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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>675386   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                          | (X3) DATE SURVEY COMPLETED<br><br>09/04/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Whispering Pines Lodge   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2131 Alpine Rd<br>Longview, TX 75601 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |   |  |
| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46929</p> <p>Based on interview and record review, the facility failed to report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken for 2 of 11 residents (Resident #1 and Resident #2) reviewed for abuse and neglect.</p> <p>The facility failed to ensure the provider investigation report was turned into the state survey agency (HHSC) within 5 working days of the reported incident between Resident #1 and Resident #2.</p> <p>This failure could place residents at risk for abuse and neglect.</p> <p>Findings included:</p> <p>1. Record review of Resident #1's face sheet, dated 09/04/24, indicated she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included dementia (a decline in cognitive abilities that can affect a person's ability to perform everyday activities), generalized anxiety disorder (a mental health condition characterized by excessive, uncontrollable worry about various aspects of daily life), and chronic obstructive pulmonary disease (a group of progressive lung diseases that cause obstructed airflow from the lungs and make breathing difficult).</p> <p>Record review of Resident #1's quarterly MDS assessment, dated 06/07/24, indicated she was able to make herself understood and understand others. She had a BIMS score of 10, indicating moderate cognitive impairment.</p> <p>2. Record review of Resident #2's face sheet, dated 09/04/24, indicated she was an [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease (a progressive neurological disorder that leads to the degeneration and death of brain cells), generalized anxiety disorder (a mental health condition characterized by excessive, uncontrollable worry about various aspects of daily life), and paranoid personality disorder (a mental health condition characterized by pervasive and irrational distrust and suspicion of others).</p> <p>Record review of Resident #2's quarterly MDS assessment, dated 06/17/24, indicated she was usually able to make herself understood and usually understood others. She had a BIMS score of 5, indicating severe cognitive impairment.</p> <p>(continued on next page)</p> |   |  |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Record review of the facility's provider investigation report for the reported incident between Resident #1 and Resident #2, dated 07/11/24, indicated that Resident #1 had reported being slapped by Resident #2. The residents were separated and placed on 15-minute checks. There were no witnesses to the incident, and assessments of both residents showed no marks or injuries. Ultimately, the facility's investigation concluded that the allegation of abuse was unfounded. In-services were conducted with facility staff on the prevention of abuse, neglect, and exploitation. The allegation was reported to the state survey agency on 07/05/24.</p> <p>During an interview on 09/03/24 at 10:32 AM, the Administrator said she did not send the provider investigation report for the incident between Resident #1 and Resident #2 to the state. She explained that she was unable to find the email and must have forgotten to send it.</p> <p>During an interview on 09/04/24 at 12:20 PM, the Administrator said that she did not send the provider investigation report for the incident between Resident #1 and Resident #2 to HHSC within 5 days of the investigation. She said she was solely responsible for submitting the report and mentioned that she was going to send it on that day. Additionally, she noted that the abuse policy would address this deficiency.</p> <p>Record review of the facility's undated policy, Abuse/Neglect, stated:</p> <p>.F. Investigation .</p> <p>.3. A report to the appropriate agency will include the following: .</p> <p>.The written report must be sent to HHSC no later than the fifth working day after the initial report. The facility will use the designated state reporting form .</p> |