:34 p.m., the Administrator stated the DON, himself, and the therapy staff conducted care conferences with the residents and their families and afterwards they updated the resident's care plan in the facility's EMR.During an interview on 02/25/2026 at 1:46 p.m., the MDS Coordinator said the DON was responsible for completing the baseline care plan. She reported these conferences were held to establish a baseline understanding of the residents, including their diet, goals, medications, and code status. She added that without these meetings, the interdisciplinary team might not fully understand the residents' needs.During an interview on 02/26/2026 at 11:14 a.m., the DON revealed newly admitted residents had a care conference completed immediately, within 24 hours of admission, and she was responsible for those. She explained care conferences were conducted to discuss the residents' plan-of-care, provide updates, and address any concerns raised by the resident or family. When asked what impact, if any, could occur if a resident did not have a codeˆstatus order. She responded, I don't know.During an interview on 02/26/2026 at 3:46 p.m., the Administrator revealed the purpose of the care conference was to update the family and/or resident on the resident's status and to allow family members to inform staff of any changes to the resident's physician or other important updates. He further explained failing to hold care conferences could result in negative outcomes, such as misinformation, undocumented changes in the resident's condition, failure to update the plan of care, or missed medication changes.In a record review of the facility's Comprehensive Care Plan policy, dated October 1, 2025, revealed: Policy Explanation and Compliance Guidelines 3. The comprehensive care plan will describe at a minimum the following.b. Any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment.5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.7. The physician, other practitioner or professional will inform the resident and/or resident representative of the risks and benefits of proposed care of treatment and treatment alternatives/options the facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record including discussions with the resident and/or resident representative.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one of four residents (Resident #94) reviewed for accidents and supervision. The facility failed to ensure CNA A supervised Resident #94 while her bed was elevated in the air. This failure could place residents at risk for accidents and falls.Findings include: Record Review of Resident #94's admission MDS assessment, dated 01/16/26, reflected resident was a [AGE] year-old female who was admitted to the facility on [DATE]. The resident's cognitive skills for decision making were severely impaired. The BIMs score was left blank. The resident required moderate assistance for repositioning. Her diagnoses included stroke, hemiplegia (partial paralysis), and cancer. Record review of Resident #94's Care Plans reflected:01/15/26: The resident had an ADL self-care performance deficit.Facility interventions included: Transfer: The resident required mechanical lift with 2 staff assistance for transfers.02/25/26: The resident had impaired cognitive function/impaired thought processes related to difficulty making decisions and neurological symptoms.Facility interventions included: Cue, reorient, and supervise as needed.01/20/26: Risk for fallsFacility interventions included:Fall identifiers in place. Leaf on door/red band on mobility device. An observation and interview on 02/24/26 at 11:00 AM revealed Resident #94'a bed was highly elevated in the air. The positioning side rail on the right side of the bed was lowered. CNA A was in the room. After the State Surveyor entered, CNA A walked out of the room and said she was going to get the Hoyer lift to transfer the resident. Resident #94 was able to answer some questions and said she was not scared being so high in the air. 2-3 minutes later CNA A returned to the room. She said the Hoyer lift was being used for another resident. CNA A lowered the resident's bed and repositioned the side rail. An interview on 02/24/26 and 11:05 AM with CNA A revealed it was not okay to leave Resident #49's bed high in the air and leave the room. She said she did it because she was going to get the Hoyer lift. CNA A said leaving the resident's bed elevated high in the air could cause her to fall. An interview on 02/24/26 at approximately 12:00 PM with the DON revealed staff were not allowed to leave a resident alone in an elevated bed with the positioning rail down. The DON said leaving the resident in that position placed them at risk for falls. Record Review of the facility's policy, Incidents and Accidents, revised 12/01/25, reflected: Policy Explanation .Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent reoccurrences and improve the management of resident care.

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	02/26/2026

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

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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	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 observation, interview and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for one of three residents (Resident #57) reviewed for Foley catheters.The facility failed to ensure CNA B cleaned the Foley catheter and perineal area for Resident #57 during incontinence care. This failure could place residents at risk for developing urinary tract infections and skin infections.Findings include: Record review of Resident #57's quarterly MDS assessment, dated 11/21/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident's cognitive skills were severely impaired, with a BIMs score of 1. The resident required a Foley catheter. Her diagnoses included heart failure and obstructive uropathy (blockage in the urinary system). Record review of Resident #57's Care Plans, dated 10/10/25, reflected:History of urinary tract infection, presence of catheter. Facility interventions included: Clean peri -area (anal/genital openings) with each incontinence episode.An observation and interview on 02/24/26 at 12:00 PM of Resident #57 revealed staff were preparing to do catheter care. CNA A, CNA B and CNA C prepared their supplies. CNA C was translating for the resident. CNA B unfastened the brief and cleaned the peri-area. CNA B washed her hands and put on new gloves. The resident was incontinent of bowel. CNA B cleaned the peri-area and buttocks. The resident was turned to her back and a clean brief was placed. There were no issues with hand hygiene. The resident had visible bowel movement on the catheter tubing and peri-area. CNA B started to close the brief. The HHSC State Surveyor observing asked CNA B was she was going to clean the stool. CNA B said, I did not see it. CNA B recleaned the peri-area, vaginal area, and the Foley catheter tubing. There was a moderate amount of stool cleaned. CNA B placed a clean brief on the resident. An interview on 02/24/26 at 12:30 PM with CNA B revealed she was supposed to clean the catheter tubing and the peri-area during incontinence care. She said in this case she did not do it, because she did not see the stool. She said she was not wearing contacts. CNA B said failure to clean the peri-area and Foley catheter could cause infection. An interview on 02/26/26 at 11:25 AM with the DON revealed staff were supposed to clean the peri-area and catheter tubing during incontinence care and were trained to do so. The DON said she monitored incontinence care weekly. She said CNA B usually did a good job. The DON said Resident #57 did not have frequent urinary tract infections, but failure to clean the peri-area and Foley catheter tubing could cause urinary tract infections. Record review of the facility's policy, Catheter Care, revised 12/01/25, reflected: 1. Female.10. Gently separate the labia to expose the urinary meatus.11. Wipe from front to back with a clean disposable moist wipe or cloth moistened with water andperineal cleaner (soap).12. Use a new disposable moist wipe or a new part of the cloth or different cloth for each side.13. With a new disposable moist wipe or new moistened cloth, starting at the urinary meatus moving out,wipe the catheter making sure to hold the catheter in place so as to not pull on the catheter.14. Dry area with towel if needed.

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	02/26/2026

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure it provided a safe, functional, sanitary, and comfortable environment for residents, staff and the public for one of four residents (Resident #94) reviewed for environment. The facility failed to ensure Resident #94's environment was clean and sanitary. This failure could place residents at risk for having an unclean and unsanitary environment.Findings included: Record Review of Resident #94's admission MDS assessment, dated 01/16/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident's cognitive skills for decision making were severely impaired. Her BIMs score was left blank. The resident required moderate assistance for repositioning. Her diagnoses included stroke, hemiplegia (partial paralysis), and cancer. An observation on 02/24/26 at 11:00 AM revealed Resident #94's bedroom wall next to her headboard had a large, dry, red/tan spill on it. The resident said she did not know how the spill got there. She said it did not bother her. An interview on 02/24/26 at 11:45 am with CNA A revealed she did not know anything about the spill on Resident #94's bedroom wall. CNA A said she was supposed to notify housekeeping for spills on the wall. An interview on 02/25/26 at 5:00 PM with the Administrator revealed the spill on Resident #94's bedroom wall was red juice. He said he thought the spill had been there maybe a day or two. He said if staff saw a spill on the wall they were supposed to get it cleaned. Record review of the facility's policy, Safe and Clean Environment, dated 10/01/25, reflected: Policy .the facility will provide a safe, clean, comfortable, and home-like environment .