STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675386	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whispering Pines Lodge	2131 Alpine Rd 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 (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** 44933 Based on interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 2 of 5 residents (Resident #1 and Resident #2) reviewed for quality of care. 1. The facility failed to ensure, on 1/16/25, HA B did not leave a spray bottle of cleaner, unattended in the dining room on the secured unit. a. The facility failed to ensure Resident #2 did not possibly ingest an unattended spray of bottle of cleaner on 1/16/25. b. The facility failed to follow their cleaning policy, on 1/16/25, and safely store chemicals in a locked area on the secured unit. 2. The facility failed to secure Resident #1's wheelchair with the floor straps which resulted in Resident #1 falling back in his wheelchair during transportation and sustaining two abrasions to the scalp on 1/23/25. a. The facility failed to train Transport CNA A on how to properly secure and transport residents in the facility's van before transporting Resident #1 to dialysis on 1/23/25. b. The facility failed to ensure Transport CNA A did not move Resident #1, after he fell back in his wheelchair, and sustained two abrasions to the scalp on 1/23/25. The noncompliance was identified as PNC. The IJ began on 01/23/25 and ended on 01/30/25. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk of potential accidents, injuries, harm, or death. Findings included: (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Record review of Resident #2's face sheet dated 2/26/25 indicated Resident #2 was an [AGE] year-old, female admitted on [DATE] and readmitted on [DATE]. Resident #2 had diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), chronic obstructive pulmonary disease (is a condition caused by damage to the airways or other parts of the lung), and other symptoms and signs concerning food and fluid intake. Record review of Resident #2's significant change in status MDS assessment, dated 1/1/25 indicated Resident #2 was sometimes understood and sometimes had the ability to understand others. Resident #2 had impaired vision and no corrective lenses. Resident #2 had a BIMS score of 02 which indicated severe cognitive impairment. Resident #2 wandered daily. Resident #2 did not use a mobility device. Resident #2 required setup or clean up assistance for eating. Record review of Resident #2's care plan dated 7/25/22 indicated Resident #2 had impaired cognitive function and impaired thought processes due to Alzheimer's/dementia. Intervention included the resident needs supervision assistance with all decision making. Record review of Resident #2's progress notes dated 1/7/25-2/26/25 indicated the following: *1/16/25 at 1:00 p.m., by the DON, indicated, .location of event: dining room .cognition/behavior at time of event: cognitive impairment and wanders . [Resident #2] was found with bottle of spray cleaner .sprayer lid removed and in her left hand and bottle in her right hand sitting on the table in front of her by RD D (dietary consultant) who removed it from [Resident #2] and called for this nurse [DON] .bottle and lid given to me at this time .I [DON] went over to check on resident and I asked her if she was ok, she nodded she was .I [DON] leaned in and smelled her mouth and could smell lemon scent which was the scent of the cleaning solution .immediately retrieved the ADM and ADON E .ADON E confirmed that she could smell the lemon smell in her [Resident #2] mouth as well .mouth rinsed and water given per Safety Data Sheet (is a document that contains information about the health and safety of a chemical) instructions .poison control number called as well for further instructions .sent to ER for evaluation .resident [Resident #2] gave no verbal response when questioned what happened .family representative called .any cleaning supplies not on facility approved list removed .verified that there was no other cleaning supplies located where residents could get them . *1/16/25 at 1:04 p.m., by the DON indicated, .call placed to MD V to make aware of possible ingestion of cleaner . *1/16/25 at 1:08 p.m., by the DON indicated, .call placed to emergency number/poison control number on back of cleaner bottle .located Safety Data sheet for the cleaner and began following instructions for ingestion .if resident had taken 2 swallows or equivalent of 60ml .60ml being the cut off .if had ingested more than 60mls send to ER due to being unaware of exact amount [Resident #2] to be sent to ER for evaluation . Record review of witness statement by RD D, dated 1/16/25, indicated .I [RD D] found an open bottle of cleaner during my noon rounds with Resident #2 .she [Resident #2] had the nozzle in her left hand and the bottle sitting on table in front of her with her right hand holding bottle .I [RD D] called for the DON speaking with the charge nurse .the DON arrived and took the cleaner bottle I [RD D] had retrieved from resident [Resident #2] . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of witness statement by HA B, dated 1/16/25, indicated .I [HA B] was serving lunch trays with LVN C .I [HA B] noticed .vomit up and spilled milk on the table and floor and I [HA B] went into the nurses room to grab a mop to clean it up because I did not want anyone to slip .I [HA B] grabbed the cleaner spray and mop and went back into the dining room .once I [HA B] was done I felt the spray bottle with cleaner was empty and at that time .I [HA B] sat the spray bottle on the table and helped .I [HA B] forgot to put the almost empty cleaner bottle away . Record review of a handwritten statement by LVN C, dated 1/16/25, indicated .an almost empty bottle of cleaner spray was left on dining room table after it was used to clean up a spill .a resident sitting at the table picked up and opened the bottle .it is unknown if the cleaner was ingested . During an interview on 2/26/25 at 10:00 a.m., LVN C said an almost empty bottle of cleaner was left on the dining room table. She said she was sitting at the nurse desk outside the dining room area. She said she had not witnessed the incident on 1/16/25. She said she had heard the nozzle on the bottle cleaner was unscrewed. She said she did not smell the cleaner on Resident #2 breath. She said the bottle of cleaner was an outside cleaner not provided by the facility. She said the bottle of cleaner and mop were in the nurse's room. She said it was a commonly known rule not to bring outside cleaners to the facility. She said she did not think the facility figured out who brought in the outside cleaner. She said she had not seen a staff use the outside cleaner before the incident on 1/16/25. She said outside cleaners were not allowed because they could not be compatible to patient care and the facility environment. She said outside cleaners should not be left unattended due to possible ingestion. She said ingesting cleaners could cause poisoning, vomiting, seizures and death. She said the hospital did not think Resident #2 ingested the outside cleaner. She said after the incident on 1/16/25, the facility in-serviced staff on not bringing outside cleaner to the facility, not to leave cleaners/chemicals unattended, and only use cleaners on the housekeeping cart, and where the SDS binders were located. She said she was also coached about the incident on 1/16/25. During an interview on 2/26/25 at 10:14 a.m., CNA K said she did not work on 1/16/25. She said she had not seen the outside bottle of cleaner or seen any staff using the bottle of cleaner before the incident. She said outside cleaners should not be brought to the facility and left unattended because the residents could drink or spray it their faces. She said the residents could get a chemical burn, sick, blindness, or death. She said before the incident, she had been told not to bring outside cleaner into the facility. She said after the incident on 1/16/25, she had been in-serviced on not to bring outside chemicals, where the SDS binders were located, and only use approved chemicals. She said the housekeeping carts, at that time, had a list of the approved cleaner stored in the carts and their use. On 2/26/25 at 1:37 p.m., called HA B and left a message. A phone call was not received before or after exit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/26/25 at 2:02 p.m., ADON E said HA B called and told her about the incident involving Resident #2, on 1/16/25. She said HA B had poured some cleaner on the floor to clean up a mess. She said Resident #2 was found with the bottle of cleaner in her hands. She said she had smelled Resident #2's breath and it smelled like the lemon scented cleaner. She said it did not appear Resident #2 had ingested the cleaner. She said Resident #2 was sent to the ER for evaluation. She said HA B had gotten the outside cleaner from the storeroom near the nurse's desk. She said HA B had previously seen the outside cleaner in the storeroom and knew to find it in the storeroom. She said prior to the incident on 1/16/25, staff had not been in-serviced on not bringing outside cleaner into the facility. She said on admission, the residents and family were instructed not to bring the outside cleaners, into the facility. She said outside cleaners should not be used because the facility did not have the SDS listing. She said the facility also did not have the information on what to do if the cleaner/chemical was ingested. She said it was not a good thing for a cleaner/chemical to be ingested. During an interview on 2/27/25 at 8:36 a.m., RD D said she was making her lunch rounds on the secured unit when the incident on 1/16/25 happened. She said Resident #2 was sitting at a dining room table with the spray nozzle in one hand and the bottle in the other hand. She said she could not remember if there was any cleaner left in the bottle when she arrived. She said some of the nursing staff were at the nurse's desk. She said she could not remember if there were any CNAs in the dining room when she arrived. She said when saw Resident #2 with the bottle of cleaner, she immediately tried taking it away and called for help. She said she did not know what happened after the DON arrived and took over the situation. During an interview on 2/27/25 at 10:22 a.m., the DON said she was on the secured unit when Resident #2's incident happened. She said RD D called her into the dining room. She said Resident #2 had the sprayer in one hand and the bottle in her other hand. She said she and ADON E smelled the lemon scent on Resident #2's breath. She said the lemon scent bottle of cleaner did not have much left in it. She said HA B reported to her that the bottle of cleaner did not enough in it to use on the floor. She said she called poison control and looked the outside cleaner up in the SDS for what to do if ingested. She said MD V was notified. She said they could not determine how much Resident #2 ingested. She said they sent Resident #2 to the ER. She said the hospital did not believe Resident #2 had ingested any of the cleaner because she did not vomit, have redness in her throat, and tolerated water. She said before the incident on 1/16/25, she did not know if staff had been told not to bring outside cleaners into the facility. She said staff had required on-line training on handling chemicals which probably covered not leaving then unattended. She said it was important not to bring outside chemicals because the facility did not know how to treat exposure to them. She said the facility also did not have a readily available copy of the outside chemical/cleaner SDS sheet. She said when a chemical/cleaner was left unattended, there was a possibility of ingestion, skin burns, and getting in the resident's eyes. She said after the incident, the facility did a sweep for any other unapproved chemicals/cleaners in the building. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/27/25 at 11:13 a.m., the ADM said she started at the facility on 12/9/24. She said on 1/16/25, the DON and ADON E came and got her from the office. She said she was told RD D found a resident with a bottle of cleaner. She said the facility did not know if Resident #2 had ingested the cleaner or how much. She said poison control told them if Resident #2 had swallowed 60 mls or more, to send the ER. She said to be safe, the facility sent Resident #2 to the ER for evaluation. She said the hospital observed Resident #2 and sent her back to the facility. She said Resident #2 returned the same day (1/16/25). She said the hospital did not do any lab works while she was in the hospital. She said the facility drew labs the next day (1/17/25) on Resident #2. She said outside chemical/cleaners were not allowed because the facility did not have a SDS listing on them. She said the MD reviewed the labs and no new orders were received. She said if chemicals/cleaners were ingested, the resident could experience nausea, vomiting, and burning of the esophagus. She said she did not know if staff were aware outside cleaners were not allowed before 1/16/25. She said after the incident on 1/16/25, staff were in-serviced on outside cleaners and new hires were told upon hire. Record review of a facility conducted in-service, Cleaning Supplies/Chemicals dated 1/16/25 reflected training to all staff were provided education on the topic. Record review of a facility conducted in-service, MSDS Binders dated 1/16/25 reflected training to all staff were provided education on the topic. Record review of a facility conducted in-service, Personal Care Items/Chemicals on the Secured Unit dated 1/16/25 reflected training to all staff were provided education on the topic. Record review of a facility conducted in-service, Abuse/Neglect dated 1/16/25 reflected training to all staff were provided education on the topic. Record review of a facility conducted in-service, Chemicals dated 1/16/25 reflected training housekeeping and laundry staff were provided education on the topic. Record review of a facility conducted in-service, Hydration dated 1/16/25 reflected all nursing staff were provided education on the topic. Record review of HA B's Coaching Form dated 1/16/25, indicated . problem: outside chemicals/cleaning solutions being brought into facility and not being in a secured location .education: no outside cleaning chemicals can be brought into facility, we must use the chemicals housekeeping provides .all chemical/cleaning supplies must be locked up at all times .do not leave chemicals unattended at any time . Educator: DON .Student: HA B . Record review of LVN C's Coaching Form dated 1/16/25, indicated . problem: outside chemicals/cleaning solutions being brought into facility and not being in a secured location .education: no outside cleaning chemicals can be brought into facility, we must use the chemicals housekeeping provides .all chemical/cleaning supplies must be locked up at all times .do not leave chemicals unattended at any time . Educator: DON .Student: LVN C . Record review of HA B's Employee Disciplinary Report dated 1/16/25 indicated .Type of Disciplinary Action: Investigatory Suspension .TCNA A will be placed on an investigatory suspension pending an investigation into allegations of safety and security of the residents .ADON E .ADM . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of HA B's Employee Disciplinary Report Action Request dated 1/16/25 indicated .investigatory suspension .HA B left a non-approved cleaning agent within reach of a resident resulting in resident drinking the cleaning agent .ADON E .ADM .HR Coordinator . Record review the facility's letter to residents and family members indicated .we wanted to send a gentle reminder to everyone to please refrain from bringing any type of cleaning supply to the building .thank you . Record review of an undated facility's Daily Common Area Cleaning indicated .the goal is to keep facilities clean and odor free, while providing the resident .the safest environment possible .housekeeping carts/chemicals must be locked when not within eyesight of a staff member .use only approved pre-mixed chemicals provided by the supplier . 2. Record review of Resident #1's face sheet dated 2/25/25 indicated Resident #1 was a [AGE] year-old, male admitted on [DATE] and discharged from the facility on 2/1/25. Resident #1 had diagnoses including acquired absence of right leg above knee, end stage renal disease (is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), and dependence on renal dialysis. Record review of Resident #1's admission MDS assessment dated [DATE] indicated Resident #1 was understood and understood others. Resident #1 had moderate difficult hearing, clear speech, and adequate vision. Resident #1 had a BIMS score of 14 which indicated intact cognition. The MDS indicated Resident #1 had functional limitation range of motion to the lower extremity on one side. Resident #1 used a cane/crutch and wheelchair for mobility. Resident #1 received dialysis within the last 14 days. Record review of Resident #1's care plan dated 02/13/25 indicated the following: *Resident #1 was at risk for falls. Intervention included the resident needed a safe environment. *Resident #1 needed dialysis. Intervention included encourage resident to go for the scheduled dialysis appointments. Resident #1 received dialysis. Record review of Resident #1 progress notes dated 01/22/25-02/26/25 indicated the following: *1/23/25 at 6:24 a.m., by LVN F indicated .at dialysis . *1/23/25 at 10:00 a.m., by LVN F indicated .[Resident #1] was transferred to a hospital on 01/23/25 at 10:15 a.m. related to had a fall in his wheelchair on the transportation van .sent out to ER for treatment and assessment due to receiving a head injury . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*1/23/25 at 10:23 a.m., by LVN F indicated .resident had a fall .while on leave .unwitnessed, hit head, discovered on floor .oriented/no problem .the fall caused an abrasion to back of the head .size of abrasion 2 areas 1cmx1cm .scant bleeding to area .this nurse [LVN F] was called to facility van in the breezeway .upon arrival noted ADON [ADON E] and transportation staff [Transport CNA A] with resident [Resident #1] assisting resident .resident [Resident #1] noted seated up in wheelchair in the van with secured strap devices noted in place .resident [Resident #1] assessed for injuries .noted 2 abraised areas to back of head from hitting the lowering ramp to the van that was upright in the back of the van .Resident #1 states that all of a sudden the wheelchair went backwards .staff training . Record review of a fall incident report by LVN F, dated 01/23/25 at 9:55 a.m., indicated .[Resident #1] .out of facility/during transport .called to facility van per ADON E upon approaching the van was informed that [Resident #1] was in his wheelchair and the wheelchair had tipped backwards during transfer .[Resident #1] seated up in wheelchair at the current time .noted [Resident #1] to be safely secured in place with secured strap devices to flooring of the van . [Resident #1] stated that the wheelchair went backwards while he was riding in it and that his head hit the ramp flooring that was in position for transfer to the back of the van . [Resident #1] assessed for injuries .noted 2 small abrasions to top of head .to sent out to ER for evaluation . Record review of a staff member's statement by Transport CNA A dated 1/23/25 indicated .on January 23, 2025 after dropping a patient off for his 9:15 am appointment, I [Transport CNA A] left the wound care clinic to go to the dialysis center .I [Transport CNA A] arrived at the dialysis center around 9:25 am, patient [Resident #1] was sitting inside the center .I [Transport CNA A] rolled Resident #1 outside and proceeded to load him onto the transport van .once I got Resident #1 onto the van, I [Transport CNA A] proceeded to strap his wheelchair down .the front two wheels were strapped to the frame .the second or 1st back wheel (right side) was also strapped to the frame, the 2nd back wheel I [Transport CNA A] had trouble strapping to the frame, so I hooked it onto the wheel .I secured or tightened the straps of each wheel .I also secured the patient with the seat belts .I got back on the transport van and proceeded back to the facility .as soon as we crossed [a local road], Resident #1 said 'oww' .I looked back and his chair had flipped backwards .I pulled to the side of the road and grabbed the front arms of the patient's [Resident #1] wheelchair, and sat the patient back up .I asked Resident #1 was he hurt, he said his head kind of hurt .I restrapped the patient back down and proceeded to the facility . Record review of a staff member's statement by Transport CNA A dated 1/23/25 indicated .on January 23, 2025, I [Transport CNA A] was transporting Resident #1 back to the facility .we stopped at the red light on [a local road] and [a local road]. When the light changed, I proceeded through the light when Resident #1 said, 'oww' .I looked back and his wheelchair had flipped backwards .I immediately pulled over to the side of the road and went to see what had happened .he [Resident #1] said he just went back, I sat the wheelchair back up into its position and re-strapped the chair down, brought him back to the facility and immediately went inside and go the ADON [ADON E] to do a full assessment of the patient .he [Resident #1] only said he might have hit his head .my ADON [ADON E] and his nurse [LVN F] checked him out before I removed him from the van . On 2/25/25 at 11:00 a.m., called Resident #1, and his phone was no longer in service. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/25/25 at 11:07 a.m., LVN F said ADON E called him to come assess Resident #1 on 1/23/25. He said when Resident #1 arrived at the facility, his wheelchair was sitting up. He said all the hooks were attached to the wheelchair. He said Transport CNA A reported she looked back in the transport van and Resident #1 was gone. He said when he assessed Resident #1, there were two abrasions without bleeding to his scalp. He said Resident #1 hit his head on the bottom part of the lift in the back of the van. He said Resident #1 was a tall man with a standard size wheelchair. He said Resident #1 told him the incident scared the shit out of him. He said Resident #1 was sent to the ER for evaluation. He said Transport CNA A was the medical records staff but did transports. He said the Housekeeping Supervisor G used to do transports until Transport CNA A took over. He said he believed Transport CNA A started doing transports in December 2024 or January 2025. He said if a resident had a bad incident during transport, staff were supposed to call 911. He said Transport CNA A brought Resident #1 back to the facility after the fall incident on 1/23/25. He said as a nurse, if a resident had an incident during transport and was alert and oriented, he would transport the resident back to the facility. He said an MA or CNA could not properly assess a resident after an incident. He said if a resident had a fall incident during transport, they should not be moved before an assessment in case there was an injury or head injury. He said if a resident was moved, and had an injury or head injury, they could require emergent attention. During an interview on 2/25/25 at 11:25 a.m., ADON E said Transport CNA A came and got her when she arrived back at the facility on 1/23/25. She said Transport CNA A reported Resident #1 had fallen in the van. She said she went outside and Resident #1 was in an upright position. She said when she arrived to assess Resident #1, she did not look at the hooks and straps. She said she looked Resident #1 over, then LVN F arrived. She said Resident #1 was then removed from the van. She said Transport CNA A was the facility's designated van driver. She said Transport CNA A had not been the van driver for a long time. She said Transport CNA A said when they came across two local road, she heard something from the back of the van. She said Transport CNA A reported she looked in the rearview mirror and did not see Resident #1. She said Transport CNA A reported she turned around and saw Resident #1 had fallen. She said Transport CNA A reported Resident #1 had flipped backwards, but was still in the wheelchair. She said Transport CNA A reported she pulled over and got him in the upright position. She said Transport CNA A should have called an EMS, left Resident #1 on the floor of the van, and notified the facility of the incident. She said a resident with a fall should not be moved before an assessment because they potential could have an injury. She said the resident should also be assessed by a nurse. She said moving a resident with an injury could intensify the injury or make it worse. She said the corporate maintenance supervisor assessed the van after the incident. She said all the van drivers were retrained of van transportation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/25/25 at 11:39 a.m., TCNA A said she was the medical record staff and van driver. She said she started being the van driver in November 2024. She said that was the first time she had been a van driver for the facility. She said the facility had not trained her on being the van driver. She said as a CNA, she used to ride with the residents on transports and sort of knew what to do. She said the facility had not trained her on how to properly secure straps or load the residents, until after the incident on 1/23/25. She said Resident #1's wheelchair brakes worked. She said Resident #1 was a tall man and his wheelchair back could have been a little taller. She said on 1/23/25, she put Resident #1 on the lift, locked the brakes, and put him in the van. She said Resident #1 was toward the back on the van near the ramp. She said she was not able to hook to the frame of Resident #1's wheelchair toward the 2nd back wheel. She said she placed the hook on the wheel of the wheelchair instead of the frame. She said she could not hook onto Resident #2's wheelchair frame toward the 2nd back wheel because there was a box in the way. She said she could not get her hand underneath the wheel to strap the frame. She said she attached and tightened the lap and arm band. She said after Resident #1 had fallen, the lap and arm band were still tight around him. She said she did not know what she was supposed to look for after she tightened and secured the straps and hooks. She said she was at a local streetlight, accelerated when the light changed colors. She said she heard oww and looked back towards Resident #1. She said when she looked back, Resident #1 was not there. She said she immediately pulled over. She said Resident #1 said he was not hurt so she pulled the wheelchair upright by pushing down on the front arm rests. She said after she pulled Resident #1 upright, she noticed one of the straps looked loose. She said she placed the strap on the frame instead of the wheel and retightened the loose wheel strap. She said Resident #1 answered her questions appropriately, so she felt it was okay to move him. She said she did not notice the abrasions on back of Resident #1's head. She said Resident #1 did not report the back of his head hurting until they arrived at the facility. She said if a resident was not properly secured during transport, an accident could happen. She said after the incident on 1/23/25, she was in-serviced to not move resident after a fall and to call EMS. She said she was trained on van transportation and then suspended. During an interview on 2/25/25 at 12:04 p.m., the Corporate Maintenance Supervisor said after the incident on 1/23/25, he inspected the van's tie downs, belt straps, locking system, wheelchair lift, safety switch, and hand pump. He said there were no rip or tears in the straps and tie downs. He said the belt straps and tie downs also locked in place. He said he could only assume Resident #1's incident was caused from the tie down being placed on the wheel not the wheelchair frame. During an interview on 2/25/25 at 1:30 p.m., the ADM said ADON E told her about Resident #1's incident on 1/23/25. She said during the facility's investigation, they put a corporate staff member, with a similar build as Resident #1, in a wheelchair and tried to simulate different scenarios of what could have caused the incident. She said the corporate staff member did not flip backwards in the wheelchair. She said Resident #1 was interviewed about the incident. She said Resident #1 denied TCNA A driving badly. She said Resident #1 reported all the straps were on his wheelchair. She said the facility pulled the driving report from the van's system and it did not show any erratic driving. She said the DOR assessed Resident #1's wheelchair and recommend a high back wheelchair. She said the facility changed Resident #1's wheelchair to prevent a reoccurrence. She said TCNA A was a CNA at the facility then promoted to the medical record staff and van driver. She said she did not know if TCNA A had been trained on van driver before she started. She said she did not know how often van drivers had to be trained but she would find out. She said TCNA A should have been trained on van driving so she knew what to do. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675386	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whispering Pines Lodge	2131 Alpine Rd Longview, TX 75601

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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 2/25/25 at 2:41 p.m., the MS L said he was responsible for the van weekly inspections. He said the facility's van did not have an issue before or after the incident on 1/23/25. He said a resident needed to be properly secured for the safety of the resident. He said if a resident was not properly secured, it could cause the resident to flip over. He said if the resident flipped over, they could get bruises, or have falls and injuries. During an interview on 2/25/25 at 3:20 p.m., the DOR said Resident #1 was already on therapy service when his fall occurred in the transport van. He said the facility provided Resident #1 a standard size wheelchair after admission. He said the standard wheelchair was appropriate for him because he had good core strength and balance. He said he recommended changing Resident #1 to a high back wheelchair with anti-tippers as an intervention after the incident on 1/23/25. He said Resident #1 reported to him the wheelchair just tipped back on him unexpectedly during transport on 1/23/25. During an interview on 2/27/25 at 11:13 a.m., the ADM said TCNA A was already the van driver when she started on December 9th, 2024. She said she thought TCNA A was trained on being the facility's van driver. She said the van drivers were trained upon hire and after incidents involving the transport van. She said it was important for staff to be trained so they knew how to properly work the lift and strap residents in correctly. She said an incident could happen if the resident was not properly strapped on the transport van. She said TCNA A should have pulled over to a safe area and called an EMS when Resident #1 tipped over in the transport van. She said moving a resident after a fall without an assessment by a medical staff could cause an injury. She said she had received an in-service by corporate staff on No one is to drive the van unless they were checked off. Record review of a facility conducted in-service, No one is to drive the van unless they are checked off dated 1/23/25 reflected upper management were provided education on the topic. Record review of a facility conducted in-service, Wheelchair locks dated 1/23/25 reflected all nursing staff and therapy were provided education on the topic. Record review of a facility conducted in-service, Abuse/Neglect dated 1/23/25 reflected all staff were provided education on the topic. Record review of TCNA A's Employee Disciplinary Report dated 1/23/25 indicated .investigatory suspension . TCNA A will be placed [TRUNCATED]