

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER Whispering Springs Rehabilitation and Healthcare C		STREET ADDRESS, CITY, STATE, ZIP CODE 506 S 7th St Carrizo Springs, TX 78834	
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 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 observation, interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 11 (Resident #1) residents whose records were reviewed for assessments. The facility nursing staff failed to code Resident #1 had recent fall with injury on her MDS assessment. This deficient practice could place residents at risk of not identifying care areas and result in residents not receiving needed care and services. The findings included: Record review of Resident #1's admission Record, dated 09/22/2025, revealed a [AGE] year-old female admitted [DATE] and re-admitted on [DATE]. Resident #1 was not listed as her own responsible party with her [family member] listed as Emergency Contact #1. Resident #1 was admitted to the hospital and discharged on 07/28/2026. Record review of Resident #1's Medical Diagnoses, undated and accessed 07/28/2026 at 11:29 a.m., revealed diagnoses including congestive heart failure (chronic condition where the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), chronic kidney disease (occurs when the kidneys are damaged and cannot filter waste, toxins, and excess fluids from the blood effectively), diabetes mellitus (condition that occurs when the body cannot properly use blood sugar), protein-calorie malnutrition (severe form of undernutrition caused by insufficient intake of both protein and calories, leading to muscle wasting, fat loss, and impaired body function), unspecified dementia (refers to cases where a person shows clear signs of cognitive decline, such as memory loss, confusion, and difficulty performing daily tasks, but the underlying cause has not been definitively determined), and cognitive communication deficit (occurs when cognitive processes such as attention, memory, reasoning, and executive function are impaired, affecting how a person organizes, processes, and expresses thoughts in communication). Record review of Resident #1's care plan, undated and accessed 07/28/2026 at 11:30 a.m., revealed Resident #1 was at risk for falls/History [and] require supervision-minimal assistance with ADL's. The interventions included .Call light within reach. Visual checks every 1-2 hrs [hours] and prn [as needed]. The care plan focus was created and initiated on 03/18/2020 and revised on 01/04/2024. Record review of Resident #1's significant change MDS, dated [DATE] and signed 05/29/2026 as completed, reflected cognitive patterns, code of 03, indicating severely impaired. Resident #1 was documented as having no falls since admission/entry or reentry or prior assessment, including number of falls documented no entries. Resident #1's functional abilities for self-care and mobility were documented as requiring dependent or substantial/maximal assistance. Record review of Resident #1's SABR dated 04/16/2026 19. Other relevant information, Noted the resident on the floor lying on her left side due to an unwitnessed fall. Hematoma noted to the left side of her forehead. with orders from MD [Medical Director] Transfer to the hospital. Record review of Resident #1's Unwitnessed Fall report, dated 04/16/2026, revealed Incident Description, Noted the resident on the floor lying on her left side due to an unwitnessed fall. Hematoma noted to the left side of her (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675373	Facility ID: 675373
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	forehead.During an observation and interview on 07/28/2026 at 1:00 p.m., the MDS Coordinator revealed that the purpose of the MDS assessment is to gather information on a resident, to conduct an assessment on resident's needs, allowing NF staff to look at the whole picture of a resident and their functional abilities and cognition. She stated that not accurately completing the MDS assessments would impact the residents and their care, it would delay developing care plans and delay communication with nurses on resident reports and their continued care. The MDS Coordinator was observed to review Resident #1's Medicare - 5 Day MDS admission dated 05/01/2026 and Resident #1's significant change MDS dated [DATE] and stated section J1700. Fall History on Admission/Entry or Reentry that asked, Did the resident have a fall any time in the last 2-6 months prior to admission/entry or reentry? was coded as No and stated it should have been coded as yes to reflect the fall with injury on 04/16/2026.During an interview on 07/28/2026 at 4:31 p.m., the Administrator stated that she was not sure of policy and procedures regarding MDS assessments, but that the NF was responsible for establishing the level of care needed for each resident and stated that not accurately documenting MDS assessments could impact resident's care.Record review of policy titled, MDS Coding, date last reviewed 07/16/2026, revealed, that the facility utilized the most up to date Resident Assessment Instrument (RAI) manual for determination of coding each section of the Resident Assessment, timely and accurately.Record review of policy titled, Care Plans, Comprehensive Person-Centered, date last reviewed 07/16/2026, revealed, 9. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. 10. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident. 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 11 (Resident #1) residents reviewed for care plans. The facility nursing staff failed to revise Resident #1's care plan with a fall with injury requiring hospital admission on [DATE] and fall interventions following significant change of condition. This failure could have placed residents at risk of not having their needs identified and met. The findings included: Record review of Resident #1's admission Record, dated 09/22/2025, revealed a [AGE] year-old female admitted [DATE] and re-admitted on [DATE]. Resident #1 was not listed as her own responsible party with her [family member] listed as Emergency Contact #1. Resident #1 was admitted to the hospital and discharged on 07/28/2026. Record review of Resident #1's Medical Diagnoses, undated and accessed 07/28/2026 at 11:29 a.m., revealed diagnoses including congestive heart failure (chronic condition where the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), chronic kidney disease (occurs when the kidneys are damaged and cannot filter waste, toxins, and excess fluids from the blood effectively), diabetes mellitus (condition that occurs when the body cannot properly use blood sugar), protein-calorie malnutrition (severe form of undernutrition caused by insufficient intake of both protein and calories, leading to muscle wasting, fat loss, and impaired body function), unspecified dementia (refers to cases where a person shows clear signs of cognitive decline, such as memory loss, confusion, and difficulty performing daily tasks, but the underlying cause has not been definitively determined), and cognitive communication deficit (occurs when cognitive processes such as attention, memory, reasoning, and executive function are impaired, affecting how a person organizes, processes, and expresses thoughts in communication).Record review of Resident #1's care plan, undated and accessed 07/28/2026 at 11:30 a.m., did not reveal mention of fall with injury on 04/16/2026, Interdisciplinary Team review, or fall interventions.Record review of Resident #1's NSG [nursing]: Morse Fall Scale Evaluation, dated 04/27/2026, revealed, Reason for Morse Fall completion: 2. Readmission. History of Falling. 2. YesRecord review of Resident #1's SABR dated 04/16/2026 19. Other relevant information, Noted the resident on the floor lying on her left side due to an unwitnessed fall. Hematoma noted to the left side of her forehead. with orders from MD Transfer to the hospital.Record review of Resident #1's Unwitnessed Fall report, dated 04/16/2026, revealed the following Incident Description, Noted the resident on the floor lying on her left side due to an unwitnessed fall. Hematoma noted to the left side of her forehead.Record review of Resident #1's care plan, undated and accessed 07/28/2026 at 11:30 a.m., revealed Resident #1 was at risk for falls/History [and] require supervision-minimal assistance with ADL's. The interventions included .Call light within reach.Visual checks every 1-2 hrs [hours] and prn [as needed]. The care plan focus was created and initiated on 03/18/2020 and revised on 01/04/2024.During an interview on 07/28/2026 at 10:40 a.m. the Director of Nursing stated that care plans discuss anything going on with the residents. She stated the nursing staff relies on care plans and it was to help them know what type of care is needed for the residents and was a tool of communication between departments. She stated care plans not being updated affects residents and causes an inconsistency of care.During an observation and interview on 07/28/2026 at 1:00 p.m., the MDS Coordinator revealed that delays in (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	developing or updating care plans could delay communication with nurses on resident reports and their continued care. She stated care plans are updated as you go, if not she would fall behind. The MDS Coordinator stated that significant items added to the care plan should include falls and interventions. She stated every fall should be listed on the care plan. She stated she was responsible for care plans and updates and the ADON and DON will update them when she is out on leave. She stated she tries to keep up with all resident falls when she can. She will obtain fall details and dates, what were interventions for that date, and patient care. She stated she was responsible with updating care plans in a timely manner, needs to put interventions in place to ensure the resident does not sustain another fall, determines if the interventions are appropriate for the resident if not needs to evaluate again and if not working needs to change the intervention. The MDS Coordinator was observed to review Resident #1's electronic medical record and stated the unwitnessed fall with injury on 04/16/2026 was not documented on the care plan and she probably missed it. She stated it was not an excuse but Resident #1 was probably admitted to the hospital and she completed a discharge and readmission assessment and she thought she had documented the fall. During an interview on 07/28/2026 at 2:04 p.m., CNA C stated that care plans document important resident care, are constantly updated with important resident care. She stated falls and interventions would be listed on care plans. She stated that high risk fall residents will have interventions for fall mats, wheelchairs with footrest, keep constant eyes on them, not to be left alone in their room and all these important changes and interventions need to be documented on the care plans to help avoid falls, concussion, or hospital transport. She stated that not updating care plans frequently could impact resident care. During an interview on 07/28/2026 at 2:28 p.m., CNA B stated that care plans provide specific care for residents and stated that falls and behaviors would be documented on a care plan, and impact of not documenting falls could keep nursing staff from looking for signs or precautions for falls with high-risk fall residents. During an interview on 07/28/2026 at 2:43 p.m., LVN F stated falls are documented on care plans. He stated that not updating care plans with falls and interventions could impact residents in how the aides approach residents and could cause delayed care or cause them injury. During an interview on 07/28/2026 at 3:02 p.m., CNA A stated resident care plans tells staff what type of care was required for a resident. She stated it was important for care plans to include resident falls and interventions if the resident was a high-risk for falls. She stated if care plans are not updated or accurate residents could be hurt from a fall and not knowing their care they could be hurt. During an interview on 07/28/2026 at 4:31 p.m., the Administrator stated that care plans should be updated with falls. She stated it was important to be able to provide a plan of care for an individual, individualized plan, care plan was for staff to follow and to be able to provide specific care. She stated it depended on the situation if failing to update a care plan would impact a resident. She stated that the care plan for Resident #1 should have been updated to include falls with injury and stated there could be a negative impact to the care received and it should have been updated to include interventions and follow-up. Record review of policy titled, Fall Prevention Program, reviewed and revised 03/04/2026, revealed, The facility maintains an interdisciplinary fall prevention and management program designed to identify resident-specific fall risk factors and implement individualized, least restrictive interventions that support safety while promoting mobility, independence, dignity, and quality of life. The program focuses on risk identification, mitigation, monitoring, and reassessment as resident conditions change. A fall is defined as an unintentional change in position resulting in a resident coming to rest on the floor, ground, or other lower level. Each event will be evaluated based on the circumstances present at the time of the occurrence. Screening results will be reviewed as part of the overall nursing assessment and used to guide fall (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevention interventions and care planning. Residents identified as at risk will have individualized interventions incorporated into the interdisciplinary plan of care. Record review of policy titled, Care Plans, Comprehensive Person-Centered, date last reviewed 07/16/2026, revealed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems. m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels; n. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and o. Reflect currently recognized standards of practice for problem areas and conditions. 14. The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition. c. When the resident has been readmitted to the facility from a hospital stay.		