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	05/01/2023

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31675 Based on interview and record review, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment were reported to the State Survey Agency immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury for 1 of 6 (Resident #1) residents reviewed for abuse and neglect. On 04/28/23 at 6:30 p.m., Resident #1 sustained redness and blistering to his face when RN A lit a cigarette while Resident #1 was using Oxygen. The incident was not reported until 04/29/23 at 11:17 a.m. This failure could place residents at risk of emotional, physical, and mental abuse. Findings included: During an observation and interview on 04/29/23 at 10:25 a.m. Resident #1 had a large fluid fill blister, white in color, on his right cheek that extended to the top of his upper lip. There was another fluid filled blister on the right side of his nose that extended to the tip of his nose. Facial hair on his right upper lip appeared to be shorter than the left side of his lip. Resident #1 said he was not in pain. He said he was smoking the night before (04/28/23) and did not realize that Oxygen was flammable. He said he was wearing his Oxygen while smoking. He said he normally does not have his Oxygen on while smoking and does not use Oxygen all the time. He said while smoking the Oxygen caught fire. He said it was storming and he thought at first it was a lightning flash. He said RN A was there and quickly put out the flame. (Within a few seconds) He said he went to the doctor the next day. (04/29/23). He said he did not feel he was abused or neglected. Record review of face sheet dated 04/30/23, indicated Resident #1 was a [AGE] year-old male, last admitted on [DATE] and his diagnoses included Transient cerebral ischemic attack, (a stroke that lasts only a few minutes), hypertension, Dyspnea (Shortness of Breath), dementia, cognitive communication deficit, muscle weakness, Bipolar disorder, Chronic obstructive pulmonary disease (COPD), schizoaffective disorder (a mental health problem where you experience psychosis as well as mood symptoms), and Pulmonary hypertension (A type of high blood pressure that affects the arteries in the lungs and the right side of the heart? (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
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Whispering Pines Nursing and Rehab	910 S Beech St Winnsboro, TX 75494

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of MDS dated [DATE] indicated Resident #1 was able to express ideas and wants, alert to person, place, and time, was able to understand others, and was cognitively intact. Resident #1 required supervision and set-up assistance of 1 person for all ADLs other than hygiene where he required assistance of 2 persons. He was able to transfer independently and used a wheelchair. Record review of Resident #1's care plan initiated 12/19/22 and revised on 04/30/23 indicated he was a smoker and at risk of injury. He was to wear a smoking apron during smoke breaks. Staff were to supervise during smoking. Care plan was updated on 04/29/23 to show staff are to ensure that resident is not in the smoking area with Oxygen tank or tubing/nasal canula. Record review of consolidated physician orders dated 02/26/23, Resident #1 may have Oxygen (O2) 2L/min via Nasal Canula (NC) as needed (PRN) for oxygen sat below 92%. Every shift Days 6:00 AM - 2:00 PM, Evenings 2:00 PM - 10:00 PM, and Nights 10:00 PM - 6:00 AM. Record review of an incident report dated 04/29/23, completed by administrator indicated on 04/28/23 at 6:30 p.m., Resident #1 was smoking in the designated smoke area when RN A lit his cigarette while he was wearing oxygen. The Oxygen flashed causing his beard to singe. The next morning at 10:00 a.m. redness and blistering was discovered to Resident #1 face. Doctor notified and new orders for Silvadene (silver sulfadiazine) cream 1% was to be applied to the affected area once a day. Resident #1 was sent to the hospital on 04/30/23 for evaluation and returned the same day with no new orders. Record review of progress note dated 04/28/23 at 06:40 p.m., RN A recorded he went to the smoking area to observe resident smoke break. Resident #1 was already outside with his smoking apron on. Cigarettes were handed out and lit. RN A did not recognize Resident #1 had Oxygen on. A small flame extinguished, and Oxygen turned off. Resident #1 was assessed for injuries with left cheek and nose light pink with no open areas or blisters noted. Resident #1 denied pain. Resident sitting up at nurse's station with no signs of distress. Responsible party and physician was notified. No new orders from physician. During an interview on 04/30/23 at 9:45 a.m., the Administrator said on 04/29/23 at 6:30 p.m., RN A was taking residents out for a smoke break. Resident #1 was already in the smoking area with his apron on when RN A arrived with 2 other residents. The Administrator said RN A lit Resident #1's cigarette without noticing he had his Oxygen on. The Administrator said RN A was assisting the two other residents when Resident #1's Oxygen ignited and singed Resident #1's facial hair. The Administrator said RN A immediately responded and assessed Resident #1 for injury. The Administrator said there was some redness to Resident #1's cheek and nose. There were no other injuries found at that time. The Administrator said he asked questions about the incident, and it was determined that the incident was not a reportable incident at the time, because there was no major injury to Resident #1. The Administrator said the next morning (04/30/23) around 10:00 a.m. during an assessment LVN A, found blisters to Resident #1's face. The Administrator said he did not report the incident until 04/30/23 at 11:17 a.m. after the blistering was discovered. Record review of progress note dated 04/29/23 at 11:30 a.m. LVN A recorded she contacted with physician to report need for wound care orders to Resident #1's face after smoking incident last evening. Nurse reported areas of burns and appearance of areas of concern. New orders received of Silvadene (silver sulfadiazine) cream 1% once a day. Resident reports no pain/discomfort in area currently. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of progress note dated 04/29/23 at 3:16 p.m. DON recorded she noticed Resident #1 to have newly onset and slight difficulty breathing. Upon further assessment, swelling noted to Resident #1's right inner nare. (Opening of the nose). Physician contacted with orders to send to hospital for evaluation. Record review of hospital records dated 04/2923 indicated Resident #1 was seen at the hospital for facial burn. Diagnosis Facial burn, second degree. (Involves the top two layers of the skin, might have blisters over the burn area. The burn may leave a scar). New orders gently clean with soap and water and apply bacitracin (topical antibiotic ointment). Follow-up to be scheduled by facility staff. Review of progress note dated 04/29/23 at 4:58 p.m. Resident #1 returned from the emergency room with new orders for bacitracin ointment, apply BID. (Twice daily) Physician was contacted and ordered to discontinue bacitracin and continue with Silvadene as previously ordered. Resident continues to have difficulty breathing through nose. No distress noted. Resident at nurses' station currently. Resident #1 states he can breathe though his nose and that is does not hurt to breath. During an observation and interview on 04/29/23 at 10:45 a.m. six residents was observed in the smoking area including Resident #1. Three of the residents were wearing smoking aprons including Resident #1. There were no Oxygen tanks in the smoking area. The fire extinguisher was available and last serviced April 2023. Ash trays were appropriate for safety. Residents were being supervised by a nurse. Resident #2 said she was present when Resident #1's Oxygen ignited on 04/28/23 around 6:30 p.m. She said RN A was helping her to her table and Resident #1 was already in the smoking area with his safety apron on when she arrived. She said after RN A assisted her to her normal table and Resident #1 was sitting behind her. She said it was storming and darker than usual. Resident #1 asked RN A to light his cigarette. She said RN A turned around, lit Resident #1's cigarette and turned and lit hers. She said the next thing she knew, there was a flash. She said she thought it was a lighting flash, but she saw there was a flame at Resident #1's face. She said RN A quickly turned and extinguished the flame. She said they all went back inside the building and RN A took Resident #1 to his room. During an interview on 05/01/23 at 4:10 p.m., RN A he was working as a charge nurse on 04/28/23 2:00 PM to 10:00 PM shift. RN said at 6:30 PM, he took residents out for a smoke break. He said when he arrived at the smoking area, Resident #1 was already outside in the smoking area with his safety apron on. He said Resident #1 asked him to light his cigarette. He said he turned around and lit the cigarette for Resident #1. RN A said he did not notice the Resident #1 had his nasal canula under his nose and did not know his Oxygen was on. RN A said he should have checked before lighting the cigarette, but he did not. He said it was only a few seconds when he saw a flame and turned around and put out the fire. RN A said she assessed resident [NAME] #1 and Resident #1 said he was not in pain. RN A said he immediately ended the smoke break. RN A said he took Resident #1 to his room so he would assess him better in the light. RN A said he observed some pink areas to Resident #1's nose and cheek, but there was no blistering. RN A said he notified the Assistant Director of Nursing (ADON) April, who said she would notify the Administrator and DON. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/30/23 at 9:45 a.m., the Administrator said on 04/29/23 at 6:30 p.m., RN A was taking residents out for a smoke break. Resident #1 was already in the smoking area with his apron on when RN A arrived with 2 other residents. The Administrator said RN A lit Resident #1's cigarette without noticing he had his Oxygen on. The Administrator said RN A was assisting the two other residents when Resident #1's Oxygen ignited and singed Resident #1's facial hair. The Administrator said RN A immediately responded and assessed Resident #1 for injury. The Administrator said there was some redness to Resident #1's cheek and nose. There were no other injuries found at that time. Physician, family, and Administrator was notified of the incident. The Administrator said he asked questions about the incident, and it was determined that the incident was not a reportable incident at the time, because there was no major injury to Resident #1. The Administrator said the next morning (04/30/23) around 10:00 a.m. during an assessment LVN A, found blisters to Resident #1's face. Administrator said all residents were re-assessed for Smoking Safety and RN A was suspended pending investigation. Administrator said RN A should have monitored to ensure there was no Oxygen in the area prior to lighting a cigarette. Administrator said it is the policy of the facility that Oxygen should not be within 50 feet of the smoking area. The Administrator said he did not report the incident until 04/30/23 at 11:17 a.m. after the blistering was discovered. During an interview on 04/30/23 at 9:45 a.m. the DON said RN-A should have noticed that Resident #1 was using Oxygen and should have not lit any cigarettes before making sure there was no Oxygen in or near the area. The DON said it is the facility policy that Oxygen should not be within 50 feet of the smoking area. The DON said Residents are not allowed to have Oxygen in the smoking area whether it is on or off. The DON said all Oxygen should be left inside the building or in the resident's rooms. DON said there are ten residents who smoke and out of those ten residents, six use Oxygen. Review of an undated facility policy provided by Administrator on 04/30/23 showed: Reporting: Facility employees [NAME] must report all allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report the allegation to HHSC. * If the allegation involves abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation. * If the allegation does not involve abuse or serious bodily injury, the report must be made with 24 hours of the allegation .

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(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 - Immediate jeopardy to resident health or safety 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** 31675 Based on observation, interview, and record review the facility failed to ensure residents received adequate supervision and assistance to prevent accidents for 1 of 6 residents (Resident #1) reviewed for smoking safety. RN A did not ensure Resident #1 was not using Oxygen while smoking. RN A lit a cigarette for Resident #1 while Oxygen was on and being delivered thought a nasal cannula causing second degree burns to Resident #1's face. An Immediate Jeopardy (IJ) situation was identified on 04/30/23 at 2:15 p.m. While the IJ was removed on 05/01/23, the facility remained out of compliance at actual harm with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of physical harm, mental anguish, emotional distress, or death. Findings included: During an observation and interview on 04/29/23 at 10:25 a.m. Resident #1 had a large fluid fill blister, white in color, on his right cheek that extended to the top of his upper lip. There was another fluid filled blister on the right side of his nose that extended to the tip of his nose. Facial hair on his right upper lip appeared to be shorter than the left side of his lip. Resident #1 said he was not in pain. He said he was smoking the night before (04/28/23) and did not realize that Oxygen was flammable. He said he was wearing his Oxygen while smoking. He said he normally does not have his Oxygen on while smoking and does not use Oxygen all the time. He said while smoking the Oxygen caught fire. He said it was storming and he thought at first it was a lightning flash. He said RN A was there and quickly put out the flame. (Within a few seconds) He said he went to the doctor the next day. (04/29/23). He said he did not feel he was abused or neglected. Record review of face sheet dated 04/30/23, indicated Resident #1 was a [AGE] year-old male, last admitted on [DATE] and his diagnoses included Transient cerebral ischemic attack, (a stroke that lasts only a few minutes), hypertension, Dyspnea (Shortness of Breath), dementia, cognitive communication deficit, muscle weakness, Bipolar disorder, Chronic obstructive pulmonary disease (COPD), schizoaffective disorder (a mental health problem where you experience psychosis as well as mood symptoms), and Pulmonary hypertension (A type of high blood pressure that affects the arteries in the lungs and the right side of the heart). Record review of consolidated physician orders dated 02/26/23, reflected Resident #1 may have O2 2L/min via NC PRN for oxygen sat below 92%. Every shift Days 6:00 AM - 2:00 PM, Evenings 2:00 PM - 10:00 PM, and Nights 10:00 PM - 6:00 AM. (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of MDS dated [DATE] indicated Resident #1 was able to express ideas and wants, was alert to person, place, and time, was able to understand others, and was cognitively intact. Resident #1 required supervision and set-up assistance of 1 person for all ADLs other than hygiene where he required assistance of 2 persons. He was able to transfer independently and used a wheelchair. Record review of Resident #1's care plan initiated 12/19/22 and revised on 04/30/23 indicated he was a smoker and at risk of injury. He was to wear a smoking apron during smoke breaks. Staff were to supervise him during smoking. The care plan was updated on 04/29/23 to show staff are to ensure that resident is not in the smoking area with Oxygen tank or tubing/nasal canula. Record review of progress note dated 04/28/23 at 06:40 p.m., RN A recorded he went to the smoking area to observe resident smoke break. Resident #1 was already outside with his smoking apron on. Cigarettes were handed out and lit. RN A did not recognize Resident #1 had Oxygen on. A small flame was extinguished, and Oxygen was turned off. Resident #1 was assessed for injuries with left cheek and nose light pink with no open areas or blisters noted. Resident #1 denied pain. Resident sitting up at nurse's station with no signs of distress. The Responsible party and physician were notified. There were no new orders from the physician. Record review of an incident report dated 04/29/23, completed by the administrator indicated on 04/28/23 at 6:30 p.m., Resident #1 was smoking in the designated smoke area when RN A lit his cigarette while he was wearing oxygen. The Oxygen flashed causing his beard to singe. The next morning at 10:00 a.m. redness and blistering was discovered to Resident #1's face. The Doctor was notified and new orders for Silvadene (silver sulfadiazine) cream 1% to be applied to the affected area once a day were received. Resident #1 was sent to the hospital on 04/30/23 for evaluation and returned the same day with no new orders. Record review of progress note dated 04/29/23 at 11:30 a.m. reflected LVN A recorded she contacted the physician to report a need for wound care orders to Resident #1's face after a smoking incident last evening. The Nurse reported areas of burns and appearance of areas of concern. New orders were received of Silvadene (silver sulfadiazine) cream 1% once a day. The Resident reports no pain/discomfort in area currently. Record review of progress note dated 04/29/23 at 3:16 p.m. reflected the DON recorded she noticed Resident #1 to have newly onset and slight difficulty breathing. Upon further assessment, swelling was noted to Resident #1's right inner nare (Opening of the nose). The Physician was contacted with orders to send to hospital for evaluation. Record review of hospital records dated 04/29/23 indicated Resident #1 was seen at the hospital for facial burn. Diagnosis was Facial burn, second degree (Involves the top two layers of the skin, might have blisters over the burn area. The burn may leave a scar). New orders to gently clean with soap and water and apply bacitracin (topical antibiotic ointment) were received. Follow-up was to be scheduled by facility staff. (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of progress note dated 04/29/23 at 4:58 p.m. Resident #1 returned from the emergency room with new orders for bacitracin ointment, apply BID. The Physician was contacted and ordered to discontinue bacitracin and continue with Silvadene as previously ordered. The Resident continues to have difficulty breathing through nose. No distress was noted. (After return from hospital) The Resident is at nurses' station currently. Resident #1 states He can breathe though his nose and that is does not hurt to breathe. During an observation and interview on 04/29/23 at 10:45 a.m. six residents was observed in the smoking area including Resident #1. Three of the residents were wearing smoking aprons including Resident #1. There were no Oxygen tanks in the smoking area. The fire extinguisher was available and last serviced April 2023. Ash trays were appropriate for safety. Residents were being supervised by a nurse. Resident #2 said she was present when Resident #1's Oxygen ignited on 04/28/23 around 6:30 p.m. She said RN A was helping her to her table and Resident #1 was already in the smoking area with his safety apron on when she arrived. She said after RN A assisted her to her normal table and Resident #1 was sitting behind her. She said it was storming and darker than usual. Resident #1 asked RN A to light his cigarette. She said RN A turned around, lit Resident #1's cigarette and turned and lit hers. She said the next thing she knew, there was a flash. She said she thought it was a lighting flash, but she saw there was a flame at Resident #1's face. She said RN A quickly turned and extinguished the flame. She said they all went back inside the building and RN A took Resident #1 to his room. During an interview on 04/30/23 at 9:45 a.m., the Administrator said on 04/28/23 at 6:30 p.m., RN A was taking residents out for a smoke break. Resident #1 was already in the smoking area with his apron on when RN A arrived with 2 other residents. The Administrator said RN A lit Resident #1's cigarette without noticing he had his Oxygen on. The Administrator said RN A was assisting the two other residents when Resident #1's Oxygen ignited and singed Resident #1's facial hair. The Administrator said RN A immediately responded and assessed Resident #1 for injury. The Administrator said there was some redness to Resident #1's cheek and nose. There were no other injuries found at that time. The Physician, family, and Administrator were notified of the incident. The Administrator said he asked questions about the incident, and it was determined that the incident was not a reportable incident at the time, because there was no major injury to Resident #1. The Administrator said the next morning (04/29/23) around 10:00 a.m. during an assessment LVN A, found blisters to Resident #1's face. The Administrator said all residents were re-assessed for Smoking Safety and RN A was suspended pending investigation. The Administrator said RN A should have monitored to ensure there was no Oxygen in the area prior to lighting a cigarette. The Administrator said it is the policy of the facility that Oxygen should not be within 50 feet of the smoking area. During an interview on 04/30/23 at 9:45 a.m. the DON said RN-A should have noticed that Resident #1 was using Oxygen and should have not lit any cigarettes before making sure there was no Oxygen in or near the area. The DON said it is the facility policy that Oxygen should not be within 50 feet of the smoking area. The DON said Residents are not allowed to have Oxygen in the smoking area whether it is on or off. The DON said all Oxygen should be left inside the building or in the resident's rooms. DON said there are ten residents who smoke and out of those ten residents, six use Oxygen. (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 05/01/23 at 4:10 p.m., RN A stated he was working as a charge nurse on 04/28/23 on the 2:00 PM to 10:00 PM shift. RN A said at 6:30 PM, he took three residents out for a smoke break. He said when he arrived at the smoking area, Resident #1 was already outside in the smoking area with his safety apron on. He said he assisted the other two residents outside. RN A said he was standing at the table and Resident #1 was behind him. He said Resident #1 asked him to light his cigarette. He said he turned around and lit the cigarette for Resident #1. RN A said he did not notice Resident #1 had his nasal canula under his nose and did not know his Oxygen was on. RN A said he should have checked before lighting the cigarette, but he did not. He said it was only a few seconds when he saw a flame and turned around and put out the fire. RN A said he assessed Resident #1 and Resident #1 said he was not in pain. RN A said he immediately ended the smoke break, and all three residents went back inside. RN A said he took Resident #1 to his room so he would assess him better in the light. RN A said he observed some pink areas to Resident #1's nose and cheek, but there was no blistering. RN A said he asked Resident #1 to stay at the nurse's station so he could keep an eye on him. RN A said he notified the ADON, who said she would notify the Administrator and DON. RN A said he called the doctor and reported the incident with no new orders. RN A said he got off at 10:00 PM and there were no blisters when he ended his shift, and the area was a light pink. RN A said he was notified by the ADON the next morning that blisters had formed on Resident #1's nose and cheek. RN A said this was the first time he knew about the blistering. RN A said he was suspended at the time and was informed today (05/01/23) at 1:40 p.m., that he was being terminated. RN A said he felt bad about what happened, and he should have seen Resident #1 had his Oxygen on in the smoking area. RN A said he had been a nurse for [AGE] years and had never hurt a resident and he felt horrible. RN A said it was his fault. During an interview on 04/30/23 at 10:45 a.m., Resident #2 said she was in the smoking area on 04/28/23 at 6:30. She said there were three residents in the smoking area at the time. Resident #2 said RN A had taken them out for the break. Resident #2 said Resident #1 was already in the smoking area with his apron on when they arrived. Resident #2 said RN A assisted her to the table, turned and lit Resident #1's cigarette. Resident #2 said she saw a flash and thought it was a lighting flash because it was storming at the time, until RN A turned around and put out the flames on Resident #1's face. Resident #2 said RN A took all three residents including Resident #1 into the building. Resident #2 said she had never seen other residents using oxygen in the smoking area. Review of the facility's smoking policy dated 01-2023 showed . It is the policy of this home that: * All residents who smoke will be supervised. * Smoking will be permitted in designated safe area(s) only. * Oxygen equipment is not permitted in the smoking area(s). The minimum safe distance for Oxygen equipment from the smoking area is 50 feet . The facility was notified of the Immediate Jeopardy on 04/30/23 at 2:15 p.m. and the Administrator was provided the Immediate Jeopardy template. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. The Facility's Plan of Removal for Immediate Jeopardy was accepted on 05/01/23 at 1:44 p.m. and reflected the following: Plan of Removal - F 689 Accidents & Supervision Immediate Action Taken - Resident Specific (continued on next page)

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	05/01/2023

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.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Small flame extinguished, and oxygen immediately removed. o Resident #1 was assessed for injury on 4/28/2023 at 6:40 p.m. by RN with no open areas or blisters noted. o MD notified of the incident on 4/28/2023 at 6:40 p.m. by RN, no new orders received. o Resident #1 noted to have open areas to face on 4/29/2023 10:00 a.m., MD notified and new orders for wound care received and implemented. o Resident #1 sent to ER for evaluation on 4/29/2023 at 3:16 p.m. and returned on 4/29/2023 at 4:58 p.m. with no new orders received. System Changes o Safety checklist implemented to be filled out with each smoke break. Staff member responsible for supervising the smoke break will complete this checklist once all residents are outside, prior to lighting any cigarettes. - completed 4/29/2023 o Updated smoking safety assessments performed by DON and Social Worker, done for all residents that smoke - completed 4/29/2023 o Updated BIMS assessments done on all residents that smoke, to assess cognitive function - completed 4/29/2023 o All care plans of residents that smoke reviewed and updated as needed to reflect current smoking needs, safety needs, and oxygen use - completed 4/29/2023 o Smoking Areas inspected, by administrator to verified that all smoking safety equipment in place and properly functioning - completed 4/29/2023 o Any oxygen tanks/tubing that are removed prior to entering the smoke area, will be stored inside the building, in an oxygen tank holder and/or in the resident's room. o Once all residents are outside and ready for smoke break, safety checklist will be completed. Then staff will safely light each individual's cigarette and remain outside during the entire duration of the smoke break. Education o Director of Nursing providing education to all staff regarding smoking safety and oxygen use, as well as abuse/neglect. Any staff member not present on 4/30/2023, will receive the education prior to working their next shift. o Director of Nursing providing education to all staff regarding Smoking Safety Checklist, including when it is to be completed (prior to any cigarettes being lit.) Any staff not present on 4/30/2023, will receive the education prior to working their next shift. (continued on next page)

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	675812	A. Building B. Wing	05/01/2023

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Social Services Director providing education to all smokers with the ability to understand, regarding smoking safety and oxygen use. Any resident that smokes that is not in the facility on 4/30/2023 will receive the education upon their return, prior to the next smoke break. Monitoring o Administrator/designee to review Smoking Safety Checklist 5 times per week for a minimum of 4 weeks to ensure any necessary interventions occurred. QAPI team to review monthly and make changes as needed. o Administrator/designee to randomly supervise 1 -2 smoke breaks a day, 5 times a week, for a minimum of 4 weeks to ensure that required safety interventions are in place, and initial Smoking Safety Checklist. QAPI team to review monthly and changes as needed. On 05/01/23, the surveyors confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: Observations, interviews, and record reviews were conducted on 05/01/23 from 2:30 p.m. through 4:20 p.m. and included 4 other alert residents,(Not including Resident #1) nurses including 3 RN, 3 LVNs, Social Worker, ADON, Housekeeping Supervisor, and DON. Staff were able to identify residents requiring supervision while smoking and the need for aprons and protective equipment. Staff were able to confirm that only licensed nurses can supervise residents during smoking breaks and Nurses had been trained on completing the smoking check list prior to starting smoke breaks. Nursing Staff provided appropriate resident supervision during smoke breaks. There were no observed concerns. Staff were able to discuss the required level of staff assistance for residents in the smoking area and the requirement for Oxygen not being allowed in the smoking areas. Show knowledge of only licensed nurses are allowed to supervise Residents during smoke breaks. All residents who smoke were assessed for safety needs including BIMS and smoking safety assessments were completed by Social Worker and DON. Staff were using the Smoking check list prior to starting smoking break. Staff were able to identify the Abuse Coordinator, indicated reporting was immediate to the charge nurse or administrator and were able to give example of physical, verbal, sexual abuse and immediate intervention procedures. Nursing staff were in-serviced on monitoring residents during smoking breaks, completing smoking safety check, Storing Oxygen, and Abuse/Neglect. The training was completed on 04/29/23 and is ongoing. Staff who were unavailable and not in-serviced were on a list to receive training prior to their next scheduled shift. Staff were in-service on abuse and neglect. The training was completed on 04/29/23. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff who were unavailable and not in-serviced were on a list to receive training prior to their next scheduled shift. There were no additional allegations of abuse or smoking incidents identified during the investigation. No residents indicated they were afraid during care or had complaints of their care. The facility Administrator and the DON will continue to monitor smoking areas as shown in the Plan of Removal and will ensure all residents are safe in the smoking area. were provided education on abuse/neglect on 04/29/23. On 05/01/23 at 4:24 p.m., the Administrator was informed the IJ was removed; however, the facility remained out of compliance at actual harm with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems.