STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675940	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hemphill Care Center	2000 Worth St Hemphill, TX 75948

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36491 Based on observation, interview and record review the facility failed to immediately inform the resident's responsible party when there was an accident involving the resident which resulted in injury or had the potential for requiring physician intervention for 2 of 8 residents (Resident #1, and Resident #2) reviewed for notification of change of condition. The facility failed to notify Resident #1's responsible party and physician when Resident #1 sustained a witnessed fall on 3/3/24 in her room when she was found sitting on the floor. The facility failed notify Resident #2's responsible party and physician when Resident #2 sustained a bruise to her right eye on 3/31/24 after hitting her face on the wall while being turned for incontinent care. This failure placed residents' caregivers at risk of not being aware of any changes in their conditions and could result in a delay in treatment and decline in residents' health and well-being. Findings included: 1. Record review of an Admission Record for Resident #1 dated 3/21/2024 indicated she was a [AGE] year old female admitted to the facility on [DATE] with a recent readmitted [DATE]. Diagnoses included chronic kidney disease, (A condition characterized by a gradual loss of kidney function.), dementia, (a term used to describe a group of symptoms affecting memory, thinking and social abilities), difficulty in walking and history of falling. Record review of an MDS for Resident #1 dated 2/6/24 indicated she had moderately impaired cognition and required moderate assistance with activities of daily living. Record review of an undated care plan for Resident #1 indicated she had a history of falls, with actual falls on 2/1/24, 3/3/24, and 3/5/24. Interventions included anticipate and meet the needs of the resident, be sure call light is within reach and encourage resident to use it, and physical therapy to evaluate and treat as ordered. Record review of an undated care plan for Resident #1 indicated she had impaired cognitive function or impaired thought processes. Interventions included communicate with the resident/family/caregivers regarding residents capabilities and needs. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of nurse progress notes for Resident #1 indicated the following: 3/3/24 11:45 p.m. Resident was hollering Can someone please come help me. Upon arrival to the room Resident was awake, alert sitting on floor in upward position near wheelchair. Resident states I missed the wheelchair and my bottom hit the floor, No change in normal behaviors noted at this time. Resident was assisted to wheelchair and then to bed for further assessment. Resident assessed for injuries; no injuries noted at this time. Signed by LVN A. Record review of a physician progress note dated 3/4/24 at 9:40 a.m. indicated the following; patient complains of back pain after having a fall a couple days ago. Signed by the PA. Record review of a witnessed fall incident report for Resident #1 dated 3/3/24 at 11:45 p.m. revealed no documentation indicating the physician or RP were notified of the fall. Signed by LVN A. Record Review of a radiology report dated 3/5/24 indicated that a lumbar spine x-ray was performed on Resident #1. X-ray conclusion indicated compression deformity at the L1 level (lumbar spine which consists of five vertebrae in the lower back), age indeterminate. Record review of a grievance/complaint form dated 3/5/24 and signed by the ADON indicated Resident #1's family member stated family was not notified of fall on 3/3/24. Actions taken included in-service training on notification of families. 2. Record review of an Admission Record for Resident #2 dated 4/1/2024 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with a recent readmitted [DATE]. Diagnoses included cerebral infarction (stroke), Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves) with dyskinesia (uncontrolled, involuntary movements of the face, arms, or legs), vascular dementia (a condition caused by the lack of blood that carries oxygen and nutrients to a part of the brain. It causes problems with reasoning, planning, judgment, and memory), hairy cell leukemia (a cancer of the blood that starts in your bone marrow) in remission, psychotic disorder, and SLE (systemic lupus erythematosus-the most common type of lupus. SLE is an autoimmune disease in which the immune system attacks its own tissues, causing widespread inflammation and tissue damage in the affected organs). Record review of an MDS for Resident #2 dated 1/6/24 indicated she had severely impaired cognition and was totally dependent on staff assistance with activities of daily living. Record review of a care plan with a revision date of 2/7/24 for Resident #2 indicated she was prone to skin tears and bruising of unknown origin related to fragile skin and banging arms and hands on objects, tables, doors, etc. Interventions included all injuries will be monitored until resolved, notify charge nurse of any new bruising or skin tears. Notify physician and responsible party of any abnormal findings. Record review of nurse progress notes for Resident #2 indicated the following: 3/29/24 10:43 a.m. late entry. This nurse in residents room performing incontinent care on resident, while rolling resident over this nurse bumped resident right side of face on wall. No complaints of pain, no redness noted. No injuries noted. This nurse notified charge nurse to check for any delayed injuries. Signed by ADON. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/31/24 5:00 p.m. this nurse was approached per family members of Resident #2 concerned with a bruise to right side of face. This nurse notified them that resident was being changed and the nurse had rolled her over hitting her head on the right side of wall and we are monitoring her to see if she had any delayed injuries. This nurse went and assessed resident. Resident #2 noted to have bruise to right side of eye red in color. Family also stated that Resident #2 had a bruise to left side of face and jaw was swollen. This nurse examined Resident #2's jaw but jaw is not swollen. Resident #2 able to move jaw up and down without difficulty, denies any pain or discomfort. Discoloration noted to left side of face per normal. This nurse spoke to RP to address concerns of other family members. RP stated that she was unaware of resident hitting head while being changes. This nurse explained that Resident #2 didn't have any injuries at the time, denied any pain, and that this nurse had been watching to make sure resident didn't have any delayed injuries. This nurse explained to RP that there was a bruise to the left side of Resident #2's face but the discoloration had always been there. RP agreed that resident has had that since her initial fall. ADON in facility to assess resident. Hospice enroute to facility. MD updated. Signed by LVN B 3/31/24 5:00 p.m. This nurse received call from LVN B. LVN B states Resident #2's family members are at the facility because resident is showing to have a bruise to right side of face under eye. This nurse reminds charge nurse of the other day when this nurse was performing incontinent care and this nurse asked to watch for delayed injuries. Charge nurse expressed understanding and said that she had went over that with the family but family was still having concerns. This nurse called and spoke to RP. RP stated that she understood that but she was not notified of this nurse accident during incontinent care. This nurse explained to RP that at the time there was no injuries or incident to report but bruises do not occur suddenly and usually take hours/overnight to appear. RP stated that the Resident #2's jaw looked swollen and appeared to have a bruise to left side of face. This nurse told RP that I was unaware of the bruise to left side of face or swollen jaw but I would get with the charge nurse. LVN B stated that the discoloration to Resident #2's face has always been there on the left side of face but her jaw did not appear swollen. This nurse came to facility on 3/31/24 at 5:30 p.m. to examine resident herself. Upon entering room resident had two visitors. Resident's family member stated they were waiting on a hospice nurse to come and examine the resident. This nurse assessed resident. No swelling noted to jaw. Resident #2 able to move up and down without pain or discomfort. Resident #2 does have a discoloration to the left side of face but nothing of abnormality. Even per face sheet picture there is discoloration to left side of face. Went over this with RP who stated that the discoloration on face had been there since an initial fall a few years ago. MD and Hospice made aware. Will continue to monitor and assess as allowed. Signed by ADON. Record review of a PA progress note for Resident #2 dated 4/2/24 at 8:57 a.m. Indicated the following: Resident #2 is a [AGE] year female with PMH of Systemic Lupus Erythematosus, Vascular dementia, HTN, hyperlipidemia, and Hairy Cell Leukemia, Shingles and is lying in bed in normal state. She responds when talking to her and recognizes me but is confused and at baseline. No distress noted. No SOB, no fever, no vomiting, or diarrhea, does have chronic rash face, bilateral arms, and bilateral legs. Chronic rash of face and bilateral extremities secondary to Hairy Cell Leukemia, SLE and shingles. Assessment and Plan: 1. Chronic Rash: patient with chronic rash on face, and bilateral upper and lower extremities secondary to Hairy Cell Leukemia, Lupus, and Shingles. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/1/24 at 4:57 p.m., LVN A stated she had worked in the facility since July 2023. LVN A stated she was working on 3/3/24 when Resident #1 was found on the floor around 11:45 p.m. LVN A stated she was walking down the hall making rounds and heard Resident #1 call for help. LVN A went into the room and Resident #1 was on the floor in a sitting position near the bathroom, and her wheelchair was behind her. LVN A stated she believed Resident #1 was coming from the bathroom and tried to get back into the wheelchair and it rolled out from under her. LVN A stated Resident #1 said she did not have any pain at that time. LVN A stated that around 4:00 a.m. on 3/4/24 Resident #1 complained of pain to her back and she gave her Tylenol, which was effective for her pain. LVN A stated she did not notify the doctor or the family. LVN A stated she did not call the doctor because Resident #1 did not hit her head and it was a witnessed fall. LVN A stated the DON was working with her and was aware of the fall. LVN A stated she was going to call the family, but it just slipped my mind. LVN A stated when a resident had a fall the family were to be notified and the doctor if there was a head injury. LVN A stated the physician was not notified. LVN A stated Resident #1 would transfer herself to the bathroom, and also had a bedside commode. Resident #1 did not use her call light to call for help when she needed it. LVN A stated the breaks on the wheelchair were not locked at the time of the incident, and she checked them and found them to be in working order. LVN A stated Resident #1's family should have been notified. During a phone interview on 4/1/24 at 11:15 a.m., the RP stated that on 3/31/24 Resident #2's family members were visiting and sent her a picture of Resident #2 with a black eye, and her jaw was swollen. The RP called the facility and told someone to go check on Resident #2. RP stated the ADON called her and told her she was changing Resident #2 and her face hit the wall, and she had asked the staff to notify her of any bruising. RP stated Hospice RN G went in and assessed Resident #2 and confirmed the black eye. RP stated Hospice RN G told her a wall could not do that bruising, her nose would have hit the wall. Hospice RN G told her there were other areas of bruising which were never reported to her. RP stated Hospice RN G told her the bruising was due to pressure on her legs, not her Lupus, it had to be due to pressure. During an interview on 4/1/24 at 10:55 a.m., the ADON stated that there was an incident on Friday 3/29/24 with Resident #2. The ADON stated she was providing incontinent care to Resident #2 and when she rolled Resident #2 over to her right side towards the wall, Resident #2's right side of her face hit the wall. The ADON stated there was no injury at the time, and she told the nurses to watch her for any delayed injuries. The ADON stated that a bruise showed up on Sunday 3/31/24 under Resident #2's right eye. Resident #2 had discoloration under her left eye, but that had been there for a long time. The ADON stated she was not working at the time but she came up to the facility on [DATE] to assess Resident #2 because a family member told the nurse on duty that they were worried about her jaw being swollen as well as the bruise under her eye. The ADON stated that when she assessed Resident #2 she did not notice any swelling to her jaw. The ADON stated the Hospice nurse came in to assess Resident #2 as well. The ADON stated Resident #2's RP was called at 6:40 p.m. on 3/31/24 and told about the bruising. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of Resident #2 on 4/1/24 at 11:15 a.m., Resident #2 was noted to have a purplish brown bruise under her right eye and discoloration under her left eye. There was also a small spot of discoloration to the middle of her forehead. Resident #2 had discoloration to both of her forearms and on both of her legs from the knee to the calf area. The ADON demonstrated how she had pulled up the draw sheet while providing incontinent care on 3/29/24 to Resident #2 and stated she pulled too hard when turning Resident #2 over towards the wall. The ADON stated in talking with Resident #2's RP, her main concern was that she was not notified of the incident. The ADON stated that she did not call the RP on the day of the incident because there was no injury to report. The ADON stated that LVN B called her Sunday 3/31/24 at 4:00 PM to tell her of the bruising and that the family members were upset. During a telephone interview on 4/1/24 at 12:43 p.m., Hospice RN D stated that her last visit with Resident #2 was on 3/25/24. Stated Resident #2 had dark pigmentation spots to both upper extremities and both lower extremities. Stated Resident #2 had pigmentation spots to her forehead and under her left eye. Hospice RN D stated she did not notice any discoloration on her visit under Resident #2's right eye. During an interview on 4/1/24 at 1:05 p.m., CNA E stated she had worked in the facility for 2 years and worked the secured unit. CNA E stated Resident #2 came in with bruises/discoloration to her skin. CNA E stated she did not work the past weekend and did not know when the bruise under Resident #2's right eye appeared and did not remember seeing it when she last worked. During an interview on 4/1/24 at 1:10 p.m., CNA F stated said she had worked in the facility for 1 year and 4 months and worked the secured unit. CNA F stated Resident #2 came to the facility with discoloration to her arms and legs. CNA F stated she did not work the past weekend and was not sure when the bruise under Resident #2's right eye showed up. During an observation on 4/1/24 at 1:15 p.m., CNA E and CNA F rolled Resident #2 to her side. Observation of Resident #2's skin showed no bruising or discoloration to Resident #2's back , buttock area or posterior legs. During an interview on 4/1/24 at 1:25 p.m., the ADON stated that the nurse on duty was responsible for notifying the family and physician of any falls. The ADON stated she talked to Resident #1's family member on 3/5/24, as she was upset she had not been notified of Resident #1's fall on 3/3/24, and that was when she found out that the nurse had not notified the family member. The ADON stated that she filled out a grievance form at that time. ADON stated LVN A was working on 3/3/24, and did not notify the family, she thought she had notified the physician, and the previous DON who was in the facility working at the time was aware. The ADON stated she counseled LVN A on reporting information. The ADON stated this was a verbal counseling, and no paperwork was filled out except for the grievance when she talked to Resident #1's family. The ADON stated that the LVN A told her she honestly forgot to call. The ADON stated that LVN A should have called the family when Resident #1 fell on [DATE]. During a phone interview on 4/1/24 at 2:10 p.m., the PA stated he was aware of the incident with Resident #2. The PA stated Resident #2 had discoloration to her skin since admission. The PA stated he did not suspect any type of abuse to Resident #2. The PA stated Resident #2 had Lupus, and that was the reason for the scaring/ discoloration to Resident #2's skin. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/1/24 at 2:15 p.m., LVN C stated that Resident #2 had discoloration to her left cheek under her eye, and that it had always been there since she was admitted , as well as the darkened areas to her arms and legs. LVN C stated she did not work the past weekend and this date was the first time she had seen the bruise to Resident #2's right eye. During an interview on 4/1/24 at 2:23 p.m., Hospice Nurse RN G stated Resident #2's family contacted the on call number on Sunday 3/31/24. Hospice Nurse RN G stated she was told that family members were visiting and noticed Resident #2 had a black eye and wanted a visit. Hospice Nurse RN G stated that the facility reported the black eye came from rolling her over. Hospice Nurse RN G stated Resident #2 resided on the dementia unit. Hospice Nurse RN G stated Resident #2 had a bruise to her right hand side of her face. Resident's left side of her face and her cheeks had discoloration. Hospice Nurse RN G stated she knew the Resident had Lupus, and knew she bruised easily. Hospice Nurse RN G stated I understand she has dementia. I worked in the ER for [AGE] years and I have seen it. The first thing the Resident asked when I went to assess her was if I was going to hurt her. Hospice Nurse RN G stated that her concern was if the Resident hit the wall, why did she not hit her nose?. Stated she knew that dementia residents were at high risk for abuse. Hospice Nurse RN G stated that when she spoke to the Resident #2's RP, she was concerned just from hearing her story. Hospice Nurse RN G stated the nurse (name unknown) said she reported the incident to the daughter, but the daughter was adamant she was not notified. During an interview on 4/2/24 at 9:30 a.m., the ADON stated that every fall required physician notification. On 4/2/24 at 10:20 a.m., an attempted phone interview with LVN B was made. Voicemail left. No response received. During an interview on 4/2/24 at 11:04 a.m., the Assistant Administrator stated she had worked in the facility since mid-November. The Assistant Administrator stated she was not aware of the incident with Resident #1 until Investigator came into the facility. The Assistant Administrator stated Resident #1's family and physician should have been notified, and after she learned of the incident in-service trainings were initiated. Assistant Administrator stated in regard to Resident #2, she knew that the ADON was very thorough in her patient care and had every intention of having Resident #2 monitored after her hitting the wall. The Assistant Administrator stated the ADON told staff to monitor the Resident which did not happen, and monitoring should have been documented. The Assistant Administrator stated that family of Resident #2 should have been notified of the incident when it happened so when the bruise developed the family would have already been alerted. The Assistant Administrator stated, we have rules to be followed. During an interview on 4/2/24 at 11:20 a.m., the ADON stated that at the time of Resident #2's incident, there was no injury and that was why she didn't call the family. The ADON stated that in looking back, Resident #2's family should have been called after the incident occurred. Record review of a facility policy titled Accidents and Incidents-Investigating and Reporting with a revised date of July 2017 indicated, .the following data shall be included on the Incident/Accident form, the date and time physician was notified, the time the person's family was notified and by whom .