

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Whispering Pines Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 523 Country Club Drive Fayetteville, NC 28301	
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** Based on record reviews and interviews with staff and the Physician, the facility failed to notify the physician when a resident with dysphagia (difficulty swallowing) had a choking incident when she was being fed dinner by a facility staff member for 1 of 3 residents reviewed for notification (Resident #42). Findings included: Resident #42 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus type II, hemiplegia (complete or near-complete paralysis of one side of the body) and hemiparesis (partial weakness of one side the body) following cerebral infarction (stroke) affecting right non-dominant side and dysphagia. During an interview on 7/28/26 at 7:04 PM, Medication Aide (MA) #1 reported that on 9/14/25 at approximately 5:45 PM, Resident #42 had a choking episode while she (MA #1) was feeding Resident #42 her dinner meal. MA #1 explained that she had fed Resident #42 most of her meal and was feeding her breaded okra that had been cut to about 1/4 inch long pieces and were soft. MA #1 stated that she had fed Resident #42 some okra and there were about 2 pieces remaining when Resident #42 started coughing and MA #1 immediately called Nurse #1 to the room who came to assess Resident #42. A nursing progress note written by Nurse #1 dated 9/14/25 at 8:32 PM indicated Nurse #1 was called to Resident 42's room at around 5:45 PM. Resident #42 was observed to be discolored and had choked on a piece of okra. Nurse #1 placed Resident #42 on her left side and gave her back blows. A piece of Okra was expelled out orally and Resident #42's color returned to normal. Vital signs: Blood pressure: 124/82, Pulse: 84 beats per minute, Temperature: 97.0 degrees Fahrenheit, oxygen saturations: 94% on room air. Resident began talking and joking as usual. An interview was conducted on 7/28/26 at 7:09 PM with Nurse #1 she reported that she was called to Resident #42's room on 9/14/25 at around 5:45 PM by MA #1. When Nurse #1 entered the room, Resident #42 was coughing and trying to get the food out but continued to have difficulty. Nurse #1 stated that Resident #42 was unable to clear her throat and her skin looked discolored. Nurse #1 reported that she could not visibly see the food in the resident's mouth to perform a mouth sweep, so she positioned Resident #42 on her left side and performed back blows to expel the food. Resident #42 was able to successfully expel the food which appeared to be a piece of okra with the back blows. Resident #42 returned to her baseline and was laughing and joking with staff immediately after the episode. Her vital signs were stable and her lungs were clear. Nurse #1 stated that she entered a note of the incident in Resident #42's medical record but did not think to inform the physician or Resident #42's Responsible Party (RP) because Resident #42 was back to her baseline. Nurse #1 further stated that she could not recall if she had mentioned the choking episode to the oncoming night shift nurse (Nurse #4). Nurse #1 indicated that Nurse #3 who was the Registered Nurse (RN) Supervisor during that shift, was aware of the incident as she came into the room when Nurse #1 was assisting Resident #42 to expel the food. Attempts to interview Nurse #4 were (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	unsuccessful. During an interview on 7/28/26 at 4:17 PM with Nurse #3 she revealed that she was the RN Supervisor on 9/14/25 when Resident #42 had a choking incident. Nurse #3 reported that when she entered the room Resident #42 was positioned on her left side and she was actively coughing out the food. She indicated that Resident #42 went back to her usual state after the coughing episode and her vital signs were stable. She indicated that she did not report it to anyone because she expected Nurse #1 to follow facility protocol and notify the physician and RP. During an interview with the Physician on 7/28/26 at 2:45 PM he reported that he could not recall exactly when he was notified of Resident #42's choking incident. He reported that he expected the facility to notify him or the on-call provider when any resident had a change in condition. He further stated that had been notified of Resident #42's incident on 9/14/25, the treatment would not have changed since Resident #42 was stable once she coughed up the food that she was having difficulty swallowing. An interview was conducted on 7/28/26 at 3:20 PM with the Director of Nursing (DON) and the Director of Operations. The DON reported that she became aware that Resident #42 had a choking incident when she was being fed dinner on 9/14/25 when she was in a regularly scheduled interdisciplinary team (IDT) meeting to discuss residents' conditions and go over progress notes on 9/16/25. The DON reported that when she read Nurse #1's progress note from 9/14/25 and asked Nurse #1 about the incident she realized that the physician had not been notified. The DON referred Resident #42 to speech therapy for evaluation and notified the physician of the choking incident with no new orders at that time. The DON indicated Nurse #1 should have notified the physician and Resident #42's RP on 9/14/25 when Resident #42 choked on her food on 9/14/25 during dinner. The DON reported that nursing staff were to follow facility policy and notify the physician and RP of any residents' change in condition or acute episodes that were out of the norm that could require further evaluation or change in treatment. The facility provided the following corrective action plan. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 9/14/2025 Resident #42, began to have difficulty with her meal. Medication Aide #1 was assisting Resident #42 with her meal and immediately notified Nurse #1. Nurse #1 came to room and assisted the resident with expelling the food by placing resident on her side and performing back thrusts. Resident #42 was able to cough and successfully expel the food. Nurse #1 reported that after Resident #42 expelled the food, Resident #42 immediately returned to baseline and was laughing and talking with staff. Nurse #1 obtained Resident #42's vital signs which were within normal limits as follows: Blood pressure: 124/82, Pulse: 84 beats per minute, Temperature: 97.0 degrees Fahrenheit, oxygen saturations: 94% on room air. The Medical Doctor (MD) and Resident Responsible Party (RP) were not notified of the incident by Nurse #1 per facility protocol. Resident #42 remained stable on 9/14/25 after the incident through 9/16/2025. Vital signs remained stable, oxygen saturation stable, and no further difficulty with meals. On 9/16/2025, the Director of Nursing (DON) became aware of choking incident during morning review of residents' notes. The physician was notified and a speech evaluation was requested. Resident #42 was stable. On 9/16/2025, Resident #42 was evaluated by the speech therapist and no change in diet was recommended. Resident #42 was able to safely tolerate mechanical soft diet with chopped meats and thin liquids as ordered. On 9/17/25, RP became aware of Resident #42's choking incident that occurred on 9/14/25 when Nurse #2 was notifying RP of physician orders for chest x-ray and blood work (complete blood count [CBC] comprehensive metabolic panel [CMP]) due to Resident #42's altered mental status on 9/17/25. During this conversation, RP stated that they were never notified that Resident #42 had a choking incident on Sunday, 9/14/25. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 9/17/25, Corporate Clinical Nurse Liaison completed 100% (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	audit of resident documentation from 9/1/25 to 9/16/25 to ensure physician and RP notification of change in condition. There were no negative findings. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.100% of licensed nurses were in-serviced by the DON and/or designee in person, regarding physician and RP notification for resident change of condition and acute episodes. Education was completed on 9/17/2025, and any licensed nurse not in-serviced by that date received education prior to their next scheduled shift. Newly hired nurses would be trained on timely notification of residents' change in condition to physician and RP by the DON or designee. Nursing staff were educated to document residents' change in condition and notification in the residents' electronic records. Nursing staff were also educated to document in the residents' chart if a voicemail was left or if the nurse was unable to leave a voicemail.Beginning 9/17/25, nurse's notes would be reviewed by Interdisciplinary Team (IDT), daily during clinical IDT daily meeting. Any noncompliance was addressed by the DON and/or designee. If the physician and/or RP were not notified, notification was completed by end of that day. Nurses' notes were reviewed during the daily clinical IDT meeting for 3 months.4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.Notification of resident changes/acute episodes to RP and/or physician were audited by the DON by reviewing nurses' progress notes weekly x 4 weeks and then bi-weekly x 4, results were reported to QAPI (Quality Assurance and Performance Improvement) quarterly x 2 and any changes and updates were made as recommended by the team beginning with the September 2025 meeting.Alleged Date of Compliance: 9/18/25.Onsite validation of the corrective action plan was completed on 7/30/26. Interviews with nursing staff confirmed they received in-service training on immediately notifying RP and physician of a resident's change in condition or any acute episodes out of the norm. A review of sign off rosters revealed all licensed nurses had been trained on timely notification of residents' change in condition or acute episodes to RP and physician. A review of the audit tools revealed auditing had been completed as documented in the plan of correction.The corrective action plan compliance date of 9/18/25 was validated.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 2 of 27 residents whose MDS assessments were reviewed (Resident #67 and Resident #28). Findings included: 1. Resident #67 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease. Record review revealed Resident #67 had elected hospice care on 6/17/25. Hospice Nurse Practitioner documentation dated 5/30/26 noted Resident #67 likely has less than six months of survival and is appropriate for hospice. Review of Resident #67's most recent annual MDS assessment dated [DATE] was not coded that hospice care had been received. An interview with the MDS Coordinator was conducted on 7/30/26 at 2:00 PM. She explained an off-site MDS Nurse had coded Resident #67's MDS, and not including hospice care had been an error. During an interview with the Administrator on 7/30/26 at 3:06 PM she stated she expected MDS assessments to be completed accurately. 2. Resident #28 had been admitted to the facility on [DATE]. A Progress Note dated 5/21/26 at 11:47 AM indicated Resident #28 had been discharged home with home health services. Review of Resident #28's discharge return not anticipated MDS assessment dated [DATE] noted the discharge was unplanned. An interview with the MDS Coordinator was conducted on 7/30/26 at 2:00 PM. She explained staff use a discharge communication form and after reviewing one dated 5/20/26 she stated she had missed seeing Resident #28 was planning to discharge on [DATE]. She explained that Resident #28 had filed an appeal with the insurance company to continue her stay at the facility, but it had not been granted, and when Resident #28 discharged she thought it was unplanned. She stated this had been an error. During an interview with the Administrator on 7/30/26 at 3:06 PM she stated she expected MDS assessments to be completed accurately.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a request for an updated Preadmission Screening and Resident Review (PASRR) evaluation for a resident who was admitted to the facility with diagnoses including post-traumatic stress disorder (PTSD) and depression for 1 of 3 residents reviewed for PASRR (Resident #2). Findings included: A PASRR Determination Notification letter dated 9/29/25 revealed Resident #2 had a Level I PASRR with no expiration date. A review of a North Carolina PASRR Level I screening form provided by the facility Director of Transitional Services revealed the hospital Social Worker had submitted a PASRR evaluation on 9/29/25 for Resident #2 that did not include the diagnoses of PTSD or depression. Resident #2 was admitted to the facility on [DATE] with diagnoses that included depression and PTSD. An admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Resident #2's active psychiatric/mood disorder diagnoses included PTSD and depression. She received an antidepressant medication during the MDS assessment review period. During an interview on 7/29/26 at 10:35 AM with the facility Director of Transitional Services, he revealed that he was responsible for submitting requests for PASRR evaluations. He stated that Resident #2 was admitted to the facility with diagnoses of PTSD and depression and that her PASRR Level I screening form had been submitted by the hospital prior to her admission to the facility. He verbalized that he had not verified what diagnoses were included in the PSARR Level I screening that was submitted at the hospital prior to being made aware during this interview. He further stated that he should have verified that all of Resident #2's mental health diagnoses were included in the application and if not submitted another screening to ensure all the diagnoses were included. An interview was conducted on 7/30/26 at 10:03 AM with the Administrator. She stated that the Director of Transitional Services should have submitted a request for a PASRR evaluation for Resident #2 with all the diagnoses to include PTSD and depression when Resident #2 was admitted to facility. The Administrator explained that the Director of Transitional Services was supposed to review the admission diagnoses and request a PASRR evaluation within a month of admission.		