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| 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 04/16/2025 |
| 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) |
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| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929</p> <p>Based on interview and record review, the facility failed to ensure each resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 10 residents (Resident #1) reviewed for reasonable accommodations.</p> <p>The facility failed to ensure Resident #1 was allowed to use his personal motorized wheelchair during his stay at the facility.</p> <p>This failure could place residents at risk for a loss of independence, decreased quality of life, self-worth, and dignity.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, dated 04/15/25, indicated he was a [AGE] year-old male, admitted to the facility on [DATE], and discharged on [DATE]. His diagnoses included spastic quadriplegic cerebral palsy (a severe form of cerebral palsy that affects all four limbs, leading to paralysis and muscle stiffness), and chronic kidney disease (a long-term condition where the kidneys are damaged and can't filter blood as effectively, leading to a buildup of waste and fluids in the body).</p> <p>Record review of Resident #1's MDS assessment, dated 02/21/25, indicated he had a BIMS score of 15, which indicated intact cognition. The assessment indicated he used a motorized wheelchair prior to his admission. He had impairment of one of his upper extremities, and both of his lower extremities.</p> <p>During an interview on 04/15/25 at 1:05 PM, the ADON said the facility did not allow the residents to use motorized wheelchairs in the facility. She said this had been in effect since before the current corporate entity took over. She said it has always been this way.</p> <p>(continued on next page)</p> |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 04/15/25 at 1:18 PM, the ADON said Resident #1 had Cerebral Palsy. She said when he admitted to the facility, he used a wheelchair for mobility. She said he had poor trunk control. She said she did not think he was able to move the wheelchair on his own and had to be propelled when he wanted to be moved. She said he required substantial to maximal assistance with mobility. She said a previous administrator disallowed the motorized wheelchairs because of a previous resident that was unsafe with the motorized wheelchair. She said from then on they would allow the residents to use a motorized wheelchair, provided that they were assessed to be safe to use the motorized wheelchair.</p> <p>During an interview on 04/15/25 at 2:00 PM, Resident #1 said the facility did not let him use his motorized wheelchair. He said when he arrived, he told the facility that his motorized wheelchair was on the way, and the facility staff did not allow him to use his motorized wheelchair. He said he did not have the strength to move his facility provided wheelchair. He said he did not like having to wait on staff to help him. He said he was used to being independent. He said it felt like they were taking away his independence. He said he was in the facility for about a week. He said he was frustrated about it while he was in the facility. He did not recall who specifically did not allow him to use his motorized wheelchair.</p> <p>During an interview on 04/16/25 at 9:43 AM, the ADON said the risk to not allowing residents to use motorized wheelchairs was that residents would have to depend on staff for care and could lose their sense of independence</p> <p>During an interview on 04/16/25 at 9:56 AM, RNC A said she expected the facility to allow the resident to use his motorized wheelchair. She said they required a safety assessment with therapy, and the motorized wheelchair should be in working condition. She said the facility was under the impression they did not allow wheelchairs from an administrator about 4 administrators ago. She said not allowing a resident to use their motorized wheelchair could affect their dignity and diminish their sense of independence.</p> <p>During an interview on 04/16/25 at 10:14 AM, the Administrator said she was not working in the facility during Resident #1's stay. She said she expected the staff to allow the motorized wheelchair as long as they are assessed by the therapy department, and were found to be safe. She said the risk was that it was possible the resident could feel isolated from the building, socialization, and activities if they were not allowed to use their motorized wheelchair.</p> <p>Record review of the facility's undated policy, Resident Rights, stated:</p> <p>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy.</p> <p>A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident .</p> <p>.Respect and dignity - The resident has a right to be treated with respect and dignity, including: .</p> <p>(continued on next page)</p> | | |

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| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>.2. The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.</p> <p>3. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents .</p> <p>Record review of the facility's policy, Electric or Motorized Wheelchair, last revised 02/27/15, stated:</p> <p>.A Medicaid and Medicare certified [Nursing Facility] must not discriminate on the basis of disability. A nursing facility that denies access and service to a potential resident may be found in noncompliance with state rules and federal regulations.</p> <p>It is out policy to ensure, to the best of our ability, the safety of residents who own and use an electric wheelchair, as well as the safety of all other resident's, staff and visitors in the facility. Therefore, resident's owning/using an electric wheelchair will be assessed on admission, quarterly and upon a significant change of condition for their ability to guide/drive the wheelchair .</p> <p>.The facility should allow a resident to store the power mobility device in the resident's room if there are no Life Safety Codes concerns, such as blocking or limiting egress .</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929</p> <p>Based on observation, interview, and record review, the facility failed to ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 10 residents (Resident #2) reviewed for accidents and supervision.</p> <p>The facility failed to ensure an oxygen cylinder found in Resident #2's room was properly stored.</p> <p>This deficient practice could place residents at risk of injury.</p> <p>Findings included:</p> <p>Record review of Resident #2's face sheet, dated 04/14/25, indicated he was an [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included pleural effusion (a condition where excessive fluid builds up in the space between the lungs and chest wall), heart failure (occurs when the heart can't pump enough blood to meet the body's needs), and end stage renal disease (the most severe stage of chronic kidney disease where the kidneys can no longer adequately filter waste from the blood).</p> <p>Record review of Resident #2's admission MDS assessment, dated 04/11/25, indicated he had a BIMS score of 13, which indicated intact cognition.</p> <p>During an observation and interview on 04/14/25 at 2:25 PM, Resident #2 was lying in bed in his room. There was an oxygen tank upright on the floor in this room. The oxygen tank was not in a caddy. Resident #2 said he was not sure how long the tank had been in his room on the floor.</p> <p>During an observation on 04/14/25 at 3:10PM, the oxygen tank was still in Resident #2's room on the floor. It was not in a caddy.</p> <p>During an observation and interview on 04/14/25 at 3:26 PM, this surveyor observed LVN B carry the oxygen tank out of Resident #2's room. She said the oxygen tank should have been stored in a caddy while it was in the resident's room. She said it should have been in a caddy while she moved it down the hallway. She said the tank could hurt someone if it fell down or was knocked over.</p> <p>During an interview on 04/16/25 at 8:37 AM, the Maintenance Supervisor said the oxygen tanks should be stored in a carrier or in the storage room. He said they should never be stored directly on the floor. He said the risk was a potential explosion.</p> <p>During an interview on 04/16/25 at 9:43 AM, the ADON said she expected the oxygen tanks to be stored in the oxygen room or in a caddy. She said the tank could hurt someone or cause damage if it was knocked over.</p> <p>During an interview on 04/16/25 at 9:56 AM, RNC A said she expected the storage tanks to be secured so they do not fall over. She said the risk was that the tank could potentially hurt someone.</p> <p>(continued on next page)</p> |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 04/16/25 at 10:14 AM, the Administrator said the oxygen tanks should be stored properly and kept on a cart. She stated they should never be out on the floor. The Administrator stated they could also be stored in a caddy. She said the tank could be knocked over and a resident could potentially get hurt.</p> <p>Record review of the Facility's policy, Safe Handling Of Compressed Gases, last revised 12/10/15, stated:</p> <p>.11 . When tanks are stored, all tanks and cylinders should be stored in a cylinder cart or securely chained in a secure storage area. Never leave cylinders free-standing. All cylinders must be individually secured .</p> |

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| <p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents could call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside for 1 of 10 residents (Resident #4) reviewed for the ability to call for staff assistance.</p> <p>The facility failed to ensure Resident #4 had a call light that was functional. Resident #4's call light did not turn on when the button was pressed.</p> <p>This failure could place residents at risk for a delay in assistance and decreased quality of life, self-worth, and dignity.</p> <p>Findings included:</p> <p>Record review of Resident #3's face sheet, dated 04/15/25, indicated she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included chronic obstructive pulmonary disease (a condition caused by damage to the airways or other parts of the lung).</p> <p>Record review of Resident #3's admission MDS assessment, dated 04/11/25, indicated she had a BIMS score of 15, which indicated intact cognition.</p> <p>Record review of Resident #4's face sheet, dated 04/15/25, indicated she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included dementia (loss of brain function, including memory, thinking, language, judgment, or behavior, that interferes with daily life), heart failure (occurs when the heart can't pump enough blood to meet the body's needs), and major depressive disorder (a serious mental illness that involves persistent feelings of sadness and loss of interest in activities).</p> <p>Record review of Resident #4's quarterly MDS assessment, dated 03/05/25, indicated she had a BIMS score of 7, which indicated severe cognitive impairment. She had impairment of all four extremities. She was completely dependent on staff for toileting, bathing, lower body dressing, personal hygiene, and bed-to-chair transfers. She required maximal assistance with upper body dressing, roll left and right, sit to lying, and lying to sitting on side of bed. She was always incontinent of both bowel and bladder.</p> <p>Record review of Resident #4's care plan, dated 04/01/25, indicated a focus of the resident was dependent on staff for activities, cognitive stimulation, social interaction related to cognitive deficits, disease process, and physical limitations. Interventions included ensure that adaptive equipment that the resident needs is provided and is present and functional.</p> <p>During an interview 04/15/25 at 10:17AM, Resident #3 was sitting up in bed watching TV. She said her roommate Resident #4's call light had not been working for around 2 weeks. She said while she was in the room, if Resident #4 needed anything, then she would press her own call light for Resident #4.</p> <p>(continued on next page)</p> | | |

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| <p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an observation and interview on 04/15/25 at 10:22AM, Resident #4 was lying in bed resting. She asked this surveyor if she could be changed. This surveyor pressed her call light to call for a staff member. The light did not turn on. This surveyor asked her roommate Resident #3 to press her light and it then came on.</p> <p>During an observation and interview on 04/15/25 at 10:27AM, CNA C came into Resident #3 and Resident #4's room and answered the call light. She attempted to press the call light on Resident #4's side and it did not come on. She said she would notify the maintenance department. She said the risk to the resident was that she would be unable to call for help if she needed something or if she fell and needed help.</p> <p>During an interview on 04/16/25 at 8:37AM, the Maintenance Supervisor said he checked the call lights in at least 5 rooms each week. He said he checks the call light panel at the nurse's station daily. He said if he notices an issue, then he checks on the lights right away. He said he was not aware of the light not working in Resident #4's room before this surveyor noticed it was not working. He said he replaced the call light cord in Resident #4's room and it was functional at that time. He said the risk to the resident was they could fall and get hurt and be unable to call for help. He said someone could have a nursing related issue and be unable to call for help. He said he had worked in the facility since the end of February. He said he was unaware of the last time the call light was checked because it would have been before he started working there. He said they use a maintenance request program to request the maintenance director to check things. He said he had not received a request for the call light in Resident #4's room.</p> <p>During an interview on 04/16/25 at 9:43AM, the ADON said she was not aware of the call light in Resident #4's room not working before this surveyor pointed it out. She said it was replaced and was working. She said the cable was bad and not working. She said the risk was that the resident could miss care she wanted due to not being able to turn on the light. She said it was possible the resident could fall and not be able to call for help.</p> <p>During an interview on 04/16/25 at 9:56AM, RNC A said she expected the call light to be functional. She said she expected the call light, if it was not working, to be communicated to the maintenance director to be addressed immediately. She said the risk was that the resident's needs could not be met timely. She said it was possible the resident could fall and not be able to call for help.</p> <p>During an interview on 04/16/25 at 10:14AM, the Administrator said she expected the call lights to be functional at all times. She said if it was not working, then staff should notify maintenance immediately. She said the risk was that the resident could need assistance and the staff would not know to come help her. She said it was possible the resident could fall and be unable to get help.</p> <p>Record review of the facility's undated Life Safety Binder stated:</p> <p>.Call Lights - Check 2 rooms a hall weekly and 100% before full book .</p> <p>Record review of a sheet titled Call Lights Check, dated 03/03/25 through 04/15/25, indicated Resident #3 and Resident #4's room call lights were checked on 04/15/25. There were no other dates for Resident #3 and Resident #4's room.</p> | | |