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No. 0938-0391

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	03/29/2025

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** 27140 Based on observations, interviews, and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for 1 of 7 residents reviewed for accidents. (Resident #1). The facility did not prevent Resident #1, who resided on the secured unit, from leaving the facility unsupervised on 03/13/2025. Resident #1 was found at a local hospital emergency room where he had been taken by local police. The facility was not aware the resident was missing for approximately 4 hours until staff went to get him for his evening meal. The noncompliance was identified as PNC (past noncompliance). The IJ began on 03/13/2025 and ended on 03/14/2025. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of potential accidents, injuries, harm, or death. Findings included: Record review of a face sheet on 03/28/2025 indicated Resident #1 was a [AGE] year-old male who admitted on [DATE] with diagnoses including: stroke, dysphagia (difficulty swallowing), alcohol abuse, cocaine use, and impaired cognitive function. Record review of a quarterly MDS dated [DATE] indicated Resident #1 had clear speech, usually understood others and was usually understood, he had a BIMS score of 06 indicating severe cognitive impairment. He had a behavior of wandering daily. He required partial assistance with ADLs and could feed himself. He was incontinent of bladder and frequently incontinent of bowel. He was independent with mobility and walking unassisted. He had a feeding tube and also ate a mechanically altered diet. (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	Record review of care plans for Resident #1 indicated he had a care plan initiated on 12/23/2024 and revised on 01/22/2025 indicating he was at risk for wandering. Goals included: The resident will not leave facility unattended and the resident's safety will be maintained through the next review period. He had another care plan initiated on 12/23/2024 and revised on 01/22/2025 which indicated he was at risk for elopement and required a secured unit. Care plan goals included: Will remain safe within the facility unless accompanied by staff or other authorized person through the next review date. Interventions included: Supervise closely and make regular compliance rounds whenever resident is in room. This care plan was updated on 03/14/2025 and indicated he had eloped from a window in an empty room on the secure unit and a new intervention initiated on 03/13/2025 indicated 1:1 monitoring was in use. Review of Resident #1's Progress Notes in the electronic record indicated the following: Notes dated 12/22/2024 at 1:20 PM indicated resident goes from room to room rummaging attempting to find something to eat. He takes other resident's clothing and packs and goes to the doors and attempts to leave.; Notes dated 12/30/2024 at 4:44 PM Resident continues to pace up and down the halls. He goes in and out of rooms taking food and other items. Resident must be monitored closely. Packs up his belongings and attempts to exit.; Notes dated 01/18/2025 at 11:50 AM Resident is extremely restless this shift. He is pacing the hallway and going in and out of other resident's rooms. Demanding to go home. Says he will walk if he has to. Not accepting direction well Interventions: Talked with him and explained his need for care at this point in his life. Talked about it being the winter season and bad weather expected.; Notes dated 1/19/2025 at 11:07 AM Resident continues the same behavior pattern as last shift. He is pacing up and down the hall and going in and out of other resident's rooms. Does not accept direction well. Is insistent that he is going home. Has packed his belongings and carried them with him in the hall. He has called his niece several times over the past two shifts. He does not get an answer. This nurse has left a message with the niece the last two shifts letting her know the resident wishes to speak with her if she has the time to call him. At this point, no return call. This nurse has advised the resident that he may speak with the social worker and/or administrator on Monday when they are in the facility regarding his wish to leave the facility. Resident is calm and accepting of that information at this time.; Progress notes continued with entries on 01/21/25 at 10:45 AM, 02/01/25 at 1:49 PM, 02/13/25 2:46 PM, and 02/21/25 9:51 AM regarding pacing and packing of clothes and wanting to go home; Progress Notes dated 2/28/2025 at 2:16 PM It was reported to this nurse just now that resident took the window alarm apart in room [ROOM NUMBER] yesterday (2-27-25). As I was just made aware I immediately reported it to the facility administrator. Resident was just in the room across the hall from his (room [ROOM NUMBER]) taking clothing that belongs to another resident from the closet. He also pulled the call light cord out of the wall and put it in his bag that he packs and carries around. Resident was directed into his own room and educated about taking other resident's belongings. He will not accept the direction. (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 03/28/2025 at 9:25 AM, the DON said she was on vacation the week Resident #1 eloped from the facility and her ADON was the person the staff reported the incident to. She said Resident #1 had been transferred on the morning of 03/14/2025 to an inpatient psychiatric facility out of state. She said he had returned to the facility on the evening of 03/27/2025. She said he was on 1:1 monitoring before he transferred and was placed on 1:1 monitoring when he returned. During an interview on 03/28/2025 at 10:10 AM CNA A said she worked the memory care unit from 6AM-6 PM. She said she checked residents every hour to see if residents were in their rooms they are assigned to. She said residents wander in and out of each others rooms sometimes. She said they have to make sure every resident was present on the secure unit. She said she was working the day Resident #1 eloped. She said she saw him at lunch. She said lunch was over a little before 1:00 PM and she was going to start her showers assigned. She said Resident #1 was in front of the linen closet and she had to ask him to move so she could get towels for the showers. She said there was an LVN assigned to the unit but did not know if she was on the unit at the time of the elopement. She said the charge nurse came on and off the unit. She said she finished her showers about 2:00 PM. She said while in the shower area she could not hear anything happening on the unit. She said after the showers she was sitting at the dining room door where she could see the dining room residents and the hallway. She said there were 4 residents in the dining room that were almost 1:1 because they tended to stand and fall. She said she assumed Resident #1 was in his room taking a nap because that was what he usually did after lunch. She said Resident #1 did go in and out of other rooms and rummaged in the closets and drawers of other residents at times. She said it was about 4:30 PM and close to supper time and she went down to his room to bring him to the dining room. She said Resident #1 lived in room [ROOM NUMBER] and was not in his room. She said she opened the closed door on unoccupied room [ROOM NUMBER] and found the window broken. She said she immediately reported the broken window to the ADON. She said staff began an immediate sweep of the secure unit and Resident #1 was not found. She said Resident #1 was on 1:1 monitoring before he was transferred to the inpatient psychiatric facility. She said he had returned to the facility on [DATE] and had a staff member assigned to sit in the room with him 1:1 and document where he was and what he was doing every 15 minutes. She said he had been asleep most of the morning except he did get up and eat breakfast. During an interview and observation on 03/28/2025 at 10:45 AM, CNA B was sitting in room [ROOM NUMBER] at the foot of Resident #1's bed. Resident #1 was observed covered with a sheet and sleeping. She had a clipboard with log sheets with a check list for every 15 minute checks. She said they started the checks immediately upon Resident #1's return to the facility. She said she started her tour at 8:00 AM. She said the observation and documentation was to continue until they were told to stop. She said he had been sleeping except for getting up to eat breakfast. The toilet tank lid in the bathroom was secured with 2 zip-ties (0.25 wide) to keep the lid from being removed. The thumb locks and window alarms were present and intact on the window. During an observation on 03/28/2025 at 11:05 AM room [ROOM NUMBER] window secured with alarm and thumb locks. room [ROOM NUMBER], across the hall, window had been replaced and was secured with alarm and thumb locks. During an observation on 03/28/2025 at 11:06 AM the glass exit door at the end of the hall (adjacent to rooms [ROOM NUMBERS]) was observed to be a fenced in patio area for the secure unit's use. A construction site for homes being built was observed across the street with workmen present along with their personal vehicles. (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 03/28/2025 at 11:10 AM CNA C said she had worked on the secure unit as well as other halls in the facility. She said she worked mostly the day shift (6AM-6PM). She said she was not working the day Resident #1 eloped. She said he had tried to leave through the doors on occasion but was always re-directed by staff. She said she had never seen him take any object and try to break the glass door or windows. She said when 2 aides are on the unit, while one is doing her showers the other one aide was on the hall and then they switch so the other aide can do her showers. She said when they had a nurse on the unit instead of an aide the nurse stayed on the hall while the aide did her showers. She said between breakfast and lunch she usually checked where residents were twice and then after lunch until supper she checked for residents 2-3 times. During an interview on 03/28/2025 at 11:20 AM the ADON said she had been the ADON for almost 3 years. She said she did not remember exact times but on 03/13/2025 CNA A told her Resident #1 was gone. She said it was about supper time. She told her the window had been broken out in room [ROOM NUMBER] on the secure unit. She said the toilet tank lid in room [ROOM NUMBER] had been placed neatly on the floor under the window and was not broken. She said they did an immediate head count in the general population areas of the facility and in the secure unit. Resident #1 was the only resident missing. She said she had staff start searching the grounds on foot and in cars while she notified the administrator, the medical director and the police. She said no one found the resident and when talking with persons living in the area no one had seen anyone fitting his description. She said there were no people or vehicles at the construction site at the time of the search. She said the first officer that responded made a tour in his vehicle around the immediate area. She said the second officer that responded recognized the resident from the picture provided. He said he was at one of the local hospitals. She said the medical director had called both hospitals to see if Resident #1 had been admitted and he had not been admitted . She said the police department had taken him to one of the hospitals and he was not admitted but still in the emergency room . She said the facility picked the resident up from the hospital and returned him to the facility. She said he was placed on 1:1 monitoring until he was transferred to inpatient psychiatric hospital the next day. She said the resident was assessed upon his return and he had no injuries other than 2 small scratches on his fingers. She said she had scheduled staff for 24-hour coverage to monitor Resident #1 through the weekend and would begin searching for coverage for Monday if it was needed. She said she was directed to schedule 1:1 monitoring and continue until she was told to stop. She said the facility was trying to secure alternate placement at the time. She said the usual rounding pattern was every 2 hours to account for residents. She said the expectation now was to make rounds and head count every 1 hour. She said all staff have been inserviced on elopement risk, elopement prevention and elopement drills have been conducted. She said she was told after the elopement Resident #1 knew how to remove the thumb locks and disable the window alarms. She did not say who told her this information. During an interview on 03/28/2025 at 12:25 PM the RN Compliance Nurse came to the facility when Resident #1 was reported missing on 03/13/2025. She said the ADON notified her at 5:09 PM. She said an administrator at another facility called and said Resident #1 was at the hospital. She said to her knowledge she did not know Resident #1 could disable the window alarms and remove the thumb locks on the windows. She said she saw the broken window and the toilet tank lid was placed under the window and was unbroken. (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 03/28/2025 at 12:40 PM CNA A said she told the office (DON, ADON, Administrator) Resident #1 knew how to disable the alarms and knew how to undo the window thumb locks. She said she had seen him peel off the window alarms in one room and put it in his sock. She said she did not remember exactly when she told them but it had been a while ago. She said maintenance came every so often and checked the windows for the alarms and thumb locks. During an interview on 03/28/2025 at 12:45 PM the DON said she had never been told Resident #1 could disable the alarms and thumb locks on the windows. During an interview on 03/28/2025 at 12:50 PM the former administrator said she was informed Resident #1 was missing from the facility at 5:02 PM on 03/13/2025. She said at the time no one knew how long he had been gone from the facility. She said no one told her the resident knew how to disable the alarms on the windows and remove the thumb locks. She said the resident was found at the hospital where he had been taken by the police department at around 1:10 PM. She said the resident had got inside a pickup truck at a nearby construction site and the owner had called the police. She said she had put in her 30-day notice on 02/12/2025 and her last day had been 03/14/2025. She said before she left she made sure staff were inserviced on elopement and the toilet lids were secured. She said her expectation was to follow the facility policy on making rounds to check on residents but said the secure unit hall was short and took little time to round the hall. During an interview on 03/28/2025 at 1:15 PM LVN D said she was charge nurse for the secure unit and another hall the day Resident #1 eloped. She said she saw Resident #1 walking down the hall after lunch. She remembered he was wearing a gray shirt and gray pants. She said at that time he did not appear to be exit seeking, just going toward his room after eating lunch. She said she had just been on the unit for 2 days so did not know all the residents really well. She said around supper time she was notified the resident was missing. She said the facility was immediately searched. She said she was off duty but still at the facility when the resident returned, and he was placed on 1:1 monitoring. During an interview on 03/28/2025 at 3:05 PM the RN Compliance Nurse said the facility did not have a specific policy on making rounds on residents at the facility. She said after the elopement the expectation was to monitor every hour. She said initially there was a head count every 15 minutes from the evening of 03/13/2025 until the morning of 03/14/2025 when Resident #1 was transferred to the inpatient psychiatric facility. She said then the checks were to be made every hour on all residents. She said window checks were also done every hour to make sure they were intact. She said that has continued while he was gone and when he returned on 03/27/2025. She said the every hour rounding would continue until Resident #1 discharged . She said at the time of the elopement all residents in the facility were assessed for elopement risk and any resident that was high risk had their care plans updated with new interventions is needed. During interviews on 03/29/2025 at 10:30 AM CNAs A and C said they had been trained to check on residents every hour until they are told to stop. They said they had been trained on elopement risk and elopement protocol. CNA A said Resident #1 had been discharged from the facility around 6:00 PM on 03/28/2025. During observations on 03/29/2025 beginning at 10:40 AM the secure unit windows were all intact with alarms and thumb locks. All toilet tank lids were secured with 2 zip-ties. Residents asleep in bed were noted to have fall mats on the floor at bedside and beds were in the lowest position. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility investigation report indicated the incident occurred on 03/13/2025 and was reported to the state agency on 03/13/2025. Resident #1 was last seen at 12:54 PM on 03/13/2025 after lunch. He was reported missing at 5:02 PM. Resident had used toilet tank lid to break window in room [ROOM NUMBER]. Resident was seen getting into a pickup by construction worker and police was called. Police picked up resident around 1:11 PM and taken to a local hospital emergency room . Resident returned to facility at 6:20 PM with no injuries noted. Resident placed on 1:1 monitoring until transferred to inpatient psychiatric facility for further evaluation on 03/14/2025 at 10:45 AM. Review of typewritten note of previous administrator dated 03/13/2025 indicated she was notified of Resident #1's elopement by the ADON. She indicated the window had been broken with the toilet tank lid. Immediate search of the facility and grounds began and police were notified at 5:06 PM. Resident returned to facility at 6:20 PM. Resident on 1:1 monitoring, elopement risk assessments done, skin assessment done, all toilet lids were secured on secure unit, broken window was secured and hourly checks on residents and windows begun. Local police department informed former administrator Resident #1 was picked up at 1:11 PM. Former administrator went to construction site and found [NAME] who confirmed a black man had gotten into his pickup and he had called the police. Review of a handwritten statement dated 03/13/2025 the speech therapist had completed lunch observations and therapy with Resident #1 around 12:20 PM. The therapist continued therapy swallowing precautions training with the resident. Resident #1 was left in dining room after therapy session. Review of a handwritten statement dated 03/13/2025 indicated LVN D saw Resident #1 at approximately 12:54 PM Review of a handwritten statement dated 03/13/2025 indicated the occupational therapist returned Resident #3 (roommate) to his room about 3:30 PM and Resident #1 was not in his room. Review of handwritten statement dated 03/13/2025 CNA A indicated after picking up lunch trays around 12:50 PM she saw Resident #1 in front of the linen closet and asked him to step away so she could get some towels for showers. She thought she saw him later in the afternoon with a group of residents by the glass exit door. She said when searching rooms looking for him she found the broken window and reported him missing. Review of facility Elopement Prevention Policy dated 10/27/2010 indicated Every effort will be made to prevent elopement episodes while maintaining the least restrictive environment for residents who are at risk for elopement.Physical Plant 1. All facility exits that residents have access to will have a device in place to alert staff of possible elopement attempts.keypad exit magnetic locks, secured unit, .3.All exit devices will be maintained by the manufacturer's recommendations and function of each door device will be verified weekly and a log maintained. Staff Training: Staff will receive training during their orientation process and then annually regarding: elopement prevention, operation of all exit devices, and actions to take if elopement occurs. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of facility Elopement Response Policy dated 10/27/2010 indicated Nursing personnel must report and investigate all reports of missing residents. When an elopement has occurred or is suspected, our elopement response plan will be immediately implemented.4. Should an employee discover a resident is missing from the facility, he/she should: A. report to the charge nurse .C. make a thorough search of the building and premises. If not located: D. notify Administrator and Director of Nursing; E. notify responsible party; F. notify attending physician; G. notify . Area Director of Operations . Facility took the following actions to correct the noncompliance prior to surveyor entrance: Review of documentation of training of all staff conducted beginning 03/13/2025 after the elopement for Elopement Prevention, Elopement Response, Abuse and Neglect. Review of electronic records indicated all residents were assessed for elopement risk on 03/13/2025. Elopement risks were identified and updated if necessary due to increased need for observation. Care plans were updated as necessary with additional interventions. Review of documentation beginning 03/13/2025 and ongoing for head count on residents every hour. Resident #1 and other secure unit residents on every 15 minute checks beginning 03/13/2025 at 6:30 PM and continuing until 03/14/2025 at 10:45 AM when Resident #1 discharged to inpatient psychiatric facility. Elopement drills to be conducted monthly on different shifts and random hours of the day. Review of elopement drill documentation indicated drills had been done. Surveyor verified the facility had corrected the noncompliance prior to survey entry through observations, record reviews and interviews.