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	05/15/2024

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 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** 43872 Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision to prevent accidents and hazards for 1 of 7 residents (Residents #1) reviewed for supervision. Resident #1 accessed the staff breakroom, obtained staff car keys, accessed staff's car, and drove off the premises on [DATE]. This failure places residents at risks for inadequate monitoring and supervision. Findings include: Review of Resident #1's face sheet, dated [DATE], revealed she was admitted on [DATE] with diagnoses including cocaine abuse with cocaine-induced psychotic disorder with hallucinations, bipolar disorder, major depressive disorder, anxiety disorder, insomnia, fusion of spine, spinal stenosis (narrowing of spinal canal), cervical disc disorder with radiculopathy (compressed or irritated nerve in the neck), overactive bladder, urinary tract infection onset [DATE], chronic obstructive pulmonary disease (lung disease), and cerebral infarction (stroke). Review of Resident #1's Optional State Assessment MDS, dated [DATE], revealed she had a BIMS score of 11, indicating moderate cognitive impairment and supervision and setup help only for ADL assistance. MDS revealed she had a Mood total severity score of 00, and Behaviors score of 0, indicating no symptoms present for mood or behavior. Review of Resident #1's care plan, revised [DATE], revealed she had impaired cognitive function/dementia/ or impaired thought processes related to Dementia, delirium or an acute confusion episode related to inattention/disorganized thinking with a goal for resident to be free of signs and symptoms of delirium (changes in behavior, mood, cognitive function, communication, level of consciousness, restlessness). Care plan Interventions included to communicate with the resident/family/caregivers regarding residents' capabilities and needs, keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion, provide medications to alleviate agitation as ordered, monitor/document side effects and effectiveness, and reorient the resident to person, place, time, situation as required. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's current Texas driver's license revealed it was valid from [DATE] and expired on [DATE]. Review of facility sign out log revealed Resident #1 signed herself out on [DATE]. During an interview on [DATE] at 9:04 AM, the ADON said the administrator and DON was not working on [DATE] when Resident #1 stole a staff's car. The ADON said she was not aware of any recent elopement incidents and was aware of the incident when Resident #1 took LVN A's vehicle and left the facility and that she followed her when she drove off. The ADON said that Resident #1 was alert and oriented and did not remember the exact date it occurred. The ADON said that Resident #1 signed herself out of the facility and took LVN A's keys from her personal belongings stored in the breakroom. The ADON said she was in her car in the parking lot when she noticed LVN A's car leaving, so she called LVN A to ask where she was going. LVN A said she was in the facility and suspected that it had to have been Resident #1. The ADON said she followed Resident #1 in LVN A's car about ,d+[DATE] of a mile down the road and then she pulled her over and took her back to the facility. The ADON said Resident #1 told her she was going to get ice cream and appeared to be headed in the right direction. The ADON said the Assistant administrator was responsible for reporting incidents and that they agreed the incident was not reportable to HHSC since the resident signed herself out prior to leaving the facility and nothing happened. The ADON said residents are allowed to sign themselves out if they are deemed cognitive enough by the physician. The ADON said they did not report the incident to the police because Resident #1 only wanted ice cream and likes to play pranks and no harm was intended. The ADON said she did not consider Resident #1 as an elopement risk because she was alert and aware of what she was doing. The ADON said Resident #1 had a BIMS score of 11 on [DATE]. The ADON said following the incident staff were in-serviced on keeping personal items away from residents and Resident #1's family was notified. The ADON said Resident #1 had no additional incidents and that staff can lock their items in the lockers or medication room and store personal items out of reach for resident access. During an observation and interview on [DATE] at 9:45 a.m., Resident #1 said that the facility was treating her good and that they helped her when she needed it. Resident #1 said her family told her the facility was number one. Resident #1 said she enjoys being at this facility and only concern was that the ADON visited her yesterday and told her she was going to have to put her in the secure unit for her going down to talk to a resident in his room. Resident #1 then appeared agitated and said she did not want to be placed on the secure unit and begun ambulating independently in her room. Resident #1 continued to ambulate towards HHSC Investigator and appeared agitated. Resident #1 said she had no additional concerns and was apologetic for visit on her behalf. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on [DATE] at 9:53 a.m., LVN A said she had been employed at the facility since [DATE] and provides care for Resident #1. LVN A said she was not aware of any residents leaving the facility recently other than Resident #1 that happened over a month ago. LVN A said she was not sure what day Resident #1 stole her car but that she always stored her keys in her bag in the side pocket and that her bag was in the breakroom. LVN A said nursing staff was required to document any incidents/accidents and that she did not document due to her notifying the next up in the chain of command, the ADON, and since the resident was signed out when it happened. LVN A said Resident #1 took her keys out of her personal backpack stored in the staff breakroom and took her car without her permission sometime after lunch. LVN A said she saw Resident #1 with her keys and that she was a jokester and liked to play pranks and asked Resident #1 what she was doing with her keys and instructed her to put them back. LVN A said Resident #1 was always joking with everybody and didn't think twice about it and thought she was joking around. LVN A said she went down the hall and didn't see Resident #1 leave the facility when the ADON called her on the phone and asked where she was going and told her she was in the facility. LVN A said she parked where she could see her car and it clicked in her head that Resident #1 was not kidding so she told the ADON that it was Resident #1. After the incident, the ADON talked to Resident #1 and provided re-education that taking a staff's car was not acceptable and had an in-service about doing something different when storing our belongings out of residents reach. LVN A said she saw an aide pull up from her lunch break to help her get her car and the ADON got Resident #1 the ice cream she was wanting after she got her to pull over. LVN A said personal items are stored in the lockers with a lock or in the medication room and to not keep lanyards with keys in plain sight. LVN A said Resident #1 had no additional incidents, was doing good, and felt she was appropriately placed and did not need to be on the secure unit. LVN A said she has not noticed any personal items in plain sight from other staff and that her personal bag was located below the nurses station desk now because she just returned from hers son's award ceremony and did not have time to put it up, but that she normally locks it in the medication room. LVN A's backpack was located below nursing station desk. No keys were apparent in conspicuous view. Locks were placed on personal lockers and some lockers with employee names did not have a lock. LVN A said locks were available if needed but that she locks her items in the medication room. Breakroom had counter in locker area that was in conspicuous view from hallway and can be seen by residents in plain sight when door was open. During an interview on [DATE] at 10:06 a.m., CNA B said Resident #1 has not had any behavior of wanting to leave the facility and that no residents have left the facility unaware or eloped recently. CNA B said he was not here the day Resident #1 took staff keys. CNA B said he was aware of what happened with Resident #1. CNA B said following the incident, staff had an in-service over personal belongings to be stored in lockers with locks or in their personal cars. CNA B said he did not have a locker, but that locks were available if needed for lockers. CNA B said after the episode staff are taking more precautions on putting stuff up and there have been no similar incidents since then or Reisdnet #1 wanting to take a car and leave. CNA B said he felt like Resident #1 was appropriately placed and did not need to be on the secure unit. CNA B said Resident #1 leaves on Sunday for church and lets them know when her family arrives. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an phone interview on [DATE] at 10:51 a.m., the Ombudsman said she reported someone stealing a vehicle at this facility to HHSC and had concerns that the ADON said the resident signed herself out when it happened. The Ombudsman said she recieved three different stories on the incident and was aware that they store their purses at the nurses station in plain sight and within reach of residents. The Ombudsman said it was a concern that it was reported nobody saw her go to the breakroom or leave the facility. The Ombudsman said the facility never called to report the incident and received the information from out in the community and that that it happened two weeks ago and the DON and ADON said it happened months ago. The Ombudsman said she had concerns they did not report the incident even though they said she signed herself out because nobody asked her where she was going and it was unkown if she had a driver's license. The Ombudsman said she talked with the ADM, DON, and ADON about the concern on [DATE] over the phone. During a phone interview on [DATE] at 12:53 p.m., the Psychiatric Nurse Practioner said she was fairly new to Resident #1, but that she has seen her and was unaware of her leaving the facility or any elopement or attempted elopement events. The Psychiatric Nurse Practioner said she had no concerns with the care and services provided by the facility. During an interview on [DATE] at 12:58 p.m., the Assistant Administrator and ADON said residents are able to sign themselves out of the facility if they were alert and oriented. They said they were not sure when the incident happened with Resident #1, there was no grievance filed, and that it may not be an incident on the incident report since she was signed out of the facility. The ADON said an incident report was not completed because Resident #1 signed out and left the facility. The ADON said she talked with Resident #1 following the incident and reviewed unauthorized use of staff's car and that taking staff's keys was not appropriate and resident acknowledged and intervention appeared effective. The ADON said education was also provided to staff on storing personal items out of reach from residents locked in their lockers. The ADON said Resident #1's family was notified of what happened and that the doctor was not notified of the incident. The ADON said there was not anyone else notified of the incident aside from Resident #1's family. The ADON said if there was an incident, the nurse would be responsible for completing documentation and that it would be important for the doctor to be notified of an incident if a resident took a staff members car while signed out on pass if there was harm done or something had happened and that nothing bad happened to Resident #1. The Assistant Administrator said Resident #1 went in the breakroom and got the keys out of staff's backpack and the ADON was sitting in the parking lot and called the charge nurse to ask why she was leaving the building and the ADON intervened, the vehicle was pulled over, and the resident was taken to get the ice cream she was after. The ADON said Resident #1 was on psychiatric services after the incident and that it was unrelated to her taking LVN A's car. The ADON said she gave an in-service on personal items on [DATE] the same day the incident happened and that there have been no similar incidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:17 p.m., CNA C said she was employed at the facility for 7 to 8 years and felt residents were safe. CNA C said she was working the day Resident #1 left the facility in LVN A's car. CNA C said she was working down the hall and was informed by LVN A that Resident #1 took the keys to her car and left the facility. CNA C said Resident #1 did not tell her she was going to leave and was not sure if she told anyone she was going to leave. CNA C said Resident #1 has her days and that sometimes she is good and sometimes she is a firecracker and has agitatation. CNA C said when Resident #1 came back to the facility after taking LVN A's car she had no injuries. CNA C said residents are able to sign out on pass by themselves. CNA C said after the incident they had an in-service on personal items to be locked up or stored in the breakroom where residents cannot get to it. CNA C said she had no concerns with staff continuing to store personal items in plain sight of residents and that there were no similar incidents that occurred. During an phone interview on [DATE] at 2:00 p.m., the Attending Physicain said for most residents we have secure units and some are bed bound with a handful of patients at the facility for rehab or no other housing that have driven their own cars wthin the last 6 months. The Attending Physician said he was not notified of Resident #1 stealing a nurse's car and leaving the facility and that the resident was cognitive enough to sign herself out of the facility and felt it was more of a moral issue for a MD to possibly be aware of but not a necessity. The Attending Physician said he would probably not wish to be notified of the incident with Resident #1 taking a staff's car and that it may be more of an administrative issue with her stealing. Review of in-service, dated [DATE], revealed training was provided to nursing staff on personal item storage. Review of incident reports between February 2024 through [DATE] revealed no related incidents for Resident #1's behavior of stealing a nurse's car. Review of facility policy, titled Wandering and Elopements, revised [DATE], revealed the following: Policy Statement The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Policy Interpretation and Implementation . 2. If an employee observes a resident leaving the premises, he/she should . c. Instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident is attempting to leave or has left the premises . 4. When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall . e. Complete and file an incident report; and f. Document relevant information in the resident's medical record . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy, titled Guidelines for Notifying Physicians of Clinical Problems, revised [DATE], revealed the following: Overview These guidelines are intended to help ensure that .2) all significant changes in resident/patient status are assessed and documented in the medical record . Non-Immediate Notification Situations . 2. The following signs: In general: Any substantial change in physical condition or functional status that is causing no more than minimal distress. For example, moderate behavioral disturbances that is only partially responsive to nonpharmacological interventions .