STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676374	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlothian Healthcare Center	900 George Hopper Rd Midlothian, TX 76065

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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676374	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlothian Healthcare Center	900 George Hopper Rd Midlothian, TX 76065

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately notify the residents' representative and physician of the changes in the resident's physical and mental health for one (Resident #1) of seven residents reviewed for notification of changes. The facility failed to ensure Resident #1's RP and Physician were notified when he was found on the floor after a fall on 11/20/2025. This failure placed residents at risk of a decreased quality of life and risk of not having their responsible party represent them in medical and care decisions. Findings included: Review of Resident #1's face sheet dated 12/2/2025 reflected a [AGE] year-old male admitted on [DATE] with diagnoses that included: Dementia (progressive decline in mental ability, difficulty in walking, type II diabetes (blood sugar regulation disorder), hypertension (high blood pressure), end stage renal disease (final stage of kidney function failure), lack of coordination and neuropathy (damage to the peripheral nerves in the body. Review of Resident #1's quarterly MDS dated [DATE] reflected he had a BIMs score of 3 suggesting severe cognitive impairment. Review of Resident #1's progress noted dated 11/20/2025 at 4:17 am by LVN A reflected: Nurse witnessed resident attempting to get out of bed without assistance stating he is going to the mechanic. Nurse assisted resident with getting in wheelchair and brought him to nurses station to prevent any fall. Review of Resident #1's progress noted dated 11/20/2025 at 2:30 pm by LVN B reflected: Therapy notified this writer that resident was non-compliant with participating with scheduled therapy activities, he asked one of caregiver to leave him alone he can slide on the board to bed at this time, assessmentcompleted, noted right slightly bulging, resident quickly grabbed his pants and pulled them back resisting the assessment, at this time notified [MD] of findings received new orders to do x-ray of right hip and right pelvicbones, resident noted alert and able to voice needs, declined to take pain medication. Call placed to [RP] notified of new orders, [RP] notified this writer that while she was here on Sunday, he complained of pain, but she did not tell the nurse, she also notified this writer that resident has a tendency of throwing himself in the bed. She also reported that her [FM] came in on and noted that residents had a rusty voice and was later moved and isolated due to covid-19. This writer also notified [RP] that resident denied falling. Will follow up with the results. During an interview on 12/2/2025 at 1:40 pm, the ADM stated she did not find out about Resident #1 falling until they got in touch with LVN A who had worked that shift - she stated that was around 6:30 pm on 11/20/2025. She stated her expectation around resident falls is that staff will provide the proper documentation and report to the proper people; to include the DON, Physician and Family. She stated an incident report was done earlier in the shift, but it wasn't' classified as a fall it was classified as an injury of unknown origin because they hadn't' yet found out about him being found on the floor. During an interview with the DON on 12/2/2025 at 2:20 pm, she stated her expectation of staff is that they will report all falls, do an assessment, document their assessments in the EMR, complete a detailed incident report and make appropriate notifications. She stated [LVN A] did not do any of that. She stated if falls are not reported their could be injuries of unknown origin, unexplained fractures, bleeding and the staff not being able to provide the care needed.She further stated that Resident #1's RP should have been notified when he fell so the family was aware of what was going on and there was no delay in care. During an interview on 12/2/2025 at 2:43 pm with the MD he stated he had been contacted late in the afternoon on 11/20/2025 about Resident #1 complaining of pain. He stated he was not informed that the resident had fallen and the nursing staff may not have known at that time either that the resident had fallen. He stated he ordered and x-ray of the hip and later the results indicated Resident #1 had a fracture. He stated he ordered Resident #1 sent to the hospital for additional care. He stated his expectation is that staff will make the appropriate notifications when a resident falls. During an interview on 12/2/2025 at 3:12 pm, LVN A stated she was the LVN working overnight from 11/19/202 to 11/20/2025. She stated after midnight she went into Resident #1's room and found him on the floor. She stated the resident denied he had fallen so she assumed he had just slipped out of bed and landed on his bottom. She stated she did not report this to anyone or call the RP because she didn't think it was a fall and the resident wasn't hurt or complaining of pain. During an interview on 12/3/2025 at 8:42 am, LVN A stated she did not call Resident #1's RP when she found him on the floor after midnight on 11/2025 because she didn't think it was considered a fall. She stated it is important to call the RP when something happens to a resident because RP's have to be aware of what is going on with their family members. When LVN A was asked why it was important that RPs know what is going on with a resident, she replied I don't know how to answer that - am I in trouble? During an