

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675940	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/24/2025
NAME OF PROVIDER OR SUPPLIER Hemphill Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - 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, mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 5 residents (Residents #1) reviewed for care plans. The facility failed to develop a comprehensive care plan to address the risk for developing pressure ulcers and the lack of interventions caused Resident #1 to experience a pressure ulcer to her left heel on 8/28/2025. This failure could place residents at risk of not receiving the necessary care and services. Findings included: Record review of a facility face sheet dated 9/20/2025 revealed Resident #1 was an [AGE] year-old female that admitted on [DATE] with a diagnosis of fracture to left lower leg. Record review of an admission MDS assessment dated [DATE] revealed Resident #1 had a BIMS of 10 indicating moderately impaired cognition and was at risk for developing pressure ulcers. Record review of a Braden Scale for predicting pressure sore risk assessment dated [DATE] revealed Resident #1 was at risk for developing pressure ulcers. Record review of Resident #1's comprehensive care plan dated 8/20/2025 revealed Resident#1's care plan did not address her risk for developing pressure ulcers or that she had a splint in place to her left ankle. Record review of care area assessment (CAA) trigger report dated 8/20/2025 revealed Resident #1 needed a care plan to be developed to address pressure ulcer risks, and a care plan was not developed to address the problems/risks identified in the MDS assessment. Record review of a progress note dated 8/25/2025 from the NP G revealed Resident #1 had limited range of motion to the left leg and a splint was in place to the left lower extremity. Record review of order summary report dated 8/28/2025 revealed Resident #1 had an order to apply skin prep to unstageable to left heel every shift until area resolves or treatment changes. Record review of a skin assessment report dated 8/29/2025 revealed Resident #1 had a deep tissue injury to her left heel. Record review of a weekly skin assessment report dated 8/30/2025 revealed Resident #1 had black discoloration noted with skin intact to left heel. Review of wound care note dated 9/05/2025 by the wound care doctor revealed Resident #1 had a pressure injury to her left heel measuring 3 cm x 2.4 cm and to apply skin prep and offload wound. During an interview on 9/22/2025 at 12:19 pm LVN B said that when residents were admitted the nurse completed an initial baseline care plan, but the DON was responsible for completing the comprehensive care plans. She said a comprehensive care plan was a tool used by the nurses to know what care each resident needed. She said by not having an accurate and complete care plan it could cause a decline in resident health. During an interview on 9/22/2025 at 1:35 pm the DON said she was responsible for completing and updating the comprehensive care plan. She said Resident #1 should have had a comprehensive care plan that addressed her splint, skin breakdown risk and actual breakdown on her left heel. She said she completed the care plan but did not realize those items had not been identified. She said that by not having a comprehensive care plan resident care could be delayed. She said she was responsible for completing and updating the comprehensive care plan. She said Resident #1 should have had a comprehensive care plan that (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 0656 Level of Harm - Actual harm Residents Affected - Few	addressed her splint, breakdown risk and actual breakdown on her left heel. She said she completed the care plan but did not realize those items had not been identified. She said that by not having a comprehensive care plan resident care could be delayed. During an interview on 9/24/2025 at 11:00 am the Administrator said the DON was responsible for all care plans and she expected all residents to have a comprehensive care plan that identifies their CAA triggers and interventions were put in place. She said a resident at risk for pressure ulcers should have a care plan. She said by not accurately care planning residents were at risk for medical issues not being identified and addressed appropriately. She said going forward all residents' care plans would be addressed with the IDT and reviewed to ensure they were accurate. Record review of a facility policy titled Care Plans, Comprehensive Person-Centered dated 2002 indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 7.The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (3) which professional services are responsible for each element of care; c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions.		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent new pressure injuries from developing was provided for 1 of 4 residents reviewed for pressure injuries (Resident #1). 1. The facility did not ensure Resident #1 had orders and interventions in place related to an ankle splint to prevent pressure injuries on admission 8/07/2025.2. The facility failed to ensure Resident #1 did not develop a pressure related deep tissue injury on 8/28/2025. These failures could place residents at risk for new development or worsening of existing pressure injuries, pain, and decreased quality of life. Findings included: Record review of a facility face sheet dated 9/20/2025 revealed Resident #1 was an [AGE] year-old female that admitted on [DATE] with a diagnosis of fracture to left lower leg. Record review of an admission MDS assessment dated [DATE] revealed Resident #1 had a BIMS of 10 indicating moderately impaired cognition and was at risk for developing pressure ulcers. Record review of a Braden Scale for predicting pressure sore risk assessment dated [DATE] revealed Resident #1 was at risk for developing pressure ulcers. Record review of Resident #1's comprehensive care plan dated 8/20/2025 revealed Resident#1's care plan did not address her risk for developing pressure ulcers or that she had a splint in place to her left ankle. Record review of Resident #1's consolidated order summary report dated 8/08/2025 revealed Resident #1 did not have in place any orders related to a splint to her left ankle. Record review of an admission assessment report dated 8/8/2025 revealed Resident #1 was admitted with a left ankle fracture, but the nurse did not address the splint to her ankle. Record review of a skin assessment report dated 8/8/2025 revealed no information related to a splint or device to Resident #1's ankle. Record review of a skin assessment report dated 8/29/2025 revealed Resident #1 had a deep tissue injury to her left heel. Record review of a history and physical note from the hospital dated 7/27/2025 revealed Resident #1 had a left ankle splint. Record review of a history and physical note dated 8/13/2025 from a local hospital revealed Resident #1 had a recently fractured left ankle and a splint was in place. Record review of a progress note dated 8/25/2025 from the NP G revealed Resident #1 had limited range of motion to the left leg and a splint was in place to the left lower extremity. Record review of order summary report dated 8/28/2025 revealed an order for Resident #1 to apply skin prep to unstageable to left heel every shift until area resolves or treatment changes. Review of wound care note dated 8/29/25 by the wound care doctor revealed Resident #1 was not assessed by the doctor for the deep tissue injury to her left heel. Record review of a weekly skin assessment report dated 8/30/2025 revealed Resident #1 had black discoloration noted with skin intact to left heel. Review of wound care note dated 9/05/2025 by the wound care doctor revealed Resident #1 had a pressure injury to her left heel measuring 3 cm x 2.4 cm and to apply skin prep and offload wound. During an interview on 9/21/25 at 10:21 am LVN D said Resident #1 had a splint on her left ankle that was to remain in place until she saw the doctor, but she could not recall any specific orders for the splint or if that information was documented anywhere in her admission note. She said she was not the nurse that admitted Resident #1. She said when a resident had a device it should be documented and there should be orders and interventions in place to prevent pressure ulcers. She said they did use pillows to offload but Resident #1 would kick them away. She said the nurses rounded with the wound care doctor and was not sure why he did not see her for the pressure injury on her heel on 8/29/2025 but they had treatment orders for skin prep already. She said that not having orders and interventions in place for any device or for residents at risk for pressure injuries could cause pressure ulcers to develop and a decline in health. Attempted call on 9/21/2025 at 10:34 am to admission nurse LVN C with no answer and message left. During an interview on 9/22/25 at 8:30 the Wound Care Doctor said he had seen Resident #1 a few times but couldn't recall how many times. He said he was treating a DTI to her heel that developed. He said she had a splint on her leg at one time but could not recall the (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	date he was called about the heel. He said the facility notified him of any new areas and he assessed them on his weekly visits. He said the nurses often would call and get orders prior to his visit and then he would modify those orders if needed once he saw the resident. During an interview on 9/22/25 at 12:05 pm CNA F said she cared for residents that had ADL care issues and required assistance with positioning. She said residents that needed assistance, pillows and wedges were used to offload pressure. She said she cared for Resident #1, and she had a splint on her leg, and it couldn't be removed so they put her feet on pillows. She said if a resident was at risk for pressure sores, then they should have things in place to prevent those sores from developing. During an interview on 9/22/25 at 12:19 pm LVN B said Resident #1 was admitted to the facility with a splint in place to her left ankle. She said she could not recall any specific orders related to the splint but at some point, it was removed. She said there should have been a progress note regarding the splint. She said Resident #1 developed a DTI to her left heel but could not recall the date of the development. She said the area was dark purple, the skin was intact, and the order was for skin prep. She said she completed the readmission assessment on 8/15/2025 on Resident #1 when she returned from a hospital stay and the skin assessment should have addressed the splint and there should have been measures in place to prevent pressure ulcer development. She said that by not having thorough assessments, orders and interventions for residents at risk for pressure ulcers then ulcers can develop and affect the resident's well-being. During an interview on 9/22/25 at 1: 18 pm the ADON said skin assessments were completed weekly, on admission/readmission and as needed for new skin issues found. She said Resident #1 had a nonremovable splint on admission that should have been documented, and she was to see the orthopedic doctor but got sick and went to the hospital for a few days. She said when Resident #1 returned she contacted the orthopedic doctor the next week about the splint. She said they called her back to arrange an appointment and told her it was ok to remove the splint. She said when she removed the splint Resident #1 had a deep tissue injury to her left heel and redness to the side of her foot. She said the doctor and family were notified and an order for skin prep was started. She said the wound doctor saw her and assessed the areas and was assessing it weekly. She said his initial visit was 8/29/2025 and was not aware he did not address the heel wound. She said he addressed it the next week on 9/05/2025. She said she thought she charted all that information but must have forgotten. She said by not properly assessing and initiating interventions for residents at risk for pressure ulcers, pressure ulcers could develop. During an interview on 9/22/25 at 1:35 pm the DON said Resident #1 had a left ankle splint on admission and that splint was to remain in place until she returned for her follow up visit with the orthopedic. She said on admission the nurse should have called to receive orders related to the splint and she should have reviewed the admission to ensure all measures were in place. She said she did not recognize the wound care doctor did not assess the heel wound the following day after it was found but she had assessed it and put in a skin assessment. She said she made sure the wound doctor saw her on his next visit 9/05/2025. She said that devices were a cause of pressure injuries and there should have been measures in place to prevent pressure ulcers from developing. During a phone interview on 9/23/2025 at 3:59 pm LVN C said that she was the nurse that admitted Resident #1 on 8/07/2025. She said she did her assessments and Resident #1 had a splint in place to her left ankle. She said when she received report from the hospital that evening, she was told to leave the splint in place until the resident had her follow up visit. She said she could not get the resident entered in the facility charting program and forgot to chart the splint and orders in a progress note once she was in the system. She said that she charted Resident #1's skin color and pulses but no mention of the splint. She said the resident should have had orders and interventions in place for the splint because of her risk of developing pressure ulcers. She said care plans were completed by the DON. During an interview on 9/24/2025 at 9:25 am the orthopedic staff nurse said that when Resident #1 admitted to the facility she had a nonremovable splint to her left ankle and typically that splint stayed in place until their follow up with the orthopedic. She said the facility did not contact the office according to (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	the records to receive post operation instructions for the splint. She said the facility did call later regarding removing the splint and orders were given and they saw the resident in the office on 9/03/2025. During an interview on 9/24/2025 at 11:00 am the Administrator said the DON and the ADON were responsible for ensuring that all residents have an accurate assessment, orders and interventions in place. She said that the facility also had a regional nurse that reviews the resident records. She said when a resident was admitted she expected the nurse to complete a complete and accurate assessment of that resident and identify any devices such as splints and risk for pressure ulcers. She said that by not doing that residents were at risk for developing pressure ulcers. She said going further the interdisciplinary team would discuss more depth each admission at morning meeting and identify any areas of concern that need to be addressed. Record review of a facility policy titled Pressure Ulcers/Skin Breakdown dated 2001 indicated, .1. The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss, and a history of pressure ulcer(s). 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; c. Resident's mobility status; d. Current treatments, including support surfaces 3. The staff will examine the skin of a new admission for ulcerations or alterations in skin. Record review of a facility policy titled Skin assessment dated [DATE] indicated, .It is our policy to perform a full body skin assessment as part of our systematic approach to pressure injury prevention and management. 1.A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury. 7. Documentation of skin assessment: a. Include date and time of the assessment, your name, and position title. b. Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc).		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 1 vaccine/medication storage refrigerators reviewed for labeling and storage. The facility failed to monitor and record temperatures of the refrigerator located in the medication room used for vaccine storage twice daily as required per the Centers for Disease Control (CDC) guidelines for vaccine storage when temperatures were logged for the refrigerator one time each day from September 1, 2025, until September 22, 2025. This failure could place residents who receive medications at risk of not receiving the intended therapeutic benefit of the medications. Findings included: During an observation and interview on 9/23/2025 at 8:45 AM 5 packages of ten injectable influenza vaccines were inside the medication room refrigerator. LVN B said the staff check and log the refrigerator once a day. LVN B said the nursing staff check the temperature and make sure it is between 35 to 40 degrees. Record Review of the medication refrigerator log for September 2025 indicated the refrigerator was monitored daily and a temperature was documented on the log within perimeters (36- and 46-degrees Fahrenheit), one time each day from September 1, 2025, until September 22, 2025. During an interview on 09/23/2025 at 1:30 PM The ADON said the facility had not been checking the temperature or logging as required by standards of care. The ADON said she would start checking the temperatures twice daily and logging as required. The ADON said not maintaining the correct temperature could diminish effectiveness. During an interview on 9/24/2025 at 9:00 AM the DON said the refrigerator was checked daily and the temperature was recorded on the log located on the refrigerator in the medication room. She said she was not aware that the temperature should be checked and logged twice daily if vaccines were stored in the refrigerator. She said that if the vaccine were not stored appropriately, they could lose potency and may not be effective. During an interview on 9/24/2025 at 9:15 AM the Administrator said the ADON and DON were responsible for medication storage, and she expected all requirements for storage of immunizations and medications to be followed. She said that if the vaccine were not stored appropriately, they could lose potency and may not be effective. Record Review of a policy and procedure titled Medication Storage in the Facility dated 2018 indicated, .The facility should check the refrigerator or freezer in which vaccines are stored, at least two times a day, per CDC Guidelines. Record Review of policy and procedure titled Medication Labeling and Storage dated 2001 indicated, .The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Record review of https://CDC.gov/vaccines/storage document accessed 9/23/2025 Indicated: Keep your storage units and vaccines within the appropriate temperature ranges. Store vaccines between 36- and 46-degrees Fahrenheit. Check and record storage unit min/max temperatures at the start of each workday. If your device does not display min/max temperatures, then check and record current temperature a minimum of 2 times (at start and end of workday).		