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	09/13/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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

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	09/13/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner that promotes maintenance or enhancement of her quality of life for 1 of 25 residents (Resident #15) reviewed for resident rights. The facility failed to ensure LVN M spoke to Resident #15 in a respectful and dignified manner on 8/21/25. This failure could place residents at risk for decreased quality of life, quality of care, and self-esteem. Findings included: Record review of Resident #15's face sheet dated 9/8/25 indicated Resident #15 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #15 had diagnoses including fibromyalgia (is a long-term condition that involves widespread body pain), low back pain, major depressive disorder (a persistently low or depressed mood and a loss of interest in activities that you used to enjoy), and anxiety (intense, excessive, and persistent worry and fear about everyday situations). Record review of Resident #15's quarterly MDS assessment dated [DATE] indicated Resident #15 had clear speech, adequate hearing and vision. Resident #15 was understood and had the ability to understand others. Resident #15 had a BIMS score of 15 which indicated intact cognition. Resident #15 was independent for eating, oral hygiene, and toilet hygiene, partial assistance for shower/bathe self and personal hygiene. Resident #15 received scheduled pain medication regimen. Record review of Resident #15's care plan dated 5/25/22, revised on 9/13/24 indicated Resident #15 had the potential for psychosocial well-being concerns. Intervention included increase communication between resident/family/caregivers about care and living environment. Explain all procedures and treatments, medications, results of lab/test, condition, all changes, rules, and options. Record review of Resident #15's event nurses' note-behavior dated 8/22/25 indicated, .resident room. verbal, resident to staff, alleged behavior. oriented/no problem, agitated. No documentation noted to determine writer. Record review of Resident #15's Other note by the DON, dated 8/22/25 at 1:50 a.m. indicated, . Charge nurse [LVN M] state that she attempted to explain and educate the resident on why she could not administer her missed evening medications at the same time of her night medications, but the resident [Resident #15] started yelling at her. Resident #15 state that the charge nurse was verbally abusive to her when she was requesting for the charge nurse to give her missed evening medications at the same time of her night medications. Record review of Resident #15's progress note dated 8/22/25 by LVN M at 9:37 a.m. indicated, . CNA to this nurse that resident [Resident #15] was upset because she didn't get her 3pm Oxycodone.Informed CNA I[LVN M] would go down to speak with her[Resident #15].I [LVN M] entered the resident [Resident #15] room with PM medications in hand.Greeted resident asked how I could assist her. the resident [Resident #15] immediately began yelling.this nurse [LVN M] to resident [Resident #15] I understand your anger and frustration however I cannot administer any medication that was due prior to my shift.I [LVN M] voiced understanding then informed resident [Resident #15] that I have explained to her several times and at this time I will not continue to go back and forth. Record review of Resident #15's PIR dated 8/27/25 indicated, . 8/22/25 at 5:00 a.m.resident room.interviewable. alleged perpetrator.LVN M. denied. Resident #15 stated she did not receive 4:00 pm medications, and LVN M would not administer the 4:00 pm in addition to the 6:00 am medication. Resident #15's behavior was upset about missing the medications. Record review of an undated facility's investigation summary by the ADM indicated, .on the morning of August 22, 2025, this writer [ADM] was informed that Resident #15 informed the AIT that she was verbally abused by LVN M because she refused to administer her 4:00 a.m. pain medications in addition to the 6:00 a.m. pain medication at the same time. Resident #15 reported that LVN M was screaming and clapping her hands at her as she was speaking and still refused to administer the pain medication. the writer interviewed LVN M. LVN M stated that she was not screaming at the Resident [Resident #15]. She [LVN M] stated that she was trying to explain to the Resident [Resident #15] that her 4:00 medications should have been on the previous shift. She [LVN M] explained that she cannot legally administer pain medications that were due on the previous shift. She [LVN M] stated that she offered to administer the 6:00 medication, but the Resident [Resident #15] refused. During an interview on 9/8/25 at 5:04 p.m., Resident #15 said she did not get her Gabapentin and Oxycodone at 4 p.m. on 8/21/25. She said she woke up around 5:30 p.m. in pain. She said she had called the front desk at 6:15 p.m. and 6:40 p.m., asking for her 4 p.m. medications. She said LVN M did not show up until almost 10:00 p.m. She said she was so upset. She said she and LVN M both raised their voices at each other. She said LVN M was clapping her hands at her. She said she did not like how

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	09/13/2025

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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	09/13/2025

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 0580 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 interview and record review, the facility failed to consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 of 25 residents (Resident #6) reviewed for quality of care.The facility failed to notify the physician when Resident #6 experienced low blood pressure, low heart rate and/or low blood pressure with an increased heart rate on 7/16/25, 7/18/25, 7/20/25, 7/21/25, 7/23/25, 7/25/25, 7/26/25, 7/27/25, 7/28/25,7/29/25, 7/30/25, and 8/1/25. On 8/1/25, Resident #6 had low hemoglobin 5.8 and low hematocrit 21.6. Resident #6 was sent to the ER due to critical lab values. Resident #6 was admitted and diagnosed with gastrointestinal hemorrhage. Resident #6 received a blood transfusion at the hospital. An Immediate Jeopardy (IJ) was identified on 9/11/25. The IJ Template was provided to the facility on 9/11/25 at 2:01 p.m. While the IJ was removed on 9/12/25 at 4:40 p.m., 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 that was not immediate jeopardy due to the facility's need to complete training in-services with all staff and evaluate the effectiveness of the corrective systems. This failure could place residents at risk of a decline in condition, delay in life-saving treatments, hospitalization, serious harm, and death. Findings included: Record review of Resident #6's face sheet dated 9/8/25 indicated Resident #6 was an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #6 had diagnoses including Dementia (is a general term describing a group of conditions that cause a progressive decline in cognitive abilities, including memory, thinking, reasoning, and judgment, which interfere with daily life), gastrointestinal hemorrhage (is when there is blood loss from any of the several organs included in your digestive system), iron deficiency anemia (is a common blood disorder that affects your red blood cells) secondary to blood loss (chronic), hypertension (is when the pressure in your blood vessels is too high (140/90 mmHg or higher)), and acute embolism and thrombosis of deep veins of right lower extremity (is a condition where a blood clot forms in a deep vein, often in the leg). Resident #6's most recent hospital stay was 8/1/25-8/5/25. Record review of Resident #6's quarterly MDS assessment dated [DATE] indicated Resident #6 was sometimes understood and sometimes had the ability to understand others. Resident #6 had a BIMS score of 2 which indicated severe cognitive impairment. Resident #6 required supervision for eating, substantial assistance for oral and personal hygiene, and dependent for toileting hygiene, shower/bathe self and dressing. Resident #6 was on an anticoagulant (is a medical treatment that prevents blood clots from forming). Record review of Resident #6's care plan dated 3/5/25 indicated: *Resident #6 was on an anticoagulant therapy. Intervention included monitor/document/report to MD signs/symptoms of anticoagulant complications such as lethargy, loss of appetite, sudden change in mental status, and significant or sudden changes in vital signs. *Resident #6 had a diagnosis of hypertension. Intervention included give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (is a condition where blood pressure drops significantly upon standing up from a sitting or lying position) and increased heart rate and effectiveness. Record review of Resident #6's order summary dated 8/1/25 indicated: *Eliquis (anticoagulant) Oral Tablet 5 MG, give 1 tablet by mouth two times a day related to acute embolism and thrombosis of deep veins of right lower extremity. Start date 3/4/25. *Lisinopril (antihypertensive; treats high blood pressure) Oral Tablet 5 MG, give 1 tablet by mouth one time a day related to hypertension. Hold for systolic blood pressure (is the pressure when your heart beats to pump blood around your body) below 100, diastolic blood pressure (measures the pressure on blood vessel walls when your heart is relaxed between contractions) below 55 or heart rate less than 50. Start date 3/5/25. *Metoprolol Tartrate (antihypertensive; treats high blood pressure) Oral Tablet 50 MG, give 1 tablet by mouth two times a day related to hypertension. Hold for systolic blood pressure below 100, diastolic blood pressure below 55 or heart rate less than 50. Start date 3/5/25. Record review of Resident #6's medication administration record dated 7/1/25-7/31/25 indicated: *Eliquis (anticoagulant) Oral Tablet 5 MG, give 1 tablet by mouth two times a day related to acute embolism and thrombosis of deep veins of right lower extremity. Resident #6 received 61 out of 62 doses. *Lisinopril (antihypertensive; treats high blood pressure) Oral Tablet 5 MG, give 1 tablet by mouth one time a day related to hypertension. Hold for systolic blood pressure below 100, diastolic blood pressure below 55 or heart rate less than 50. Resident #6's MAR indicated (AM) 7/16/25 (BP: 118/63, HR: 98) MA B, 7/18/25 (BP: 90/65, HR: 88) MA X; Vitals Outside of

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	09/13/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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	09/13/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 20 of 25 (Resident's #2, #4, #5, #6, #8, #9, #10, #12, #13, #14, #16, #17, #18, #19, #20, #21, #22, #23, #24) reviewed for abuse and neglect. 1. The facility failed to ensure LVN D did not physically abuse Resident #4 when she picked her up from her wheelchair and threw her on to the mattress on the floor on 07/17/25. Resident #4 sustained a bruise to her right elbow and redness to the mid abdomen. 2. The facility failed to ensure LVN E did not verbally abuse Resident #9 when LVN E yelled and cursed at Resident #9 when she asked for pain medication on 08/17/25. 3. The facility failed to ensure Resident #12 did not physically abuse Resident #13 when he shoved her on 08/07/25 and on 08/23/25. On 08/23/25, Resident #13 sustained scratches to her face. 4. The facility failed to ensure Resident #5 was properly positioned during a tube feeding on 08/20/25. Resident #5's head and torso were leaning over the left armrest of his Geri-chair for approximately 1 hour and 30 minutes, which resulted in aspiration pneumonia. 5. The facility failed to ensure sufficient staff were available to provide wound care treatment and documentation for Resident's #2, #16, #17, #18, #19, #20, #23 and #24 during August 2025 and September 2025. 6. The facility failed to ensure Resident's #4, #6, and #19 were provided feeding assistance during mealtimes. 7. The facility failed to ensure the secured unit was adequately staffed to prevent accidents for Resident's #8, #10, #12, #13, #14, #19, and #21. 8. The facility failed to ensure Resident #7, Resident #8, Resident #14 Resident #21, and Resident #22 were provided supervision during the lunch meal on 09/08/25. An immediate jeopardy (IJ) was identified on 09/11/25 at 12:59 PM. The IJ template was provided to the facility on [DATE] at 2:01 PM. While the IJ was removed on 09/13/25 at 12:49 PM, the facility remained out of compliance at a scope of a pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all staff had not been provided education on abuse and neglect, notification of changes in condition, documentation policy, pain management policy, fall prevention policy, pressure prevention policy, medication administration policy, enteral feeding policy, and the bathing and showers policy. These failures could place residents at risk of abuse, humiliation, intimidation, fear, shame, agitation, decreased quality of life, serious harm, injury, impairment, and death.Findings included:1. Record review of a face sheet dated 09/17/25 indicated Resident #4 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Huntington's disease (an inherited condition in which nerve cells in the brain break down over time), schizoaffective disorder (a mental health condition including schizophrenia and mood disorder), anxiety disorder, abnormal weight loss, dysphagia (difficulty swallowing foods or liquids). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #4 understood others and was never/rarely understood by others. The MDS indicated Resident #4 had a BIMS score of 0 which indicated Resident #4 was severely impaired and unable to complete the interview. The MDS indicated Resident #4 required supervision and touching assistance with eating, and dependent for showering, toileting, hygiene and transfers. Record review of Resident #4's care plan with a revised date of 09/08/25 indicated Resident #4 had a history of falls due to Huntington's disease and required staff times two for transfers. Record review of Resident #4's Order Summary Report dated 09/17/25 indicated an order for mattresses on floor with walls and floor surrounding mattresses padded every shift dated 07/12/25. Record review of a Provider Investigation Report dated 07/17/25 at 07:09 PM, indicated Resident #4's family member come to the facility and reported that she saw on the camera that a staff member had brought Resident #4 to her room in her wheelchair and threw her down on the mattress. The facility completed skin and pain assessment and order x-rays. Documented facility follow-up action was to in-service staff members with 1:1 education and physical therapy in-service regarding transfer of residents, police department notified, safe surveys conducted, trauma assessments for all residents. Record review of skin assessment completed on 07/17/25 by LVN CC indicated Resident #4 had bruising on right elbow and redness to lower abdomen. Record review of written statement by LVN D dated 07/17/25, indicated after Resident #4 had finished eating, she was slipping out of her chair. LVN D returned Resident #4 to her room in the wheelchair. LVN D stated when she stood up Resident #4 and she pulled against her, and she let her go before she knew it and had tried to grab her. LVN D stated she did not want to fall on her. LVN D wrote she saw Resident #4 was ok and left to clean up the wheelchair. During an observation on 09/09/25 at 09:32 AM, Resident # 4 was laying on the mattress in room, Resident #4 was

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	09/13/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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	09/13/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident had the right to be free from misappropriation of property for 1 of 2 residents reviewed for misappropriation of property. (Resident #15) The facility failed to prevent a drug diversion (misappropriation) of Resident #15's Oxycodone 10 MG on 8/15/25. This failure could place residents at risk for decreased quality of life, unrelieved pain, misappropriation of property, and dignity.Findings included:Record review of Resident #15's face sheet dated 9/8/25 indicated Resident #15 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #15 had diagnoses including fibromyalgia (is a long-term condition that involves widespread body pain), and low back pain.Record review of Resident #15's quarterly MDS assessment dated [DATE] indicated Resident #15 had clear speech, adequate hearing and vision. Resident #15 was understood and had the ability to understand others. Resident #15 had a BIMS score of 15 which indicated intact cognition. Resident #15 was independent for eating, oral hygiene, and toilet hygiene, partial assistance for shower/bathe self and personal hygiene. Resident #15 received scheduled pain medication regimen. Resident #15 received opioids. Record review of Resident #15's care plan dated 3/23/22 indicated Resident #15 was on pain medication therapy related to fibromyalgia and wound. Intervention included administer medications as ordered. Record review of Resident #15's order summary report dated 8/1/25 indicated: Oxycodone Oral Tablet 10 MG (is used to relieve pain severe enough to require opioid treatment and when other pain medicines did not work well enough or cannot be tolerated), give 1 tablet by mouth five times a day for pain. Start date 8/8/25. Record review of Resident #15's MAR dated 8/1/25-8/31/25 indicated Oxycodone Oral Tablet 10 MG, give 1 tablet by mouth five times a day for pain. Times: 6am, 11am, 4pm, 9pm, and 1am. The MAR indicated on 8/15/25, Resident #15 received doses at 1am, 6am, 11am, 4pm, and 9pm. Record review of Resident #15's Individual Control Drug Record for Oxycodone 10 MG dated 8/8/25 indicated:*8/15/25 at 1am or 9am (notation of time is unclear), 1 pill given, 55 pills left, LVN E.*8/15/25 at (notation of time is unclear), 1 pill given, 54 pills left, LVN E.*8/15/25 at 6am, 1 pill given, 53 pills left, LVN E. *8/15/25 at 11am, 1 pill given, 52 pills left, MA B.*8/15/25 at 4pm, 1 pill given, 51 pills left, LVN Q*Unknown date at 8:26 pm, 1 pill given, 50 pills left, LVN LResident #15's Individual Control Drug Record reflected 6 administrations of oxycodone on 8/15/25. Resident #15 is scheduled for 5 oxycodone doses each shift (1am, 6am, 11am, 4pm, and 9pm). Record review of Resident #15's e-MAR report dated 9/9/25 provided by RCN EE indicated:*8/15/25: Scheduled for 1am, 1 tablet, given at 12:25 am by LVN E.*8/15/25: Scheduled for 6am, 1 tablet, given at 5:58 am by LVN E.*8/15/25: Scheduled for 11am, 1 tablet, given at 11:04 am by MA B. *8/15/25: Scheduled for 4pm, 1 tablet, given at 4:25 pm by LVN Q.*8/15/25: Scheduled for 9pm, 1 tablet, given at 8:25 pm by DON.Resident #15's e-MAR report did not reflect 6 administration times on 8/15/25 to correlate with the Individual Control Drug Record. Record review of a witness statement by the DON dated 8/15/25 indicated, .issue related to: medication administration error. on Friday, August 15th this nurse was notified around 2 pm by the CMA [MA B] and Treatment Nurse [LVN L] that LVN E had signed out too many Oxycodone for Resident #15 on the morning of August 15th. This nurse [DON] assessed the resident and asked her about this. Resident #15 state that [LVN E] administers her medications but not always at the right time. No adverse side effects or harm was done to the resident. Signature of witness: DON. Signature of Management Employee Obtaining Statement: ADM. During an interview on 9/9/25 at 9:46 a.m., MA B said she had been working at the facility for 2 years. She said she worked Hall C and D. She said on 8/15/25, she started the shift and counted Resident #15's oxycodone pills. She said she noticed an extra entry on the narcotic count sheet for Resident #15. She said when she asked LVN E about the extra entry, LVN E said she must have given Resident #15 too many pills. MA B said that did not seem right because Resident #15 counted her pills before she took them. She said she asked Resident #15 if LVN E gave her an extra oxycodone pill. She said Resident #15 said, no. She said she reported the issue to the ADM and DON. She said 8/15/25 was the first time she had noticed a medication administration issue from LVN E. She said LVN E had strange behaviors. She said LVN E moved around really fast all time. She said LVN E continued to work Hall D with Resident #15. She said she eventually was fired for another incident. Attempted telephone call to LVN E on 9/9/25 at 01:15 PM left a voice message and requested a call back. Attempted telephone call to LVN E on 9/9/25 at 07:49 PM left a voice message and requested a call back. During an interview on 9/10/25 at 9:45 a.m., LVN L said on 8/15/25, MA B reported to her that she did a shift-to-shift narcotic count

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	09/13/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all allegations of abuse and neglect had evidence that all alleged violations were thoroughly investigated and prevent further potential for 2 of 20 residents (Resident #15 and Residents #9) reviewed abuse, neglect and misappropriation. 1. The ADM and DON, failed to thoroughly investigate allegation of misappropriation of property, when LVN E documented an extra administration of Resident #15's oxycodone on 8/15/25. Resident #15 denied receiving an extra dose on 8/15/25. The ADM and DON, failed to provide evidence that Resident #15's incident on 8/15/25, with allegation of misappropriation of property, Oxycodone 10 MG, was thoroughly investigated. The facility failed to protect Resident #15 from potential further misappropriation of property after the allegation. LVN E continued to work from the date of the incident until suspension on 8/18/25. 2. The facility failed to protect Resident #9, after not thoroughly investigating Resident #15 incident on 8/15/25, from experiencing allegation of neglect from LVN E. LVN E failed to administer Resident #9 her pain medication as requested on 08/17/2025. The facility failed to investigate Resident #9's allegation of neglect when LVN E failed to administer Resident #9 her pain medication as requested on 08/17/2025. These failures could place residents at risk increased pain, decreased quality of life, and further abuse and neglect.Findings include: 1. Record review of a witness statement by the DON dated 8/15/25 indicated, “…issue related to: medication administration error… on Friday, August 15th this nurse was notified around 2 pm by the CMA [MA B] and Treatment Nurse [LVN L] that LVN E had signed out too many Oxycodone for Resident #15 on the morning of August 15th… This nurse [DON] assessed the resident and asked her about this… Resident #15 state that [LVN E] administers her medications but not always at the right time… No adverse side effects or harm was done to the resident… Signature of witness: DON… Signature of Management Employee Obtaining Statement: ADM…” Record review of LVN E's “Employee Disciplinary Report” dated 8/15/25 indicated, “…LVN E… date of Infraction: 8/15/25… written counseling… LVN E failed to adhere to the Corporate Code of Conduct by failing to meet their job duty/responsibility expectations… On 8/15/25, LVN E failed to administer medication correctly, resulting in a medication error…” Record review of Resident #15's face sheet dated 9/8/25 indicated Resident #15 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #15 had diagnoses including fibromyalgia (is a long-term condition that involves widespread body pain), low back pain, major depressive disorder (a persistently low or depressed mood and a loss of interest in activities that you used to enjoy), and anxiety (intense, excessive, and persistent worry and fear about everyday situations). Record review of Resident #15's quarterly MDS assessment dated [DATE] indicated Resident #15 had clear speech, adequate hearing and vision. Resident #15 was understood and had the ability to understand others. Resident #15 had a BIMS score of 15 which indicated intact cognition. Resident #15 was independent for eating, oral hygiene, and toilet hygiene, partial assistance for shower/bathe self and personal hygiene. Resident #15 received scheduled pain medication regimen. Resident #15 received opioids. (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	09/13/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #15's care plan dated 3/23/22 indicated Resident #15 was on pain medication therapy related to fibromyalgia and wound. Intervention included administer medications as ordered. Record review of Resident #15's “Individual Control Drug Record” Oxycodone 10 MG dated 8/8/25 indicated LVN E signed out administrations on 8/15/25, 8/16/25, 8/17/25, and 8/18/25. During an interview on 9/9/25 at 9:46 a.m., MA E said she had been working at the facility for 2 years. She said she worked Hall C and D. She said on 8/15/25, she started the shift and counted Resident #15's oxycodone pills. She said she noticed an extra entry on the narcotic count sheet for Resident #15. She said when she asked LVN E about the extra entry, LVN E said she must have given Resident #15 too many pills. MA E said that did not seem right because Resident #15 counted her pills before she took them. She said she asked Resident #15 if LVN E gave her an extra oxycodone pill. She said Resident #15 said, “no”. She said she reported the issue to the ADM and DON. She said 8/15/25 was the first time she had noticed a medication administration issue from LVN E. She said LVN E had strange behaviors. She said LVN E moved around really fast all time. She said LVN E continued to work Hall D with Resident #15. She said she eventually was fired for another incident. She said she did not recall receiving an in-service related to the incident on 8/15/25. Attempted telephone call to LVN E on 9/9/25 at 01:15 PM left a voice message and requested a call back. Attempted telephone call to LVN E on 9/9/25 at 07:49 PM left a voice message and requested a call back. During an interview on 9/10/25 at 9:45 a.m., LVN L said on 8/15/25, MA B reported to her that she did a shift-to-shift narcotic count with LVN E. She said MA B said the count with LVN E was not right. She said MA B reported there were too many entries for LVN E's shift. She said she could not quite remember LVN E exact words on what caused the discrepancy. She said LVN E reported to the effect, that she thought she gave Resident #15 her oxycodone but could not remember. She said one of Resident #15's oxycodone pills was missing and could not be accounted for. She said LVN E did not say she wasted or discarded one of Resident #15's oxycodone pills. She said she reported the incident to the ADM and DON. She said the DON went to Resident #15 to see if she had received pain medication. She said she did not know what Resident #15 had reported to the DON. She said Resident #15 counted and inspected her pills during medication pass. She said the incident with LVN E could have been a drug diversion. She said that was why she reported the incident to the ADM and DON. She said LVN E was an “abnormally strange” person. She said LVN E was eventually let go, but not for the incident on 8/15/25. She said she may have received abuse and neglect training after the incident. She said she did not recall training about medication administration and narcotic counts sheets. During an interview on 9/10/25 at 12:42 p.m., Resident #15 said she did not recall the incident on 8/15/25. She said sadly, she got asked about her pain medication all the time. She said she inspected and counted her pills before she took them. She said she would not have taken an extra oxycodone on 8/15/25. Attempted telephone call to LVN E on 09/10/2025 at 02:30 PM left a voice message and requested a call back. (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	09/13/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/25 at 8:57 a.m., requested a copy of Resident #15's investigation by email. The email was sent to the ADM and RCN EE. On 9/11/25 at 1:00 p.m., requested a copy of Resident #15's investigation from ADM. During an interview on 9/12/25 at 10:45 a.m., the DON said the incident on 8/15/25 with LVN E was reported by MA B. She said she told the ADM about the incident. She said the ADM was the Abuse Coordinator. She said the ADM told her to investigate the incident. She said she got a statement from MA B, spoke to Resident #15 and called LVN E. She said she did not get a written statement from LVN E about the incident on 8/15/25. She said when she questioned LVN E about the documented extra oxycodone dose on Resident #15; LVN E said she administered it at the right time but wrote down the wrong time. She said the incident on 8/15/25 could have possibly been a drug diversion. She said the staff did not report LVN E having any suspicious behaviors. She said she did not ask Resident #15 if LVN E gave her an extra oxycodone dose on 8/15/25. She said LVN E continued to pass medication to Resident #15. She said it was important to do a thorough investigation to make sure the abuse did not go any further and stop it from happening. She said when it was not done the resident could experience continued abuse. She said after the incident on 8/15/25, LVN E yelled at the staff and a resident. She said similar allegation were reported on LVN E related to pain medication. Requested a copy of Resident #15's investigation. Did not receive a copy prior or after exit. During an interview on 9/12/25 at 12:51 p.m., the ADM said she was aware of the incident on 8/15/25 regarding LVN E. She said if Resident #15's oxycodone pill was missing then it would be considered a drug diversion. She said the staff did not report LVN E had any suspicious behavior on 8/15/25. She said the DON investigated the incident because it was nursing related. She said the DON told her it was a medication error. She said she also thought RCN EE was a part of investigation and agreed it was a medication error. She said it important to do a thorough investigation because it affected the residents' quality of life. She said if the incident was thorough investigated, the drug diversion process would have been followed. She said whoever the investigation was assigned to, was responsible its thoroughness. She said she was the abuse coordinator for the facility. During an interview on 9/12/25 at 4:37 p.m., RCN EE said the DON asked her for help with a medication error. She said the DON texted her and reported that LVN E had administered Resident #15's oxycodone too close together. She said the DON reported when she looked at Resident #15's narcotic count sheet, it looked like LVN E signed the oxycodone out too close together. She said the DON may have not known how to run an eMAR report on Resident #15's oxycodone to see the actual times of administration. She said the DON was new to the facility and role as a DON. She said the DON reported LVN E said she gave Resident #15's oxycodone too close together also. She said if the DON did not ask Resident #15 if she received two pills at an administration time, then it was not thorough investigated. She said when an investigation was not thoroughly investigated, it put the resident at risk for continued misappropriation of property. She said the ADM and DON were responsible for investigating allegation of abuse and neglect. She said if a drug diversion was suspected, then the facility suspended the MA or CN involved in the incident. She said the facility also drug tested the staff members if suspicious behavior was noted. (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	09/13/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of a face sheet dated 09/11/2025 indicated Resident #9 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including acute kidney failure (condition in which the kidneys cannot filter waste from blood), metabolic encephalopathy (imbalance in body's chemical processes leading to abnormal brain function), chronic obstructive pulmonary disease (progressive lung disease causing shortness of breath, cough, and airflow limitations), and type 2 diabetes mellitus (excessive sugar in the blood). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #9 understood others and was understood by others. The MDS indicated Resident #9 had a BIMS of 11 and was moderately cognitively impaired. The MDS indicated Resident #9 was independent with eating, required moderate assistance with showering and dressing, and was dependent with toileting hygiene. Record review of Resident #9's care plan dated 08/06/2025 indicated Resident #9 had a history of trauma related to being choked that may have a negative impact. The interventions included to monitor for escalating anxiety, depression and sleep disturbances, perform de-escalation techniques as needed. Record review of Resident #9's Order Summary Report dated 09/11/2025 indicated Resident #9 had an order for Hydrocodone/Acetaminophen (a narcotic pain reliever) 5-325 tablet, give one tablet by mouth every four hours as needed for pain with a start date of 08/10/2025. Record review of a Provider Investigation Report dated 08/18/2025 at 08:17 AM, indicated Resident #9 alleged, “LVN E refused to give her pain medications and hit the side of her mattress with her fist and told her she didn't need the pain medication. Resident #9 alleged LVN D stormed out of the room cussing and yelling up and down the hall. LVN E was suspended pending investigation and safe surveys conducted, staff in services and trauma assessment completed on Resident #9”. Record review of A The Provider Investigation indicated there was no documentation to reflect a pain assessment was completed for Resident #9. Additionally, there was no documentation that reflected Resident #9's medication administration record had been reviewed to verify whether the medication was charted as given or omitted, and there were no documented attempts to determine the reason for the alleged omission. Record review of trauma assessment completed on 08/18/2025 by the SW indicated Resident #9 had no trauma. Record review of a written statement by LVN E dated 08/20/2025 stated, “whenever, Resident #9, asks for her medicine (pain meds) I always check the time, assess her pain and let her know whether it's time or not. Sometimes she agrees and sometimes she doesn't. She often states that she doesn't know why she turns her light on (forgets) or she just shrugs her shoulders. Most times she is easily redirected. Sunday, August 17th, 2025, I had the opportunity to meet and greet Resident #9's son and his wife. I kneeled down in front of Resident #9 because she was in her wheelchair, took her left hand held it and greeted her and introduced myself to her family and thanked them for allowing me to be a part of her care. I stated it was my pride and privilege to take care of their loved one. The son smiled, nodded and said, “that is enough”. It startled me just a bit, I stood up and apologized for interrupting their visit. His wife smiled and that was it. I empathically deny any allegations of cussing up and down the hall. First, profanity is verbal abuse. Second, there were CNA's present most of the night. I was the only one there at 02:30 AM. Third, I respect these elders home period.” (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	09/13/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #9's Individual Control Drug Record for Hydrocodone/Acetaminophen (a narcotic pain reliever) 5-325 tablet, give one tablet by mouth every four hours as needed for pain was not signed on for 08/17/2025. During an interview on 09/09/2025 at 12:25 PM, Resident #9's family member stated, he had received a call at approximately 03:00 AM on 08/17/2025 from Resident #9. Resident #9's family member stated that Resident #9 complained she was in pain and that LVN E would not give her pain medications and was cussing and yelling at her. Resident #9 stated LVN E snatched up the blanket and slammed it back down on to her feet. Resident #9's family member stated he contacted the facility by phone and spoke with a nurse (unsure of name) and requested Resident #9 to be checked on and pain medication to be administered appropriately. Resident #9's family member stated he did not hear anything more from Resident #9 or the facility the remainder of the night. Resident #9's family member stated that on 08/17/2025 while visiting Resident #9, he had encountered LVN E. Resident #9's family member stated LVN E was talking to Resident #9 like she was a child and in a condescending manner. Resident #9's family member stated he told LVN E that was enough. Resident #9's family member stated, “LVN E acted very peculiar as if she was on drugs.” Resident #9's family member stated he received a call from the Administrator on 08/18/2025 regarding Resident #9's previous allegations regarding LVN E. Resident #9's family member confirmed he had received the call from Resident #9. Resident #9's family member stated he also reported the incident where he had told LVN E to stop talking to Resident #9 in the childlike, condescending manner on 08/17/2025 during a visit. Resident #9's family member stated he had requested LVN E not take care of Resident #9 due to her behaviors. Resident #9's family member stated that later perhaps the next day or so, he had received a call from the Administrator where she stated the allegations had been confirmed and LVN E was terminated from the facility. During an interview on 09/09/2025 at 12:45 PM, Resident #9 stated on the day of the incident (08/17/25) she had used the call light button because she was in pain and needed pain medication. She said she waited on LVN E for a long time that night. Resident #9 stated upon LVN E entering her room she asked for her pain medication. Resident #9 stated LVN E “began cussing and hitting the side of her bed and said she was not getting my pain medication, and I could not have it”. Resident #9 said LVN E picked up her covers and slammed it back down over her feet. Resident #9 said LVN E “then left her room yelling and cussing that she was not going to get the pain medication for me”. Resident #9 stated she called her family member and reported the incident to them. Resident #9 stated she did not see LVN E for the remainder of the shift. Resident #9 stated she drifted off to sleep. Resident #9 said it was not very long before the day shift arrived, and she received her pain medication at that time. Resident #9 said LVN E was always talking and moving around fast and rushed. Resident #9 stated she reported the incident to one of the night shift nurses the following evening. Resident #9 stated that later that evening after she told the nurse about the incident with LVN E, the Administrator spoke with her regarding the incident. Resident #9 stated the Administrator did not ask her anything more about her pain medication. Resident #9 stated the day nurse assessed her pain around 7 the next AM. Resident #9 stated that was approximately 3 to 4 hours later after she had requested the pain medication from LVN E. (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	09/13/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/09/2025 at 12:55 PM, the Administrator stated upon interviewing Resident #9, she stated she had used her call light and requested pain medication after waiting a long time. Resident #9 stated when LVN E walked into the room, she told Resident #9 she was not getting pain medication and begin hitting the side of the bed and slung the covers off her. The Administrator stated Resident #9 said she was not physically touched by LVN E. The Administrator stated LVN E left the room and was cussing and yelling in the halls. The Administrator stated when she contacted Resident #9's family member, she was told that LVN E had talked to Resident #9 in a condescending manner. The Administrator stated Resident #9's family member expressed concern and requested LVN E be kept away from Resident #9. The Administrator stated she had interviewed staff and confirmed LVN E had erratic behaviors such has yelling and cussing in front of the residents. The Administrator stated LVN E had only worked at the facility for about 2 weeks. The Administrator stated LVN E was terminated on 08/21/2025. The administrator stated she had not inquired any further regarding the pain medication because she was not clinical and had told the DON. The Administrator stated she was not responsible to follow -up on clinical side. The Administrator said neglect and misappropriation was considered abuse. The Administrator said she was the abuse coordinator for the facility. The Administrator said the lack of appropriate investigations of alleged allegations could result in a resident experiencing an increase in pain as well as a decreased quality of life. Attempted telephone call to LVN E on 09/09/2025 at 01:15 PM left a voice message and requested a call back. Attempted telephone call to LVN E on 09/09/2025 at 07:49 PM left a voice message and requested a call back. Attempted telephone call to LVN E on 09/10/2025 at 02:30 PM left a voice message and requested a call back. During an interview on 09/12/2025 at 10:57 AM, the DON stated she had not investigated the allegations of Resident # 9 not receiving pain medications. The DON stated that was the responsibility of the Administrator because she was the Abuse Coordinator. The DON stated when she had heard of the allegations it was days later and the resident was no longer complaining of pain. The DON said misappropriation was considered abuse. The DON said when allegations not investigated could leave the resident at risk of decreased quality of life if they had experience untreated pain. Record review of the facility's undated “Abuse/Neglect Policy”, indicated, “The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart … Comprehensive investigations will be the responsibility of the administrator and/or Abuse Preventionist… All allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injuries of unknown source will be investigated… The administrator in consultation with the Risk Management Department will be responsible for investigating and reporting cases to the HHSC… The Abuse Preventionist and/or administrator will conduct a thorough investigation of the incident(s)…”

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	09/13/2025

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 - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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	09/13/2025

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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure adequate supervision and assistance devices to prevent accidents for 11 out of 25 (Resident's #4, #7, #8, #10, #11, #12, #13, #14, #19, #21, and #22) residents reviewed for accidents. 1. The facility failed to ensure adequate supervision on the secured unit to prevent two resident-to-resident physical altercations between Resident #12 and Resident #13 on 08/07/25, and 08/23/25, which resulted in scratches to Resident #13's face. 2. The facility failed to ensure the secured unit was adequately supervised to prevent unwitnessed fall accidents for Resident's #8, #10, #12, #13, #14, #19, and #21. Resident #14 sustained a radius fracture and required 6 sutures to her left eye on 07/01/25. Resident #21 was sent to the ER after she hit her head and complained of pain on 07/03/25. Resident #10 sustained an abrasion to his left knee on 08/08/25. 3. The facility failed to ensure CNA H provided Resident #11 the correct level of assistance during toileting hygiene. On 07/14/25, CNA H provided incontinence care without assistance to Resident #11 which resulted in Resident #11 falling to the floor and hitting her head. Resident #11's fall mat had been moved for care, and she sustained a skin tear and facial bruising. An immediate jeopardy (IJ) was identified on 09/11/25 at 12:59 PM. The IJ template was provided to the facility on [DATE] at 2:01 PM. While the IJ was removed on 09/13/25 at 12:49 PM, the facility remained out of compliance at a scope of a patterned and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all staff had not been provided education on abuse and neglect, notification of change in condition, fall prevention policy, and the Kardex. This failure could place residents at risk of serious injuries, harm, impairment, and death.The findings included: 1. Record review of the face sheet, dated 09/11/25, reflected Resident #12 was a [AGE] year-old male who initially admitted to the facility on [DATE] with diagnoses of dementia (memory loss) psychosis (state of impaired reality), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of the admission MDS assessment, dated 08/11/25, reflected Resident #12 had clear speech, was usually understood, and was usually able to understand others. Resident #12 had a BIMS score of 9, which indicated moderately impaired cognition. The MDS reflected Resident #12 had physical behaviors directed toward others 1-3 days and wandering behaviors 4 to 6 days during the look-back period. Record review of Resident #12's comprehensive care plan, initiated on 08/06/25, reflected no care plan had been developed for behaviors. Record review of the order summary report, dated 09/11/25, reflected Resident #12 had an order, which started on 07/31/25, that indicated he may reside on the secured unit related to exit seeking behaviors. Record review of the behavior incident report, dated 08/07/25 at 7:25 AM, reflected CNA N reported that Resident #13 was in Resident #12's room looking at pictures on his nightstand when Resident #12 pushed Resident #13. There were no injuries. The report reflected Resident #12 and #13 were separated and the Administrator was notified. Record review of the behavior incident report, dated 08/23/25 at 6:20 AM, reflected Resident #12 pushed Resident #13 to the floor. Resident #12 reported Resident #13 tried to come into his room, so he stopped her. The incident was unwitnessed by staff. Record review of Resident #12's progress notes, reflected the following: On 09/06/25 at 12:41 PM, Resident #12 was transferred to another facility. 2. Record review of the face sheet, dated 09/11/25, reflected Resident #13 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of dementia (memory loss) and anxiety disorder. Record review of the quarterly MDS assessment, dated 05/29/25, reflected Resident #13 had clear speech, was usually understood, and was sometimes able to understand others. Resident #13 had a BIMS score of 3, which indicated severe cognitive impairment. The MDS reflected Resident #13 had no behaviors or refusal of care. Record review of the comprehensive care plan, last reviewed 06/05/25, reflected Resident #13 had the potential to demonstrate verbally and physically abusive behaviors. The care plan further revealed Resident #13 was at risk for elopement and resided on the secured unit. The interventions included: supervise closely and make regular compliance rounds whenever resident is in room. Record review of the order summary report, dated 08/23/25, reflected Resident #13 had an order, which started on 02/26/25, that she may reside on the secured unit related to exit seeking behaviors. Record review of Resident #13's progress notes, reflected the following: On 08/07/25 at 4:25 PM a trauma assessment was completed and was negative. On 08/08/25 at 9:02 PM, it was documented Resident #13 had no injury or adverse reaction from being pushed. On 08/23/25 at 6:20 AM, an event note was completed that reflected Resident #13 had 2 scratches on the right side of face and redness to side of

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	09/13/2025

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 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (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	09/13/2025

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 0693 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 residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 of 3 residents (Resident #5) reviewed for enteral nutrition. During a tube feeding on 08/20/25, Resident #5's head and torso were leaning over the left armrest of his Geri-chair for approximately 1 hour and 30 minutes, which resulted in aspiration pneumonia. An immediate jeopardy (IJ) was identified on 09/11/25 at 12:59 PM. The IJ template was provided to the facility on [DATE] at 2:01 PM. While the IJ was removed on 09/12/25 at 4:40 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm that is not immediate jeopardy with the potential for more than minimal harm because all staff had not been provided education on abuse and neglect, notification of changes in condition, and enteral feeding tube management. This failure could place residents with gastrostomy tube at risk for complications from feeding tube administration such as aspiration and pneumonia, serious injury, harm, impairment, and death. The findings included: Record review of the face sheet, dated 09/11/25, reflected Resident #5 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (a brain disorder that slowly destroys a person's memory and thinking skills), severe protein-calorie malnutrition (not getting enough protein or calories to meet the body's demands), gastrostomy status (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), anorexia (loss of appetite), and dysphagia (difficulty swallowing). Record review of the quarterly MDS assessment, dated 07/30/25, reflected Resident #5 had unclear speech, was rarely/never understood, and was rarely/never able to understand others. Resident #5 had short-term and long-term memory problems. Resident #5 had no memory or recall ability and had severely impaired decision making skills. The MDS reflected Resident #5 had upper and lower extremity impairments to both sides which interfered with daily functions. The MDS reflected Resident #5 was dependent on staff for all his ADLs. Resident #5 used a feeding tube while a resident and also received a mechanically altered diet. The MDS reflected Resident #5 received 51% of more of his total calories through tube feeding. Record review of the comprehensive care plan, last reviewed 06/17/25, reflected Resident #5 required tube feeding related to anorexia and Alzheimer's disease. The interventions included: .the resident needs the head of bed elevated 30 degrees during and thirty minutes after tube feeding. The care plan further reflected Resident #5 had an ADL self-care deficit and required staff assistance x 1 with eating. Record review of the order summary report, dated 09/11/25, reflected Resident #5 had an order for regular diet and pureed texture with pudding consistency fluids, family member or nurse to assist with feeding. The order started on 08/26/25. During an observation of a video date and time stamped, 08/20/25 3:13 PM, revealed Resident #5 leaning over the left armrest of his Geri-chair. He was moaning and grunting, unable to lift his torso or head. At 3:16 PM, CNA G walks into the room, pulls his arm and ask him to sit up, and then walked out of the room. The interaction last approximately 45 seconds. Resident #5 returned to the same position within approximately 30 seconds after CNA G left the room. Resident #5 remained in the same position, where his head and torso were leaning over the left armrest for approximately 1 hour and 30 minutes. Resident #5 constantly moans and grunts during the video until LVN L sets up him with pillows and positioned him comfortably at 4:26 PM Record review of the progress notes reflected the following: On 08/21/25 at 4:03 AM, the note reflected Resident #5's family member requested a chest x-ray due to possible aspiration . due to positioning of resident in chair on previous shift.No signs or symptoms of aspiration [entry of solid or liquid material such as secretions, food, drink, or stomach contents from the mouth or stomach into the lungs] noted . head of bed elevated to 30 degrees. On 08/21/25 at 7:47 AM, the note reflected a response was received from the physician for a chest x-ray. On 08/22/25 at 3:29 AM, the note reflected Resident #5 was transferred to the hospital related to chest x-ray results findings indicated aspiration. Record review of Resident #5's diagnostic chest x-ray report, dated 08/21/25, reflected . reported gastrostomy tube [opening from the abdomen directly into the stomach] is not definitely visualized. air distended stomach.left basilar airspace disease [condition in which the lower lungs of the left lung collapse, preventing air exchange], likely atelectasis [collapse of lung or part of lung from lack of air in the air sacs] given elevation of the hemidiaphragm. Record review of the inpatient hospital record, dated 08/22/25, reflected Resident #5 arrived at the hospital at 4:04 AM via ambulance and was discharged back to the facility at 5:46 AM. The problems addressed was aspiration into airway, initial encounter. During an interview

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	09/13/2025

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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (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	09/13/2025

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 0697 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 interview, and record review the facility failed to ensure that pain management was provided to that require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices of 2 of 11 residents reviewed for pain management. (Resident #6 and Resident #15) 1. The facility failed to ensure Resident #15 received her scheduled Oxycodone as ordered on [DATE], [DATE], and [DATE]. The facility failed to ensure Resident #15 received her scheduled Gabapentin as ordered on [DATE]. The facility failed to notify Resident #15's physician when doses of the Oxycodone and Gabapentin, scheduled for 3pm and 4pm, were not administered on [DATE]. The facility failed to offer Resident #15 alternative prn pain medication options on [DATE] per the facility's policy. The facility failed to offer Resident #15 non-pharmacological interventions on [DATE] per the facility's policy. The facility failed to follow the Pain Management policy. 2. The facility failed to ensure Resident #6, who received scheduled opioid medications, had pain assessments at least every shift. The facility failed to ensure Resident #6, who displayed nonverbal signs of pain such as grimacing, hollering out and pushing staff away during ADL care, was administered prn medication. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ Template was provided to the facility on [DATE] at 2:01 p.m. While the IJ was removed on [DATE] at 12:49 p.m., 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 that was not immediate jeopardy due to the facility's need to complete training in-services with all staff and evaluate the effectiveness of the corrective systems. These failures could place residents at risk for unrealized pain, serious harm, decrease quality of life and decline in condition.Findings included: 1. Record review of Resident #15's face sheet dated [DATE] indicated Resident #15 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #15 had diagnoses including fibromyalgia (is a long-term condition that involves widespread body pain), low back pain, major depressive disorder (a persistently low or depressed mood and a loss of interest in activities that you used to enjoy), and anxiety (intense, excessive, and persistent worry and fear about everyday situations). Record review of Resident #15's quarterly MDS assessment dated [DATE] indicated Resident #15 had clear speech, adequate hearing and vision. Resident #15 was understood and had the ability to understand others. Resident #15 had a BIMS score of 15 which indicated intact cognition. Resident #15 was independent for eating, oral hygiene, and toilet hygiene, partial assistance for shower/bathe self and personal hygiene. Resident #15 received scheduled pain medication regimen. Resident #15 received opioids. Record review of Resident #15's care plan dated [DATE] indicated Resident #15 was on pain medication therapy related to fibromyalgia and wound. Intervention included administer medications as ordered. Record review of Resident #15's order summary report dated [DATE] indicated: *Tylenol Capsule 325 MG, give 2 capsules by mouth every 6 hours as needed for mild pain. Start date [DATE]. *Instant hot pack apply to affected area every hour as needed for pain, every 1 hour as needed for pain. Start date [DATE]. *Assess for pain each shift, every shift. Start date [DATE]. *Oxycodone Oral Tablet 10 MG (is used to relieve pain severe enough to require opioid treatment and when other pain medicines did not work well enough or cannot be tolerated), give 1 tablet by mouth five times a day for pain. Start date [DATE]. *Gabapentin Oral Capsule 300 MG (is an anticonvulsant medication used to treat nerve pain), give 1 capsule by mouth three times a day for pain for 5 days. Start dated [DATE]. Record review of Resident #15's Medication Administration Record dated [DATE]-[DATE] indicated: *Tylenol Capsule 325 MG, give 2 capsules by mouth every 6 hours as needed for mild pain. The MAR did not reflect an administration on [DATE]. This alternate prn pain medication was not administered on [DATE]. *Instant hot pack apply to affected area every hour as needed for pain, every 1 hour as needed for pain. The MAR did not reflect an administration on [DATE]. This non-pharmacological option was not administered on [DATE]. *Assess for pain each shift, every shift. The MAR did not reflect assessments on [DATE] (Nights), [DATE] (Nights), and [DATE] (Nights). *Oxycodone Oral Tablet 10 MG, give 1 tablet by mouth five times a day for pain. Times: 1am, 6am, 11am, 4pm, and 9pm. The MAR indicated on [DATE] at 1am administration was not given due to sleeping. The MAR did not reflect administration on [DATE] at 4pm. The MAR indicated on [DATE] administration at 9pm. The MAR indicated on [DATE] administration at 6am. *Gabapentin Oral Capsule 300 MG, give 1 capsule by mouth three times a day for pain for 5 days. The MAR did not reflect administration on [DATE] at 3pm. Record review of Resident #15's Individual Control Drug Record for Oxycodone 10 MG dated [DATE] indicated: *[DATE] at 6am, 1 pill given

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	09/13/2025

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 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (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	09/13/2025

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 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review the facility failed to have sufficient nursing staff with the appropriate competencies and skills set to provide nursing and related services to assure resident safety and attain or maintain the highest practicable, physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment for 19 of 25 resident's (Resident's #2, #4, #5, #6, #7, #8, #10, #12, #13, #14, #16, #17, #18, #19, #20, #21, #22, #23, #24) reviewed for sufficient staffing. 1. The facility failed to ensure sufficient facility staff were available to assist Resident #5 with positioning during a tube feeding on 08/20/25. Resident #5's head and torso were leaning over the left armrest of his Geri-chair for approximately 1 hour and 30 minutes, which resulted in aspiration pneumonia. 2. The facility failed to ensure sufficient staff were available to provide wound care treatment and documentation for Resident's #2, #16, #17, #18, #19, #20, #23 and #24 during August 2025 and September 2025. 3. The facility failed to ensure the secured unit was adequately staffed to prevent accidents for Resident's #8, #10, #12, #13, #14, #19, and #21. 4. The facility failed to ensure the secured unit was adequately staffed to provide supervision during mealtime for Resident's #7, #8, #14, #21, and #22 on 09/08/25. 5. The facility failed to follow the facility assessment for sufficient nurse staffing. An immediate jeopardy (IJ) was identified on 09/11/25 at 12:59 PM. The IJ template was provided to the facility on [DATE] at 2:01 PM. While the IJ was removed on 09/13/25 at 12:49 PM, the facility remained out of compliance at a scope of patterned and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all staff had not been provided education on abuse and neglect, notification of changes in condition, documentation policy, pain management policy, fall prevention policy, pressure prevention policy, medication administration policy, enteral feeding policy, and the bathing and showers policy. These failures placed residents at risk of inadequate supervision, an unsafe environment, decreased quality of care, increased risk of pressure ulcers, unwitnessed falls, risk for impaired nutrition, serious harm, injury, abuse, and death.The finding included: 1. Record review of the face sheet, dated 09/11/25, reflected Resident #5 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (a brain disorder that slowly destroys a person's memory and thinking skills), severe protein-calorie malnutrition (not getting enough protein or calories to meet the bodies demands), gastrostomy status (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), anorexia (loss of appetite), and dysphagia (difficulty swallowing). Record review of the quarterly MDS assessment, dated 07/30/25, reflected Resident #5 had unclear speech, was rarely/never understood, and was rarely/never able to understand others. Resident #5 had short-term and long-term memory problems. Resident #5 had no memory or recall ability and had severely impaired decision making skills. The MDS reflected Resident #5 had upper and lower extremity impairments to both sides which interfered with daily functions. The MDS reflected Resident #5 was dependent on staff for all his ADLs. Resident #5 used a feeding tube while a resident and also received a mechanically altered diet. The MDS reflected Resident #5 received 51% of more of his total calories through tube feeding. Record review of the comprehensive care plan, last reviewed 06/17/25, reflected Resident #5 required tube feeing related to anorexia and Alzheimer's disease. The interventions included: .the resident needs the head of bed elevated 30 degrees during and thirty minutes after tube feeding. The care plan further reflected Resident #5 had an ADL self-care deficit and required staff assistance x 1 with eating. Record review of the order summary report, dated 09/11/25, reflected Resident #5 had an order for regular diet and pureed texture with pudding consistency fluids, [family member] or nurse to assist with feeding. The order started on 08/26/25. Record review of the progress notes reflected the following: On 08/21/25 at 4:03 AM, the note reflected Resident #5's family member requested a chest x-ray due to possible aspiration . due to positioning of resident in chair on previous shift.No signs or symptoms of aspiration noted . head of bed elevated to 30 degrees. On 08/21/25 at 7:47 AM, the note reflected a response was received from the physician for a chest x-ray. On 08/22/25 at 3:29 AM, the note reflected Resident #5 was transferred to the hospital related to chest x-ray results findings indicated aspiration. Record review of Resident #5's diagnostic chest x-ray report, dated 08/21/25, reflected . reported gastrostomy tube [opening from the abdomen directly into the stomach] is not definitely visualized. air distended stomach left basilar airspace disease [condition in which the lower lungs of the left lung

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	09/13/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (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	09/13/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 5 of 25 residents (Resident's #1, #2, #3, #7, and #8) reviewed for infection control practices. 1. The facility failed to ensure facility staff followed infection control protocol during a COVID-19 outbreak at the facility. 2. The facility failed to ensure Residents #1, #2, and #3 had airborne isolation precaution signage outside their room door on 09/08/25. 3. The facility failed to ensure the staff had access to face shields or goggles on the PPE isolation carts on 09/08/25 and 09/09/25. 4. The facility failed to ensure LVN A, MA B, and CNA C wore the appropriate PPE (face shield or goggles and N-95 mask) into a COVID-19 positive room, when providing care and services on 09/08/25. LVN A and MA B continued to provide care to residents on the secured unit and outside the secured unit who were not COVID-19 positive, wearing the same masks worn in the COVID-19 positive rooms. 5. The facility failed to ensure LVN A and MA B had access to hand sanitizer and performed hand hygiene after exiting a COVID-19 positive room and removing their PPE. 6. The facility failed to ensure Resident #7, and Resident #8 were tested for COVID-19 when they developed signs and symptoms. These failures could place residents and staff at risk for cross contamination and the spread of COVID-19, an infectious disease. The findings included: Record review of the COVID response plan, revised 05/08/23, reflected .implement source control measures. source control refers to use of respirators or well-fitting facemasks or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. source control measures are recommended for people with suspected infection, had close contact with someone with COVID or those working in an area that is experiencing an outbreak.anyone with even mild symptoms of COVID-19.should receive a test as soon as possible.suspected or confirmed COVID-19 infection health care personnel should adhere to standard precautions and use an N-95 or higher mask, gown, gloves, and eye protection (face shield or goggles) . Record review of the Fundamentals of Infection Control Precautions policy, undated, reflected . hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene.before and after enter isolation precaution settings.before and after assisting a resident with meals.the wearing of masks, eye protection, and face shields in specified circumstances is mandatory. 1. Record review of the face sheet, dated 09/11/25, reflected Resident #1 was a [AGE] year-old male who initially admitted to the facility on [DATE] with a diagnosis of cerebral ischemia (disrupted blood flow to the brain). Record review of the quarterly MDS assessment, dated 08/12/25, reflected Resident #1 had clear speech, was understood by others, and was able to understand others. Resident #1 had a BIMS score of 4, which indicated severe cognitive impairment. Resident #1 had no behaviors or refusal of care. Record review of the comprehensive care plan, revised 09/13/20, reflected Resident #1 was at risk for signs and symptoms of COVID-19. The interventions included follow facility protocol for COVID-19 screening and precautions. Record review of the order summary report, dated 09/11/25, reflected Resident #1 had an order, which started on 09/07/25, for contact droplet isolation precautions x 10 days. 2. Record review of Resident #2's face sheet dated 09/11/25 indicated Resident #2 was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 had diagnosis including acute posthemorrhagic anemia (is a condition that develops when you lose a large amount of blood quickly), heart failure (is a condition where the heart muscle cannot pump blood effectively enough to meet the body's needs), type 2 diabetes (is a chronic condition that happens when you have persistently high blood sugar levels), dementia (is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and pressure ulcer of left heel, stage 3 (injuries extend through the skin into deeper tissue and fat but do not reach muscle, tendon, or bone). Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated Resident #2 was understood and usually had the ability to understand others. Resident #2's had a BIMS score of 7 which indicated severe cognitive impairment. Resident #2 required setup assistance for eating, supervision for oral hygiene, partial assistance for upper body dressing and personal hygiene, and dependent for toileting hygiene, shower/bathe self, and lower body dressing. Resident #2 was always incontinent for urine and occasionally incontinent for bowel. Resident #2 had one, stage 3 unhealed pressure