STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675812	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whispering Pines Nursing and Rehab	910 S Beech St Winnsboro, TX 75494

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** 30527 Based on interview and record review, the facility failed to notify the resident's representative immediately when there was an accident or significant change in the resident's physical, mental, or psychosocial status that is, a deterioration of health, mental, or psychosocial status in either life-threatening conditions or clinical complications for 2 of 9 residents (Resident #9 and Resident #39) reviewed for notification of changes. The facility failed to notify Resident #9's representative when Resident #9 sustained a fall on 02/18/2024. The facility failed to notify Resident #39's representative when Resident #39 sustained a fall on 03/31/2024. This failure placed residents' at risk of not having their representative being aware of any changes in their conditions and could result in delay in treatment and decline in residents' health and well-being. Findings included: 1. Record review of a face sheet dated 05/07/2024 indicated, Resident #9 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included unspecified dementia with other behavioral disturbance (a condition in which a person loses the ability to think, remember, learn and make decisions and solve problems), weakness, vitamin D deficiency, major depressive disorder (mental disorder with persistent sadness and a lack of interest or pleasure in previously enjoyable activities), urinary tract infection, acute respiratory disease (occurs when your lungs cannot release enough oxygen into your blood), hypertension (high blood pressure). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #9 was understood and was able to understand others. The MDS assessment indicated Resident #9 had a BIMS score of 04, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #9 required maximal assistance for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. Record review of the care plan with a target date of 07/31/2024 indicated, Resident #9 required staff assistance with ADL's. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #9's progress note dated 02/18/2024 at 05:15 PM and signed by RN B indicated Resident #9 had an unwitnessed fall and noted a scratched eyebrow and applied hydrocolloid dressing and neurological checks started . Neurological checks was completed for 72 hours. The Skin Assessment was completed. The progress note did not indicate Resident #9's family member had been notified of the fall or new areas of injuries. Record review of a face sheet dated 05/08/2024 indicated, Resident #39 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included unspecified dementia with other behavioral disturbance (a condition in which a person loses the ability to think, remember, learn and make decisions and solve problems), hypertension (high blood pressure), major depressive disorder (mental disorder with persistent sadness and a lack of interest or pleasure in previously enjoyable activities), insomnia (a sleep disorder), cognitive communication deficit (difficulty with thinking and how someone uses language), Alzheimer's disease (a progress disease that destroys memory and other important mental function) with late onset. Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #39 was understood and was able to understand others. The MDS assessment indicated Resident #39 had a BIMS score of 05, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #39 required supervision or touching assistance for bed mobility, transfers, dressing, toilet use, personal hygiene, and maximal assistance for bathing. Record review of the care plan with a target date of 07/31/2024 indicated, Resident #39 had an actual fall had potential for injury related to falls with interventions for physical therapy, occupational therapy, encourage exercise, well-fitting shoes and placing call light in reach. Record review of Resident #39's progress note dated 03/31/2024 at 6:30 AM and signed by RN B indicated Resident #39 had an unwitnessed fall and noted a small bump to left forehead and bruising under eyes with neurological checks started. The Skin Assessment was completed. Neurological checks was completed for 72 hours. The progress note did not indicate Resident #39's family member had been notified of the fall or new areas of injuries. During an interview on 05/06/2024 at 03:43 PM, Resident #9's family member said they were not notified by the facility regarding the unwitnessed fall on 02/18/2024. During an interview on 05/07/2024 at 01:10 PM, Resident #39's family member said they were not notified by the facility regarding the unwitnessed fall on 03/31/2024. During an interview on 05/07/2024 at 3:05 PM, RN B said she failed to notify the family members of Resident #9 and Resident #39 because there was so much to be done with all the paperwork and she forgot. RN B said family should be notified to prevent any issues, delays in treatments and serve as coordination of care. (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 05/08/2024 at 04:00 PM, the DON said Resident #9 and Resident #39's family should have been notified regarding the falls at the time of the occurrence. The DON said the progress note did not indicate Resident #9's family was notified of the fall on 2/18/2024. The DON said the progress note did not indicate Resident #39's family was notified of the fall on 3/31/2024. The DON said the family members of both Residents #9 and #39 should have been notified of the falls because it was a change in condition, and they should have been made aware of new areas of concerns, orders, etc. The DON said it was the responsibility of the charge nurse to notify the family of any changes of condition of the residents. The DON said she gave an inservice regarding notifications to physicians and families when there has been an accident/change in condition. During an interview on 05/09/2024 at 04:22 PM, the Regional Director said he expected the resident's representatives to be notified of any changes in the resident's care. The Regional Director said he expected the staff to document the notification of the family. The Regional Director said Resident #9 and Resident #39's family should have been notified of the fall and orders because the residents' family could come in, see, and suspect the residents were being abused. The Regional Director said the charge nurse was responsible for notifying the resident's representative. The Regional Director said he was unsure if there was a system in place to monitor if resident's representatives where being notified of any changes in condition or new orders. Record review of the facility's policy Change of Condition - Observing, Reporting and Recording effective December 2018 indicated . 5. Notify resident's responsible party . 3. Document in the clinical software who was notified and when.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on observation, interview, and record review, the facility failed to provide a safe, clean, and comfortable environment for 1 of 9 residents (Resident #9's) and 1 of 1 dining rooms reviewed for a homelike environment. The facility failed to ensure Resident #9's bathroom was free of offensive odors and unbroken and misshaped tiles around the base of the toilet. The facility failed to ensure the dining room did not have plastic, folding tables used as dining tables. This failure could place residents at risk for an uncomfortable, unhomelike environment, and a diminished quality of life. Findings included: 1. Record review of a face sheet dated 05/07/2024 indicated, Resident #9 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included unspecified dementia with other behavioral disturbance (a condition in which a person loses the ability to think, remember, learn and make decisions and solve problems), weakness, vitamin D deficiency, major depressive disorder (mental disorder with persistent sadness and a lack of interest or pleasure in previously enjoyable activities), urinary tract infection, acute respiratory disease , hypertension (high blood pressure). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #9 was understood and was able to understand others. The MDS assessment indicated Resident #9 had a BIMS score of 04, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #9 required maximal assistance for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. Record review of the care plan with a target date of 07/31/2024 indicated, Resident #9 required staff assistance with ADL's. During an observation on 05/06/2024 at 09:20 AM, upon entrance of Resident #9's room a strong odor of urine was detected in the bathroom area. The floor tiles around the base of the toilet were broken and misshaped and exposed large areas of grout. During an observation on 05/06/2024 at 11:30 AM, there was a strong odor of urine in Resident # 9's bathroom. During an observation on 05/06/2024 at 2:35 PM, there was a strong odor of urine in Resident # 9's bathroom . Resident #9 was in the room asleep at this time. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/07/2024 at 1:32 PM., RN G said on occasion he had noticed the urine odor in Resident #9's bathroom. RN G said there had been water leaks around the toilets in a couple of the rooms recently and he had noticed the tile had peeled up and was exposing areas of grout. In Resident #9's bathroom, RN G said the maintenance supervisor was aware of broken and peeled up tiles because they had discussed this on different occasions over the last month or so when there was some plumbing issues in the unit. RN G said he was not aware of the status of repairs. RN G said the urine odor could be absorbed in the exposed grout. RN G said the smell of urine and the broken tiles was not a welcoming environment for the resident's family. During an interview on 05/08/24 at 9:23 AM., Housekeeping Aide O said she smelled urine odor in Resident #9's room. Housekeeping Aide O said she usually cleans the rooms once daily for a deep clean then does a walk through in the evenings. She said she used the chemicals she was able to use when cleaning Resident #9's bathroom. She said she saw the bathroom floor tiles peeling from around the toilet in Resident #9's bathroom. She said she had not placed a work order for maintenance but said she thought the maintenance supervisor was aware . She said she would clean Resident #9's room next. Housekeeping Aide O said she told the Maintenance Supervisor in person at some point weeks ago but she could also put the needed repair in the maintenance work order book. During an interview on 05/08/2024 at 2:24 PM., the Maintenance Supervisor said he was aware of the tiles in Resident #9's bathroom that were broken, misshaped and revealed areas of grout. The Maintenance Supervisor said the facility had experienced some plumbing issues that had been caused by wipes and briefs being flushed and had clogged in the system. The Maintenance Supervisor said all the plumbing repairs had been completed and he did not feel like there was any type of leakage currently that had caused the strong urine odor in Resident #9's bathroom unless it had absorbed in the grout during the recent plumbing issues. The Maintenance Supervisor said there is a written plan to complete the renovation for the peeled-up tiles in the bathroom, but he was awaiting the approval to proceed. The Maintenance Supervisor said it was his responsibility to ensure the facility created a home like environment for the residents. During an interview on 05/08/2024 at 04:00 PM, the DON said she had not noticed the offensive odors or the broken/peeled-up tiles in Resident #9's bathroom and she did not recall being in Resident #9's room lately. The DON said she expected the housekeeping staff to fully clean all resident's bathrooms daily to alleviate odors. The DON said all the staff should be making sure the facility did not have offensive odors. The DON said she expected the Maintenance Supervisor to maintain the facility to create a home-like environment. The DON said she felt like there was a plan of renovation for the flooring repairs, but she would need to verify that with the Maintenance Supervisor and Administrator. The DON said it was important to keep the facility free of offensive odors and it was important to provide the residents with a clean and safe environment. During an interview on 05/09/2024 at 04:22 PM, the Regional Director said all the staff were responsible for making sure there were no offensive odors in the facility. The Regional Director said he expected for the staff to provide a homelike environment for the residents. 2. During an observation on 05/06/2024 at 12:15 PM, approximately 17 residents were seated at the plastic, folding tables in the dining room. The arms of the wheelchair were unable to fit appropriately under the table to allow proper positioning for eating comfortably. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 05/07/2024 at 12:15 PM, approximately 17 residents were seated at plastic, folding tables in the dining room. The arms of the wheelchair were unable to fit appropriately under the table to allow the resident proper positioning for eating comfortably. During an observation on 05/08/2024 at 12:15 PM, approximately 17 residents were seated at plastic, folding tables in the dining room. The arms of the wheelchair were unable to fit appropriately under the table to allow the resident proper positioning for eating comfortably. During an observation on 05/09/2024 at 12:15 PM, approximately 17 residents were seated at plastic, folding tables in the dining room. The arms of the wheelchair were unable to fit appropriately under the table to allow the residents proper positioning for eating comfortably. During an interview on 05/09/2024 at 1:30 PM, LVN A said it had been several months that the dining room was provided with the plastic, folding tables and the other wooden tables had been removed. LVN A said the plastic, folding tables were institutional like and did not enhance the dining experience for the residents due to the cumbersome fit of the wheelchairs at the tables. During an interview on 05/09/2024 at 04:30 PM, the Regional Director said the plastic, folding tables were not homelike. The Regional Director said he had intentions of purchasing better tables for the dining area and the more homelike tables were in his basket of things to do. During an interview on 05/09/2024 at 09:24 AM, the DON said the facility does not have a policy regarding homelike environment. 45810