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	07/16/2025

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 8 residents (Resident #1) reviewed for adequate supervision.The facility failed to prevent Resident #1 from causing a burn proximal red area 5CM x 9CM, distal red area with blister 3CM X 8CM herself with coffee on 4/23/25 while she was in bed and not providing a lid for her cup. The facility failed to keep coffee available to residents or served to residents at a safe temperature.These failures resulted in the identification of an Immediate Jeopardy (IJ) on 07/15/25 at 12:09 PM. While the IJ was removed on 07/16/25 at 08:47 AM, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.This failure could place residents at risk for injury, harm, and impairment or death.Findings included: Record review of Resident #1's face sheet, dated 08/12/24, indicated she was an [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included Dementia (an umbrella term for a decline in mental abilities severe enough to interfere with daily life), Polyneuropathy (a condition where multiple peripheral nerves are damaged, causing a range of symptoms due to impaired nerve function), Muscle Weakness (a reduced ability to generate force). Record review of Resident #1's Annual MDS assessment, dated 04/11/25, indicated she had a BIMS score of 14, which indicated Resident #1 was cognitively intact. She was able to make herself understood and she was able to understand others. Resident #1's MDS reflected that she was independent on eating and drinking. Record review of Resident #1's care plan dated 6/6/2025 indicated that there was a focus area for Resident #1, risk of burns due to hot liquids and generalized weakness created on 11/1/2024. Furthermore, the care plan reflected the goal indicated that Resident #1 would not suffer any injury related to hot liquids, created on 11/1/2024. The care plan interventions were as follows: -Coffee and other hot liquids should not be served if over 140 degrees Fahrenheit Date Initiated: 11/01/2024Revision on: 11/04/2024.-DietIf hot liquid is spilled on self, staff should pour room temperature or lower templiquid on the affected area of the residentDate Initiated: 04/23/2025 -CNAResident to use a cup with a lid for hot liquids/coffeeDate Initiated: 11/01/2024Revision on: 11/06/2024 -CNAResident to use the dominant hand for drinkingDate Initiated: 04/23/2025Should be seated in upright position with table or overbed table when hot liquids arebeing consumedDate Initiated: 04/23/2025Record review of Resident #1's post incident assessment dated [DATE] revealed that Resident #1 had a burn proximal red area 5CM x 9 CM, distal red area with blister 3CM X 8CM. Shows that a new order was received to treat Resident #1's burn, Cleanse with normal saline, pat dry. Apply Silvadene ointment and cover with dry dressing. Change daily until resolved. Record review of Resident #1's progress note dated 4/23/25 revealed that Resident #1 told the Social Worker that she spilled coffee onto her abdomen and burned herself. Shows that the facility notified the resident's physician and the residents representative. Showed that the facility received new orders and updated Resident#1's care plan. Record review of facility provider investigation report dated 4/23/25 shows that the facility self-reported the incident, notified the resident's physician and received new orders, notified the resident representative, notified the incident to the Texas Health and Human Services Commission and the incident was investigated. The provider investigation report shows that Resident #1 was able to give a statement saying that she accidently burned herself when she spilled coffee into her stomach. Provider investigation report shows that the facility completed in-services regarding hot-liquids and residents at risk for burning themselves. Shows that the residents in the facility who were at risk were specifically named. Shows that staff across all disciplines were in-serviced. Record review of an undated written statement provided to the Administrator from the Social Worker, who first noticed the burn: On the morning of 4/23/25, I entered [Resident #1's] room to gather a box of hospice supplies that were left in her room. Upon entering her room, I noticed her glass of milk had been dropped on the floor and the milk was under her bed. I mentioned it to [Resident #1], and she told me she had spilled her milk and coffee when she tried to pull her overbed table closer to her. She was using her blanket to wipe the coffee off of her. I noticed that she was wiping her stomach with her blanket. I observed some redness to her stomach where the coffee had spilled. I immediately found her nurse and reported it to her, then went back to get some dry blankets on her. Record review of a written statement dated 4/23/25 provided to the Administrator from LVN B, who delivered the breakfast tray to Resident #1 On 4/23/25 at breakfast [LVN B] TX Nurse delivered [Resident #1's] breakfast tray. [Resident #1] requested