

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675386	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/10/2025
NAME OF PROVIDER OR SUPPLIER  Whispering Pines Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 19401</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident had the right to be treated with dignity and respect and free from physical restraints for 1 of 3 residents (Resident #1) reviewed for resident rights.</p> <p>CNA D said she restrained Resident #1 on three occasions during the last month or so. She said about a month ago she had swaddled Resident #1 with a blanket by folding a blanket around Resident #1 to restrict her movements. CNA D said she had swaddled Resident #1 on the night of [DATE] to calm her down. On the morning of [DATE] CNA D said around 3:15 a.m. she had used a pair of leggings and tied Resident #1's legs to the bed to keep her from getting out of bed.</p> <p>Resident #1 was tied to the bed from 3:15 a.m. until around 8:00 a.m. on the morning of [DATE].</p> <p>An IJ was identified on [DATE]. The IJ began on [DATE] and was removed on [DATE]. The facility took action to remove the IJ before the survey began. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm because all staff had not been trained on physical restraints, behaviors, fall prevention, and resident rights.</p> <p>This failure placed residents at risk of entrapment with serious injury or death.</p> <p>Findings included:</p> <p>The surveyor entered the facility on [DATE] at 1:15p.m.</p> <p>Record review of Resident #1's face sheet dated [DATE] indicated a [AGE] year-old female admitted to the facility on [DATE]. Some of her diagnoses were Huntington's Disease (disease that caused nerve cells in the brain to gradually break down-causing cognitive, psychiatric, thinking, and movement disorders), schizoaffective disorder ( mental health condition with mixed symptoms of hallucinations, delusions, mood disorders such as depression, or mania), anxiety disorder, and history of falling.</p> <p>Record review of Resident #1's significant change MDS dated [DATE] indicated she had long and short-term memory loss. She was not coded for any behaviors. She required supervision for eating and was dependent on staff for all other ADLs.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's care plan last revised on [DATE] indicated a Focused area of at risk for falls due to Huntington's Disease secondary to movement disorder. Some of the interventions were the resident was to be on a low bed with mattress on the floor beside her bed. The resident was able to and did crawl out of bed onto the mattress by herself. The resident needed activities that minimize the potential for falls while providing diversion and distraction. A Focused area of communication barrier secondary to Huntington's Disease. A Focused area of potential to demonstrate physical behaviors due to her poor impulse control such as crawling on the floor. Throwing her legs over the side of the bed, spastic movements caused her to come out of her bed or hit herself unintentionally. Some of the interventions were when the resident became agitated to intervene before the agitation escalated.</p> <p>Record review of Resident #1's active orders as of [DATE] indicated an order for a fall mat to floor at bedside dated [DATE]. An order that indicated she may have a scoop mattress to help establish bed boundaries dated [DATE]. An order dated [DATE] that indicated to admit to hospice.</p> <p>Record review of Resident #1's nursing notes dated [DATE] at 8:15 a.m. indicated Resident #1 was noted with legs tied together with a pair of leggings and tied to the bed. There was no signs and symptoms of distress noted. Investigation in progress. Signed by the ADON.</p> <p>Record review of Resident #1's Weekly skin check dated [DATE] indicated the resident had discoloration on her left and right arms. She had multiple scabs on her legs. Signed by treatment nurse.</p> <p>Record review Resident #1's Trauma Informed assessment dated [DATE] indicated the resident had a mental disorder and the questions were asked of the resident or responsible party. The assessment indicated they recently felt angry.</p> <p>Record review of CNA D's Proficiency Audit dated [DATE] indicated she had knowledge of the Abuse and Neglect Protocol.</p> <p>Record review of CNA D's personnel file indicated she began working at the facility on [DATE]. Her transcript details indicated she had a training on [DATE] regarding Creating a Restraint Free Environment, Fall Prevention, Preventing, Recognizing, and Reporting Abuse, and Essentials of Resident Rights.</p> <p>Record review of an in-service dated [DATE] regarding abuse and neglect indicated CNA D signed the training roster indicating she had received abuse training.</p> <p>Record review of a statement written and signed by CNA D indicated she said on the night of [DATE] she was taking care of Resident #1 and she took her leggings she was wearing off. She then tied one leg to the strap of the bed and put the other one through her legs. She stated she tied it to her gown to keep her from jumping out of the bed and hurting herself at about 3:15 a.m. She dated the statement [DATE]. She wrote another statement dated [DATE] that indicated in the past Resident #1 had two beds placed together and she kicked the mattress of the second bed and jumped on the metal frame. She put her back in the bed and she did it again. The aide wrote, So I swaddled her with blankets and she calmed down and went to sleep.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 2:06 p.m. RN A said she was on the unit working with a resident on the morning of [DATE]. She said CNA C came to her and said Resident #1 was tied up with a blanket or something to the bed frame. She said she told CNA C to get the ADON, because she was busy at that time. RN A said she did not actually see Resident #1 tied to the bed. She said Resident #1 had Huntington's with involuntary jerking movements of the arms and legs, and limited communication. RN A said Resident #1 communicated with gestures, was easily frustrated, and she could not walk. She said she did not know a lot about the incident as she was not really involved.</p> <p>During an interview on [DATE] at 2:10 a.m. CNA B said she heard Resident #1 was tied to the bed, but she did not see anything. She said she had written a statement saying she had not seen Resident #1 or any other resident restrained.</p> <p>During an observation and interview on [DATE] at 2:18 p.m. the ADON/LVN said CNA C called her to Resident #1's room. The ADON said when she arrived in the room Resident #1 had a pair of leggings (stretch pants) wrapped around her legs. She said Resident #1 had abnormal movements and it was hard to tell what was going on. The ADON said she first thought the pants were just pulled down until she looked closer. She said the leg part was wrapped around her leg and other leg was tied to the bed. She said the bed had straps that were used to keep the low air loss mattress in place. The pants were tied to the one of the bed straps at the foot of the bed. She said she had spoken with CNA D later and she said she did not want Resident #1 coming out of the bed. The ADON said the facility Administrator called the police, reported the incident, and suspended the aide. The ADON had a picture of Resident #1's legs tied to the bed. Review of the picture showed a black pair of pants wrapped around and through Resident #1's legs. The left leg looked like it may have still been in the appropriate pant leg. The other pant leg looked to be wrapped around the right leg and then tied to a strap on the side of the bed. The left side of the pants were below the knee, and the right side was at the knee joint.</p> <p>During an interview on [DATE] at 2:32 p.m. CNA C said on the morning of [DATE], she clocked in at 7:00 a.m. She said she had just finished passing trays, and she made Resident #1 her last resident because she required assistance with eating. CNA C said she was trying to assist Resident #1 to get up for her breakfast about 8:00 a.m. to 8:15 a.m. When she tried to get Resident #1 out of bed she could not. CNA C said Resident #1 ate her meals in her chair. She said Resident #1 could feed herself but must have staff to watch her. She said she could not get the resident out of bed and looked to see what was going on. CNA C said it looked like some pants wrapped around Resident #1's leg, connected to her leg somehow and tied to the bed. CNA C said she tried to untie the pants and she started to panic because she could not untie them. She said she had gotten the Housekeeper to come in and witness what was going on. She said she had gone and reported to RN A. She said RN A told her to report it immediately to the ADON. CNA C said the ADON came in and it took her a while to get Resident #1 untied. She said she did not know if Resident #1 was agitated or just having involuntary movements but she would not be still so she could be untied. CNA C said she came on shift and worked behind CNA D who was on the hall the night before. She said that was the first time she had seen any resident tied or restrained. She said Resident #1 would get agitated, she would crawl out of the bed, and she would jerk and move about. She said Resident #1 was mad and panicking because she could not get her up that morning.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 2:40 p.m. the Administrator, said she was notified by the ADON about 8:15 a.m. today, [DATE] of the incident. The Administrator said when she was notified Resident #1 was already untied. She said she was told CNA C found Resident #1's legs wrapped in a pair of pants or leggings and tied to the mattress. She said they had investigated and determined CNA D was the perpetrator. She said she called CNA D back to the facility and she had written statements. The Administrator said CNA D's justification for tying Resident #1 to the bed was, she had worked with a Huntington patent before, and they had fallen and died . The Administrator said CNA D said she was only trying to protect Resident #1 from hurting herself. The Administrator said they did a skin assessment, a pain assessment, the SW did a trauma informed assessment on Resident #1. She said they called the police and the family member. The Administrator said she had called the incident into the State this morning and they had started to conduct skin assessments on all the residents in the building and were in the process of interviewing all staff to determine if they had ever seen any type of restraint. She said they were doing safe surveys with all interview able residents to determine if any abuse was identified. She said they had also started in services.</p> <p>During an interview on [DATE] at 3:08 p.m. the DON said she was informed Resident #1 had been tied to the bed. She said she did not see the restraint, it had been removed when she arrived at the facility on today, [DATE]. She said she was present for the interview with CNA D who said she had tied Resident #1 to the bed because she was scared for Resident #1's safety. The DON said the aide told them Resident #1 was getting out bed, and her behaviors appeared worse on the night of [DATE] going into the morning of [DATE].</p> <p>During a telephone interview on [DATE] at 3:14 p.m. CNA D said when she arrived at work on of [DATE] at 6:00 p.m. Resident #1 was agitated, she was hollering out, and could be heard at the nursing station. She said she had asked the nurse to give her something because she was so agitated. She said LVN E refused and said it would be a chemical restraint. CNA D said about a month ago she had swaddled Resident #1. She said swaddling was like when you swaddle a baby. She said she took her blanket tucked it under Resident #1 on one side, and then wrapped her in the blanket and tucked it under her on the other side. She said she did that about a month ago when there was an issue with her being in a bed that was too high. She said at that time Resident #1 calmed down and went to sleep. CNA D said Resident #1 was fighting with her demons last night. She said on the night of [DATE] Resident #1 would not calm down. CNA D said at first, she had swaddle Resident #1. She said Resident #1 kept fighting and squirming around trying to get out of the bed. She said around 3:15 a.m. she had tied Resident #1 to the bed. She said she had gotten busy with another resident and had left the facility without checking on her. CNA D said she tied Resident #1 to the bed because she did not want her to hurt herself. She said she tied her loosely she could still move but not jump out of the bed. CNA D said she thought Resident #1's disease had gotten worse, she felt she had a bond with Resident #1 and could calm her down. She said on that day Resident #1 would not calm down and kept trying to jump out of bed.</p> <p>During an interview on [DATE] at 3:25 p.m. with the ADON she said that she had difficult time getting the pants untied from around Resident #1's legs. She said she would not cooperate. She had spastic movements, or she may have been struggling it was hard to tell. She said once she got one leg straightened out the other one was bent. She said it did not take her too long, but it was not easy. She said when she had gone in the room the bed was in the lowest position and there was a mattress on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an observation on [DATE] at 3:50 p.m. showed Resident #1's room had a bed in the lowest position. There were two mattresses on the floor lying next to the bed and at the foot of the bed was a fall matt. Observation of the bed showed all corners, and any surface of the bed was wrapped with tape and a pool noodle. Resident #1 was laying on two mattresses. Her head was on the bed, and she was stretched parallel across the mattress. She was drinking from a cup and was making gestures with the cup. She made noises but she did not communicate except for gestures.</p> <p>During an interview on [DATE] at 9:00 a.m. the Administrator said she had not gotten a statement from the LVN E, but LVN E said Resident #1 was not agitated on the evening on [DATE] going into the night of [DATE]. The Administrator said when she talked to the Responsible Party on the phone, they were upset about the situation.</p> <p>During an interview and observation on [DATE] at 9:30 a.m. CNA B (who was more familiar with Resident #1) tried to ask her questions. Resident #1 was observed on a mattress on the floor. Observation showed there was a mattress on both sides of the low bed. When CNA B asked Resident #1 if anyone had hurt her, she shook her head no. Observation showed Resident #1's left eye was dark and discolored. CNA B asked Resident #1 about being tied up but Resident #1's responses were grunts and noises. Resident #1 would hide her face in the mattress and not respond.</p> <p>During an interview on [DATE] at 10:07 a.m. the SW said Resident #1's Responsible Party was mad in the beginning at the individual. She said the Responsible Party was given the option of pressing charges if he wanted to. The SW said Resident #1 liked to interact, but not too much social stimulation. She said she went to talk to Resident #1 but was unable to have a conversation about the incident.</p> <p>During an interview on [DATE] at 10:23 a.m. the Housekeeper said on the morning of [DATE] around 8:00 a. m. she was asked by CNA C to look at Resident #1. She said she observed Resident #1 with legging tied around her legs and to the bed. She said the pants were tied to a rail strap on the side of the bed. She said Resident #1 was making noises, grunting, and struggling to get united, it appeared. The Housekeeper said CNA C could not get Resident #1 untied and had gotten the ADON to assist. She said she had been in serviced on restraints, abuse, neglect, and if residents have behaviors, report immediately. She said she had not seen any residents restrained prior to this incident.</p> <p>During an interview on [DATE] at 11:25 a.m. RN A said Resident #1 could not stand up unassisted. She said she had a hip fracture that did not heal properly prior admission. There were several falls documented and RN A said Resident #1 would throw herself on the floor. She said she was very impatient if no one was there when she wanted something she would crawl to get across the room to what she wanted. RN A said it appeared sometimes Resident #1 just preferred to be on the floor. She said they would put her in the bed, and she would immediately roll back out on purpose. She said Resident #1 should not have been tied up. She said Resident #1 had jerking movements and could have hurt herself with spastic movements and getting tangled up more. She said Resident #1 would throw her body and, got easily frustrated when she could not have her way. She said, she picture Resident #1 behaving like an animal stuck in a fence struggling to get free. She said she could have hurt herself in the struggle to get free. RN A said Resident #1 crawled out of her broad chair this morning, she was found with her feet on the chair and her body on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 11:39 a.m. CNA B said Resident #1 would try to stand on her own, and could do so by pulling up on something, but she was not steady. She said Resident #1 could stand while in her chair but not from the bed. CNA B said she would get out of her chair, by leaning forward and rolling out of the chair. She said if Resident #1 wanted to get across the room she would figure out a way to get to her drawer to get a snack. CNA B said Resident #1 was easily frustrated when things did not go her way. She said if she were tied to the bed and could not move like she wanted Resident #1 could become frustrated quickly. CNA B said they could not leave Resident #1 in chair unattended, but she often wanted to sit in the chair. She said she was in serviced on abuse, restraints, Huntington's, and resident rights. CNA B said she was not aware of any staff tying residents to the bed and she knew not to do such a thing.</p> <p>During a telephone interview on [DATE] at 1:05 p.m. a family member said they had known Resident #1 all their life and if she was in her right mind or able to voice her frustrations, she would have been very upset to be treated like an animal. The family member said Resident #1 would have been cursing and likely trying to fight. The family member said there was no way Resident #1 would have stood for that kind of treatment, she would have been very upset. The family member said they were upset when they heard about the incident. They were trying to give the perpetrator the benefit of the doubt but had concerns about how many other residents had she done that to. They also had concerns that may not have been the first time she had tied Resident #1 to the bed because the staff was too busy. The family member said Resident #1 could not say how she felt but if she could not be happy.</p> <p>During a telephone interview on [DATE] at 3:36 a.m. LVN E said at the beginning of the shift on [DATE] at 6:00 p.m. Resident #1 was in her bed. She said when she passed the room her face was toward the door, and she appeared to be fine. LVN E said there was one mattress on the floor and the bed was in the lowest position. She said Resident #1 was not hollering or screaming. LVN E said CNA D did not come to her at any time during the night. She said Resident #1 was on hospice and she had as needed medications for anxiety. LVN E said if the resident had exhibited anxiety symptoms she would have given her medications as ordered. LVN E said she never saw Resident #1 swaddled, and she had no idea Resident #1 was tied to the bed. LVN E said the idea of her being tied up broke her heart. She said Resident #1 hurt herself all the time, by swinging her arms and legs around. She said sometimes she would hit herself in the face. LVN E said Resident #1, or anyone could hurt themselves worse by being tied up. She said she worked from 6p to 6 am and had a whole stack of in services on abuse and reporting, Huntington's disease, resident rights. She said she knew no one was to be tied to the bed.</p> <p>(continued on next page)</p>

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 10:10 a.m. Resident #1's Responsible Party said the Administrator told him staff responsible for tying Resident #1 up was going to be fired. The Responsible Party said it was saddening and upsetting that someone would do that to a disabled person. The Responsible Party said Resident #1 had a cracked hip from 4-years ago, and it was not fixed, and she could not stand. The Responsible Party said if the staff did not want to be bothered, they did not have to tie Resident #1 up. He said the staff should consider their self-lucky that Resident #1 could not get up and untie herself. He said several years ago before her disease progressed, she would have wanted to fight that person for tying her up. The Responsible Party said it was hard to tell if Resident #1 had any reaction to the incident. They said they felt Resident #1 kind of clung to them more on that day. The Responsible Party said Resident #1 still had her mind but was unable to communicate. They said the most Resident #1 could do was roll out of bed and crawl all over the floor. The Responsible Party said she could pull herself up with the assistance of the chair. The Responsible Party said they tried to be sympathetic towards the person that treated Resident #1 that way, but that person did not take into consideration how his felt being tied down like she was not a human. The Responsible Party said for someone to tie Resident #1 up it took time, they would have had to tie the good leg first if not she would have kicked them. The Responsible Party said they were having a hard time dealing with the issue because they could only think that was not the first time the alleged perpetrator had tied Resident #1 up. The Responsible Party said that person should never be allowed to work in the healthcare field again because they may treat other residents the same way. The Responsible Party said staff should not tie someone up because they did not want to be bothered.</p> <p>Record review of the facility policy on Restraints revised [DATE] indicated it was the policy to ensure that residents are free from physical or chemical restraints imposed for purposes of discipline or convenience and are not required to treat the residents' medical symptoms. Physical restraints are defined as any manual method or physical/mechanical device, material, or equipment attached or adjacent to the resident's body that the resident cannot remove easily, which restrict freedom of movement or normal access to one's body. Physical restraints include, but are not limited to leg restraints, arm restraints, that the resident cannot remove. Physical restraints for behavior control shall only be used in an emergency which threatens to bring immediate injury to the resident or others. Practices that are not to be used bed rails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed. Tucking sheets so tightly that a bed bound resident cannot move.</p> <p>The facility had suspended CNA D and started putting corrective actions in place on [DATE] when the surveyor entered the building. They conducted skin assessments on Resident #1 and all residents in the facility. They conducted safe surveys on all interview able residents. They interviewed all staff to determine if any had noted any abuse or restraints in the facility. The facility in-serviced staff on Resident Rights, Restraints, Trauma Informed Care, Behaviors, Fall Prevention, and Abuse and Neglect</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] 4:15 p.m. the Administrator said they had put corrective measures in place to ensure this type of thing does not occur again. She said they were a restraint free facility and had no idea why the staff member would tie Resident #1 to the bed. The Administrator said that she was informed of the incident at 8:15 a.m. and immediately began to investigate. She called CNA D back to the facility and called the police. She said she suspended CNA D before she called the incident into the state agency into the State Agency around 10:00 a.m. on [DATE]. She said they had initiated skin assessments on all residents, safe surveys on interview able residents, initiated interviews with staff on restraints. She said they had in serviced on falls, behaviors, restraints, trauma informed care, abuse, and resident rights. The Administrator said they had suspended CNA D, and they were going to terminate her because the investigation was almost complete. She said the police had talked to CNA D, and said it was up to the family if they wanted to press charges. She said the family had not decided on what they wanted to do at the current time, but they did request a police report.</p> <p>Record review of CNA D's Employee Disciplinary Report dated [DATE] indicated she was placed on investigator suspension due to allegations of resident mistreatment.</p> <p>Record review of the facility Provider Self Reporting of Incidents indicated the Administrator was informed of the incident on [DATE] at 8:15 a.m. The State reporting system indicated they were notified at 10:04 a.m. on [DATE].</p> <p>Record review of a payroll input /personnel action form for CNA D indicated she was terminated effective [DATE].</p> <p>Record review of an in-service training dated [DATE] indicated training was provided to facility staff on the facility restraint policy.</p> <p>Record review of an in-service training dated [DATE] indicated staff were trained on Huntington's Disease with an attachment from the Mayo Clinic which indicated Huntington's Disease usually caused movement disorders. Movement disorders that cannot be controlled called Chorea. Chorea are involuntary movements affecting all muscles of the body, specifically the arms, legs, face, and tongue. Symptoms include involuntary jerking or writhing movements, muscle rigidity or contracture, slow eye movement, trouble walking or keeping posture and balance and trouble with speech or swallowing.</p> <p>Record review indicated an in-service conducted on [DATE] indicated staff were educated on Behavior management. Review of the attached Behavior Management Policy dated [DATE] indicated Behavior management included the management of anger, confusion and other behaviors that be attributed to dementia disorders or psychological conflicts resulting from a loss of control over body, environment, or unmet needs. The utilization of physical restraints by a physician order only.</p> <p>Record review indicated facility staff were in-service was conducted on [DATE] on Fall Prevention Strategies, Trauma Informed Care and Abuse and neglect.</p> <p>Record review indicated facility staff were in-service dated [DATE] on Resident Rights dated [DATE] indicated the resident has the right to exercise their rights in the facility. the resident has a right to be treated with respect and dignity including: the right to be free from any physical or chemical restraints imposed for purpose of discipline or convenience and not required to treat the residents' medical symptoms.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675386	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/10/2025
NAME OF PROVIDER OR SUPPLIER  Whispering Pines Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE  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.			
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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review witness statements indicated 41 staff had not seen any residents restrained all dated [DATE].</p> <p>Record review of 22 resident safe surveys dated [DATE] revealed there were no concerns regarding restraints.</p> <p>Record review of Weekly Nursing Skin Checks dated [DATE] indicated all residents had skin assessments completed with no suspicious areas noted.</p> <p>Interviews were conducted with 4 CNAs and 3 LVNs, from [DATE] at 10:45 a.m. to [DATE] at 3:36 p.m., who were knowledgeable about the facility abuse policy and the restraints policy. They said they were in serviced on resident rights and when a resident said no that means do not force the resident to do something they did not want to do. They were in-service on the facility policy on restraints, behaviors, Huntington's, fall prevention, and resident rights. Those interviews are as follows.</p> <p>During an interview on [DATE] at 10:45 a.m. LVN F said he had received in services on Huntington's, restrains, abuse, trauma, behaviors, and resident rights. He said they were informed how residents may react, what are appropriate things to do, do not tie up a resident, give medications or speak with the doctors.</p> <p>During an interview on [DATE] at 2:20 p.m. CNA G said she worked from 7:30 a.m. to 3:30 p.m. as a restorative aide. She said she had in- services on abuse and neglect, restraints, Huntington's, behaviors, falls, and resident rights. She said she had not seen anyone tied up and that she knew better than to tie someone up.</p> <p>During an interview on [DATE] at 2:23 p.m. CNA K said she worked 6a to 2p. She said she had in- services on abuse and neglect, restraints, Huntington's, behaviors, falls, and resident rights. She said she had not seen anyone tied up and she knew better than to tie someone up.</p> <p>During an interview on [DATE] at 2:24 p.m. LVN H said she was she had in services on [DATE] but it was not over anything she did not already know. They had in-services on behaviors, falls, do not tie anyone up, and abuse.</p> <p>During an interview on [DATE] at 2:27 p.m. MA/CNA I said she worked from 6 a to 2p and on occasion would work 2p to 10 p. She said she had not seen anyone restrained and she would report it if she did. She said they had been in serviced on [DATE] about abuse, neglect, falls, behaviors, restraints, and Huntington's.</p> <p>During an interview on [DATE] at 2:30 p.m. CNA J said she worked from 6a to 6p. She said she was in-service on resident rights, and abuse. She said she knew you could not hit residents or tie them up. She said she had never seen anyone restrained. She was also in served on falls, restraints, Huntington's disease, and behaviors.</p> <p>During a telephone interview on [DATE] at 3:36 p.m. LVN E she worked from 6p to 6a and had a whole stack of in services on abuse and reporting, Huntington's disease, resident rights. She said she knew no one was to be tied to the bed.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Whispering Pines Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE  2131 Alpine Rd Longview, TX 75601	
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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 3:53 p.m. the facility Corporate Nurse said they were not going to allow CNA D to return to work, she had been terminated. She did not know how long it took the corporate HR to have the information in the system, but CNA D no longer worked for the facility.</p> <p>The immediate Jeopardy was determined after exit on [DATE] at 4:14 p.m. The facility Corporate Nurse was informed via phone.</p> <p>An IJ was identified on [DATE]. The IJ began on [DATE] and was removed on [DATE]. The facility took action to remove the IJ before the survey began. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm because all staff had not been trained on physical restraints, behaviors, fall prevention, and resident rights.</p>		