STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675386	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/02/2026

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's respect and dignity for 1 of 5 residents (Resident #21) reviewed for dignity.The facility failed to provide dignity and respect by allowing Resident #21 to remain in soiled clothing for two hours and taking resident to dining hall without changing his clothes on 1/29/2026.This failure could place residents at risk of embarrassment and low self-esteem.Findings included:Record review of Resident #21's Face Sheet, dated 1/29/2026, indicated a [AGE] year-old male, admitted [DATE], with diagnoses of unspecified dementia (memory loss), epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures caused by abnormal electrical activity), schizophrenia (a severe mental disorder that affects how a person thinks, feels, and behaves), and major depression disorder (a mental disorder characterized by at least two weeks of pervasive low mood, self-esteem and loss of interest and pleasure), cerebrovascular disease (a group of conditions that affect blood flow to the brain, leading to serious health issues like strokes and transient ischemic attacks).Record review of Resident #21's Quarterly MDS, dated [DATE], indicated a BIMS score of 5 indicating the resident was severely cognitively impaired. Resident #21 was wheelchair bound and was dependent with bed mobility, transfers, dressing and toileting with 2-person assistance.Record review of Resident #21's Care Plan, dated 9/15/2025, indicated ADL self-care performance deficit and required assistance with ADLs. Interventions included assistance with personal hygiene as required: hair, shaving, oral care as needed, required 1 person assist for dressing, a lift for all transfers and required 1-2 person for assistance for toileting.During an observation on 1/29/2026 at 8:50 a.m., Resident #21 was seated in his wheelchair in front of the nurse's station in main area with a clear cup of white liquid spilled on his dark gray pants.During an observation on 1/29/2026 at 9:15 a.m., Resident #21 was seated in his wheelchair in front of the nurse's station in the main area with spilled white liquid on his dark gray pants and a small puddle of white substance located under his wheelchair. Resident #21 was slumped over in his wheelchair with his helmet on. Observed multiple staff members walked passed Resident #21 and were sitting at the nurse station.During an observation on 1/29/2026 at 9:23 a.m., Resident #21 was seated in his wheelchair in front of the nurse's station with absorbed white substance on black pants. Observed white substance under Resident #21's wheelchair.During an observation on 1/29/2026 at 9:51 a.m., Resident #21 remained at nurse's station seated in his wheelchair. Observation revealed the white substance below his wheelchair was cleaned up. Resident #21 remained seated in wheelchair with dark gray pants and black shirt with wet area on left upper thigh of pants.During an observation and interview on 1/29/2026 at 11:45 a.m., CNA D wheeled Resident #21 to the dining hall. CNA D said Resident #21's pants were dry but wheeled him to his room to change his clothing. Resident is non-verbal and unable to be interviewed.During an observation on 1/29/2026 at 11:55 a.m., observed CNA D transfer Resident #21 with a (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mechanical lift assistance of COTA F. Resident #21 was provided incontinent care and clothes were changed. Observed a white substance on the wheelchair and the sling for mechanical lift was wet. CNA D retrieved a clean sling to place under Resident #21 prior to transfer back to his wheelchair. Observed COTA F clean the wheelchair prior to transfer.During an interview on 1/29/2026 at 3:58 p.m., CNA D said she had gotten Resident #21 out of bed and dressed. She said he ate breakfast then she changed him before he returned to the nurse's station between 7:30 a.m. and 8:00 a.m. CNA D said she believed he had a health shake but did not observe that it spilled. She said he required assistance with eating. CNA D said the aides were responsible for ensuring he was clean and dry, and she was his assigned CNA. She said having spilled liquid could make Resident #21 feel nasty or gross. She said the morning was chaotic because she worked by herself until around 8:30 a.m. or 9:00 a.m.During an interview on 2/2/2026 at 11:35 a.m., CMA B said she would report to the charge nurse if she observed a resident who was disheveled or wearing dirty clothes. She said she would assist a resident to their room and let the staff know the resident needed to be changed. She said residents were not always able to verbalize what they needed or wanted. She said a resident could feel embarrassed or neglected if they were wearing dirty or soiled clothes. CMA B said it was the responsibility of all staff to ensure the residents were clean and dry. She said the charge nurse was responsible for ensuring the resident received the care needed and the DON should say something if she was aware the resident was wearing dirty clothes. During an interview on 2/2/2026 at 12:00 p.m., CNA G said she would change the resident if she observed a resident with soiled clothing. She said it could make a resident feel bad and was a dignity issue. CNA G said everyone was responsible for ensuring a resident was clean and dry.During an interview on 2/2/2026 at 12:13 p.m., LVN C said she would clean a resident or get someone to clean them up because they should be changed immediately if they were soiled with a liquid. She said it could make a resident feel cold and neglected if left in dirty clothing. LVN C said all staff were responsible for ensuring a resident was clean and dry, but the nurses and CNAs were primarily responsible.During an interview on 2/2/2026 at 1:15 p.m., the ADON said she expected the nurse to keep residents clean after a spill and keep the resident clean and dry. She said the nurse or staff should clean up a resident immediately if they are aware of it. She said it could make a resident feel bad about themselves and there could be a fall risk if there was a spill on the floor. The ADON said the nurse was responsible for ensuring the resident was clean and dry.During an interview on 2/2/2026 at 1:30 p.m., the DON said she expected the staff to keep residents clean and dry after a resident spilled liquids on their clothes. She said it was a dignity issue. The DON said, even if a resident was confused, they should be cleaned up. The DON said the CNA, charge nurse, and other staff can take a resident to their room and get someone to assist with changing the residents.During an interview on 2/2/2026 at 2:45 p.m., the ADM said he expected the staff to change the resident if they were soiled. He said he expected them to be changed in a reasonable time and after meals as well. He said it was everyone's responsibility to make sure residents were taken care of.Record review of facility policy titled Resident Rights, undated, indicated .the resident has the right to be treated with respect and dignity, including.3. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences.

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide residents with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for two of five residents (Resident #7, Anonymous Resident) reviewed for quality of life.The facility failed to report the Hall A water temperatures were cold and provided a bed bath to Resident # 7 with cold water during the winter storm.The facility failed to provide an anonymous resident with a warm, comfortable shower.This failure could place residents at risk for a decline in quality of life and health status.Findings included:Record review of Resident #7's face sheet, dated 1/29/2026, indicated she was a [AGE] year-old female, with diagnoses that included fracture of shaft of right tibia (a break in the shin bone), fracture of the right fibula (a break in one of the two long bones in the lower leg) and Chronic Diastolic heart failure (occurs when the left ventricle becomes stiff and cannot relax properly, leading to inadequate filling of blood).Record review of Resident #7's admission MDS assessment, dated 1/17/2026, indicated a BIMS score of 10, which indicated moderate cognitive impairment. She was able to make herself understood and she was able to understand others. Resident required substantial assistance with bathing and was dependent with dressing lower body.Record review of Resident #7's care plan undated, indicated she had ADL self-care performance deficits and required 2-staff for assistance for bathing, 2-person assistance with bed mobility and staff could provide a sponge bath when a full bath or shower could not be tolerated.During an interview on 1/29/2026 at 10:03 a.m., Resident #7 stated she took a cold bed bath during the winter storm. She said the facility lost power during the winter storm and did not have warm water. She said she wanted to feel clean, so she took a cold bed bath.During an interview on 1/29/2026 at 10:39 a.m., the SW said the Hall A shower was cold and the staff were working on it. The SW did not specify which staff were working on it. She said she discovered the water in the Hall A shower was cold when she stayed in the facility over the weekend on 1/27/2026 during the winter storm and went to take a shower. The SW said she did not think the facility was aware because she was not aware the water was running cold until she attempted to take a shower.During an observation on 1/29/2026 at 10:39 a.m., Hall A shower water ran for approximately three minutes, and the water temperature was 71 degrees Fahrenheit. The water did not rise above recommended temperature of 100-110 degrees Fahrenheit. During an interview on 1/29/2026 at 10:50 a.m., the SW said she did not think the facility was aware of the Hall A shower's water was cold because she was not. She said there were six residents currently residing on Hall A and using Hall B and D showers until the water was fixed. She did not indicate a projected time frame the repaired.During an interview at an undisclosed date and time, Anonymous Resident indicated they received a cold shower because the facility did not have hot water.During an interview on 1/29/2026 at 3:58 p.m., CNA D said she was aware the water in the shower room on Hall A was running cold. She said she reported it to maintenance and to the current DON. She said it was running cold for 1-2 months. CNA D said no one was taking a shower in Hall A shower room. She said maintenance told the staff he would fix it and the DON continued to remind him. CNA D said she had not received any complaints from residents that the shower was given to them on Hall A.During an interview and observation on 2/2/2026 at 10:30 a.m., Area Maintenance Specialist said he was not aware the water was running cold on Hall A. He said he let the maintenance man was terminated. The Area Maintenance Specialist went with surveyor to Hall A shower room and the water temperature measured with the facility's thermometer was 98.7degrees Fahrenheit. The sink temperature was also warm. He said somehow the hot water temperature was turned down. He said the facility performed weekly checks on the water temperature in each hall and he would provide the (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	temperature logs for the facility.During an interview and record review on 2/2/2026 at 10:45 a.m., the Area Maintenance Specialist presented a folder with temperature logs. He said the temperature was supposed to be between 100-110 degrees Fahrenheit. He said the last recorded weekly temperature checks logged were on 12/22/2025. He said there had not been any temperature logs documented since. He said the maintenance man was recently terminated because of a recent inspection.During an interview on 2/2/2026 at 11:20 a.m., Housekeeper E said there was something going on with the showers. She said that Hall B's shower was flooding a couple of weeks ago and toilets were stopping up. She said the water temperatures would get temporarily fixed and then would get cold again. Housekeeper E said she overhead CNAs talking and complained about having to take residents to different halls to give showers. Housekeeper E said she did not think the residents enjoyed going to a different hall to get a shower. Housekeeper E said the CNA staff report on the QR code Maintenance Care app to alert for needs within the facility. She said the application was easy to use. Housekeeper E said not having a warm shower could make a resident feel neglected and uncomfortable and their needs not being met. She said a resident could get sick from cold water temperatures or refuse showers.During an interview on 2/2/2026 at 11:27 a.m., the Housekeeping Supervisor said the facility had problems with the hot water on Hall A and Hall B. She said she had not heard any residents complaining about the water temperatures, but she had overhead the CNAs complaining. She said they complained about the water being too cold and residents refusing showers. She said she heard staff were carrying hot water from one shower to another shower. The Housekeeping Supervisor said she had heard about it before the winter storm. She said she put a complaint in the QR app to report it. The Housekeeper Supervisor said a resident could get sick. She said she observed a resident crying over a year ago because the water was too cold. She said she would report it to the ADM if she continued to see it happen and stated the previous ADM was aware. The Housekeeping Supervisor said the previous ADM was aware of the issue. She said someone fixed it, but the water would get cold again.During an interview on 2/2/2026 at 11:35 a.m., CMA B said Hall A had issues with hot water, but she was not sure if it was fixed.During an interview on 2/2/2026 at 12:13 p.m., LVN C said Hall A did not have hot water. She said it was an on and off issue and she did not know how long it was out. She said she had reported it to maintenance. She said a couple of residents had complained a couple of weeks ago about not having hot water because they wanted a hot beverage or wanted to sponge off at their sink. LVN C said residents were taken to different halls to receive their shower. LVN C said the staff member who bathed the resident was responsible for ensuring the water temperatures were comfortable for the residents. She said a resident could refuse showers or baths if the water was too cold or it could make the resident uncomfortable.During an interview on 2/2/2026 at 1:15 p.m., the ADON said whoever noticed a change in the water temperature was responsible for reporting to the maintenance and maintenance supervisor. She said the staff could scan the QR code and the report would go to the maintenance care. She said it would need to be reported immediately. She said everyone wants a warm shower. The ADON said the lack of warm water could cause a resident to have poor hygiene if they refused showers. She said she expected the staff to report the issue immediately to supervisor.During an interview on 2/2/2026 at 1:30 p.m., the DON said she expected the water temperatures to be comfortable for the residents. She said the CNAs should checking the temperature of the water prior to showering the residents. She said if the water was not working properly, the facility needed to know. The DON said the facility was notified prior to the winter weather. She said they had to turn up the thermostat. She said there was only one resident on Hall A now and they took him to another unit for showers. She said she expected staff to take residents to another hall to get a warm shower. The DON said the maintenance was (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	responsible for making sure the water temperatures were at a comfortable level and the CNAs should check.During an interview on 2/2/2026 at 2:45 p.m., the ADM said he knew the facility had concerns with water not getting as hot as it should be. He said it was brought up by the previous maintenance man, but he was terminated. The ADM said nobody wanted a cold shower. He said it could make a resident sick and uncomfortable. He said the maintenance man was responsible for ensuring the shower temperatures were appropriate and staff was responsible for reporting any issues. The ADM said he expected the residents to receive a warm bath/shower. The ADM said the staff could take the residents to other halls to get a shower. He said staff needed to report the problem.Record review of facility's grievances from 11/25/2026-1/6/2026 did not indicate any complaints of water temperature concerns in the facility.Record review of the facility's policy, Resident Rights, undated, stated: .The resident has a right to a dignified right to existence, self-determination, and communication with and access to persons and services inside and outside the facility.A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.Record review of facility checklist titled Task # 39737850, dated 1/27/2026 indicated Water temperatures: Test and log the hot water temperatures in resident rooms and showers: 1. Ensure patient room water temperatures are between 100 degrees and 110 degrees Fahrenheit. Test temperatures in shower area, check resident rooms at the end of each wing on rotating basis. 2. Should be completed weekly to ensure patients' water is adequate.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure in accordance with state and federal laws, all drugs and biologicals were stored in locked compartments for 1 of 2 residents (Resident #14) reviewed for storage of medication.The facility failed to ensure that Resident #14's Fluticasone Propionate Nasal Spray (a synthetic corticosteroid that helps reduce inflammation in the body) were not left at her bedside.This failure could place residents at risk of not receiving medications as ordered or receiving too much medication.Findings included:Record review of Resident #14's face sheet, dated 1/29/2026, indicated an [AGE] year-old female, admitted [DATE]. Her diagnoses included Chronic Obstructive Pulmonary disease (a progressive lung disease that makes it difficult to breathe, primarily caused by long-term exposure to irritants like cigarette smoke and air pollution), Acute respiratory failure (a condition where the lungs cannot adequately exchange gases, leading to insufficient oxygen in blood or excessive carbon dioxide), anxiety disorder (involves persistent, excessive worry that is mismatch to actual risk), and myopathy (a term that affect skeletal muscles, causing weakness, cramps and fatigue). Record review of Resident #14's admission MDS assessment, dated 11/18/2025, indicated she had a BIMS score of 9, which indicated moderate cognitive impairment. She was able to make herself understood and she was able to understand others. Record review of Resident #14's care plan, dated 11/13/2025, indicated she had potential for impaired cognitive function and impaired thought processes due to her oxygenation status secondary to COPD with shortness of breath. Interventions included, administer medications as ordered, engage the resident in simple, structured activities that avoid overly demanding task and review medications and record possible causes of cognitive deficit such as new medications or dosage increases, anticholinergics, opioids, benzodiazepines, drug interactions, errors or adverse drug reactions, drug toxicity. Record review of Resident #14's physician's orders, dated 11/13/2025, indicated she was prescribed Fluticasone Propionate Suspension 50 mcg/ACT 1 spray each nostril one time a day for allergies. During an observation and interview on 1/29/2026 at 9:30 a.m., Resident #14 observed sitting up in chair in room with oxygen on. Resident #14 was observed to have a Fluticasone Propionate nasal spray 50 mcg on bedside tray table. Resident #14 said the staff normally keep the medication locked up. She did not know why the medication remained on her table.During an interview on 1/29/2026 at 3:39 p.m., CMA A said residents were not supposed to have medication in their room. She said she gave Resident #14 her nasal spray, but she left the room. CMA A said Resident #14 liked to administer her own nasal spray. CMA A said she realized she left the nasal spray in Resident #14's room at the end of her medication pass. She said she noticed the empty box and returned to Resident #14's room to retrieve it. CMA A said Resident #14 was able to self-administer her nasal spray. CMA A said a resident could take too much of the medication or a roommate could pick up the medication, knocking it over causing it to break. CMA A said she was responsible for ensuring the medication was placed back on the medication cart.During an interview on 2/2/2026 at 11:35 a.m., CMA B said residents should not have medications at bedside. CMA B said the nurses were responsible for ensuring medications were stored properly. She said there were no current residents who administered their own medications. CMA B said she would administer the nasal spray to a resident if prescribed. She said CMA B if medication were left in a resident room, another resident could come in the room and take the medication and have an allergic reaction to it. She said it would not be safe to leave medication in a resident's room.During an interview on 2/2/2026 at 12:13 p.m., LVN C said residents should not have (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications in their room. She said currently she did not have any residents that administer own nasal sprays or eye drops. She said whoever catches medication in a room is responsible. She said someone could take the medication and use it incorrectly. She said if they used too much, it could make them sick.During an interview on 2/2/2026 at 1:15 p.m., the ADON said residents were not allowed to have medications in their rooms. She said the facility does not allow residents to self-administer medications. She said if another resident encountered the medication, they could use it and have an adverse reaction. The ADON said the nurse or medication aide were responsible for ensuring the medication was properly stored. She said she expected the nurses to keep the medications secured on the medication cart.During an interview on 2/2/2026 at 1:30 p.m., the DON said she expected the nurses and medication aides to not leave medications in a resident's room. The DON said if a staff member observes medication in a resident's room, they should notify the nurse. She said the staff member in charge of the medication cart was responsible for ensuring the medications were stored properly. She said it puts the resident at risk of overdose, or another resident could take the medication and cause a reaction.During an interview on 2/2/2026 at 2:45 p.m., the ADM said he expected the nursing staff to keep medications stored on the medication cart. He said a resident could take the medication inappropriately and it could create problems or make them sick. He said it could create issues with different organs depending on what the medication was. He said the nurse was responsible for making sure the medications were secure. He said a resident could self-administer medication if it was care planned. He said there was no one in the facility that were assigned to self-administer medication.Record review of the facility's policy, Medication Storage in the Facility, undated, stated: .Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.Record review of the facility policy titled Self-Administration of Medications by Residents Policy stated .each resident who desires to self-administer medication is permitted to do so if the facility's interdisciplinary team and/or facility policy allows or has determined that the practice would be safe for the resident and other residents of the facility. Procedure: 1. Each resident is offered the opportunity to self-administer his or her during the routine assessment.2. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability.5. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or room with, residents who self-administer.The following conditions are met for bedside.a. The manner of storage prevents access by other residents.lockable drawers or cabinets are required.The medications provided to the resident for bedside storage are kept in the containers dispensed .6. All nurses and aides are required to report to the charge nurse on duty any medications found at bedside not authorized for bedside storage.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to ensure an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 Halls (Hall #2) and 2 of 4 showers (Shower #2 and Shower # 4) reviewed for infection control.The facility failed to ensure trash was properly stored for Shower #4 on 1/29/2026 at 9:44 a.m.The facility failed to ensure trash was properly stored and removed from Hall #2 on 2/2/2026 at 9:46 a.m.The facility failed to ensure dirty linens were properly stored in Shower #2 on 1/29/2026 at 10:24 a.m.These failures could affect residents and place them at risk of unsanitary and uncomfortable environment. Findings included:During an observation on 1/29/2026 at 9:44 a.m., Shower #4 had dirty linens on the floor and a bag of trash in a clear bag located behind the door.During an observation on 2/2/2026 at 9:46 a.m., two bags of trash in clear trash bags were on the floor in front of the shower room on Hall #2. Observed CNA G picked up the trash and placed it on a gray barrel and rolled it down the hall towards outside.During an observation and interview on 1/29/2026 at 9:44 a.m., Laundry E said the dirty linen should not be on the shower floor but kept in the linen barrel. Laundry E, not wearing gloves, picked up the dirty linens and placed them in the yellow barrel. Laundry E said she should have worn gloves when touching dirty linen.During an interview on 1/29/2026 at 3:15 p.m., the ADON said dirty linens go into a trash bag then placed in the gray barrel. The ADON said trash was placed in yellow barrels. The ADON said dirty linens should not be on the floor. She said it was an infection control issue and a fall risk. The ADON said the nurses were responsible for ensuring dirty linens were off the floor and in the proper barrels. She said the staff should not leave trash on the floor in the shower room. During an interview on 1/29/2026 at 3:58 p.m., CNA D said trash should be placed in the yellow barrel. She said the staff should place dirty linens in bags and place them in the gray barrel in the shower room. She said dirty linens should not be stored on the floor. CNA D said trash should not be placed on the floor in the shower room and should be placed in the yellow barrel in the shower room. CNA D said it was an infection control issue and could spread bacteria causing other people to get sick.During an observation on 2/2/2026 at 9:46 AM, observed 2 bags of trash located on Hall #2 in front of the shower room. There was a yellow barrel inside the doorway of the shower room propping the door open. CNA G observed placing 2 bags on top of the gray barrel and wheeling it down the hallway to go outside.During an interview on 2/2/2026 at 9:56 a.m., CMA H said she did not see the two trash bags on the floor in the hallway. CMA H said no trash should be left in the hallway on the floor. She said the aides were responsible for taking the trash out if the barrel was full. She said someone could trip over the bags or someone could take something out of the bags, eat something out of the trash, or spread germs.During an interview on 2/2/2026 at 11:20 a.m., Housekeeper E said trash should not be on the floor in the hallways and should be placed in the yellow barrel. She said trash should not be placed on the gray barrel and taken outside to dumpster. She said the staff would need to wipe down the gray barrels and disinfect the gray barrels that they return to the facility. Housekeeper E said dirty linens should not be picked up with bare hands and gloves should be worn. She said a person could get an infection if it touched their skin. She said the staff had been in-serviced on infection control. Housekeeper E said it was everyone's responsibility for infection control measures. She said a resident could get sick if infection control measures were not implemented. She said she would report to the ADM or supervisor if anyone was observed not properly using infection control measures.During an interview on 2/2/2026 at 11:27 a.m., the Housekeeping Supervisor said trash should not be in clear trash bags in the hallways or behind shower room doors. She said trash should not be placed on top of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675386	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whispering Pines Lodge	2131 Alpine Rd Longview, TX 75601

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the gray barrels and rolled outside. She said it was an infection control issue with placing the trash on top of the barrels. She said the staff had to disinfect the barrels. She said residents could dig in the trash, wheel over the trash with their wheelchairs and drag trash on the floor if the trash was left on the floor. Housekeeper Supervisor said the floor technician was responsible for taking all trash out or the CNA could wheel the trash out to the dumpster.During an interview on 2/2/2026 at 11:35 a.m., CMA B said trash should not be placed outside in the hallway on the floor. She said it could cause cross contamination. She said a resident could cross through the trash in their wheelchair. She said it should be properly contained. She said dirty linens should be placed in the proper container and should be in a bag and never on the floor. She said a resident could trip over the dirty linens or get caught in a wheelchair. CMA B said the CNA and laundry staff were responsible for ensuring the linens were placed in clear bags and placed in gray barrels. She said if not properly placed, it could cause cross-contamination and spread germs to others.During an interview on 2/2/2026 at 12:00 p.m., CNA G said she was the one who placed the trash in the hallway on the floor. She said she thought she could place the trash on the floor if it was in a bag. She said she thought she could place trash with the dirty linens to transport outside. CNA G said dirty linens should not be left on the floor in a resident room. She said the dirty linens should be placed in a bag and taken to the laundry or placed in the laundry closet with the dirty linens. She said no trash should be left on the floor. She said it could contaminate the shower room. She said everyone was responsible for ensuring the trash and linens were taken out properly.During an interview on 2/2/2026 12:13 p.m., LVN C said linens should be placed in a bag and taken to the laundry or placed in a gray barrel. She said lines should not ideally be placed on the floor. She said it could contaminate the surface. LVN C said staff should not touch dirty linens with bare hands and gloves should be worn to prevent cross-contamination. She said it could cause contamination if someone touched resident or something a resident might touch. LVN C said everyone was responsible for ensuring staff were wearing gloves and not placing linens on the floor. LVN C said trash should not be in bags in the hallway and should be placed in yellow barrels.During an interview on 2/2/2026 at 1:15 p.m., the ADON said trash should be bagged and taken to the dumpster out back. She said the trash should not be placed on the floor or in hallways. She said it could be a fall risk and potential for spreading infection. She said she expected the staff to not place trash on the floor or hallways. She said the nurses were responsible for ensuring the trash was properly placed and not on the floors.During an interview on 2/2/2026 at 1:30 p.m., the DON said trash should not be stored in the hallways or left behind shower doors. She said the trash should be placed in the yellow barrel. The DON said she expected staff to wear gloves and properly bag linens and place them in gray barrels. She said trash should not be placed on the floor in the hallways. She said it was an infection control issue if the staff touched other surfaces or trash falls and contaminates other surfaces. The DON said all staff were responsible for ensuring trash and linens were stored properly.During an interview on 2/2/2026 at 2:45 p.m., the ADM said trash should be placed in the yellow barrels and linens go in the gray barrel. The ADM said staff should be wearing gloves while transferring dirty linens. He said it could cause cross-contamination if residents were provided care after touching dirty linens. He said he expected the staff to follow infection control policies.Record review of the facility's policy, Fundamentals of Infection Control Precautions, undated, stated: .A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions .1. Hand hygiene continues to be the primary means of preventing the transmission of infection.after handling soiled or used linens, dressings, bedpans, catheters or (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	urinals.Gloving.to provide a protective barrier and prevent gross contamination of hands when touching blood, body fluids, secretions, excretions, mucous membranes and nonintact skin. 7. Linen and laundry.soiled linen may be contaminated with pathogenic microorganism, the risk for disease transmission is negligible if it is handled, transported, and laundered in a manner that avoids transfer of microorganisms. Hygienic and common-sense storage and processing of clean and soiled c=linens is recommended. 1. All soiled linen will be doubled bagged at the site that it was generated. All personnel will utilize all personal protective equipment. Soiled linen will be transported to the laundry site by cart.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 1 of 4 Halls (Hall #2) and 2 of 4 showers (Shower #2 and Shower #4) reviewed for environment.The facility failed to ensure trash was properly stored for Shower #4 on 1/29/2026 at 9:44 a.m.The facility failed to ensure trash was properly stored and removed from Hall #2 on 2/2/2026 at 9:46 a.m.The facility failed to ensure dirty linens were properly stored in Shower #2 on 1/29/2026 at 10:24 a.m.The facility failed to ensure toilet rim was intact without cracked porcelain on the back of the toilet on 1/29/2026 at 10:38 a.m These failures could place residents at risk in an unsanitary and uncomfortable environment.Findings included:During an observation on 1/29/2026 at 9:44 a.m., Shower #4 had dirty linens on the floor and a bag of trash in a clear bag located behind the door.During an observation and interview on 1/29/2026 at 9:44 a.m., Laundry E said the dirty linen should not be on the shower floor but kept in the linen barrel. Housekeeper E, not wearing gloves, picked up the dirty linens and placed them in the yellow barrel. Laundry E said she should have worn gloves when touching dirty linen.During an interview on 1/29/2026 at 3:15 p.m., the ADON said dirty linens go into a trash bag then placed in the gray barrel. The ADON said trash was placed in yellow barrels. The ADON said dirty linens should not be on the floor. She said it was an infection control issue and a fall risk. The ADON said the nurses were responsible for ensuring dirty linens were off the floor and in the proper barrels. She said the staff should not leave trash on the floor in the shower room. During an interview on 1/29/2026 at 3:58 p.m., CNA D said trash should be placed in the yellow barrel. She said the staff should place dirty linens in bags and place them in the gray barrel in the shower room. She said dirty linens should not be stored on the floor. CNA D said trash should not be placed on the floor in the shower room and should be placed in the yellow barrel in the shower room. CNA D said it was an infection control issue and could spread bacteria causing other people to get sick.During an observation on 2/2/2026 at 9:46 a.m., two bags of trash in clear trash bags were on the floor in front of the shower room on Hall #2. Observed CNA G picked up the trash and placed it on a gray barrel and rolled it down the hall.During an interview on 2/2/2026 at 9:56 a.m., CMA H said she did not see the two trash bags on the floor in the hallway. CMA H said no trash should be left in the hallway on the floor. She said the aides were responsible for taking the trash out if the barrel was full. She said someone could trip over the bags or someone could take something out of the bags, eat something out of the trash, or spread germs.During an interview on 2/2/2026 at 11:20 a.m., Housekeeper E said trash should not be on the floor in the hallways and should be placed in the yellow barrel. She said trash should not be placed on the gray barrel and taken outside to dumpster. She said the staff would need to wipe down the gray barrels and disinfect the gray barrels that they returned to the facility. Housekeeper E said dirty linens should not be picked up with bare hands and gloves should be worn. She said a person could get an infection if it touched their skin. She said the staff had been in-serviced on infection control. Housekeeper E said it was everyone's responsibility for infection control measures. She said a resident could get sick if infection control measures were not implemented. She said she would report to the ADM or supervisor if anyone was observed not properly using infection control measures.During an interview on 2/2/2026 at 11:27 a.m., the Housekeeping Supervisor said trash should not be in clear trash bags in the hallways or behind shower room doors. She said trash should not be placed on top of the gray barrels and rolled outside. She said it was an infection control issue with placing the trash on top of the barrels. She said the staff had to disinfect the barrels. She said residents could dig in the trash, wheel over the trash with their wheelchairs and drag trash on the floor (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if the trash was left on the floor. Housekeeper Supervisor said the floor technician was responsible for taking all trash out or the CNA could wheel the trash out to the dumpster.During an interview on 2/2/2026 at 11:35 a.m., CMA B said trash should not be placed outside in the hallway on the floor. She said it could cause cross contamination. She said a resident could come through the trash in their wheelchair. She said it should be properly contained. She said dirty linens should be placed in the proper container and should be in a bag and never on the floor. She said a resident could trip over the dirty linens or get caught in a wheelchair. CMA B said the CNA and laundry staff are responsible for ensuring the linens were placed in clear bags and placed in gray barrels. She said if not properly placed, it could cause cross-contamination and spread germs to others.During an interview on 2/2/2026 at 12:00 p.m., CNA G said she was the one who placed the trash in the hallway on the floor. She said she thought she could place the trash on the floor if it was in a bag. She said she thought she could place trash with the dirty linens to transport outside. CNA G said dirty linens should not be left on the floor in a resident room. She said the dirty linens should be placed in a bag and taken to the laundry or placed in the laundry closet with the dirty linens. She said no trash should be left on the floor. She said it could contaminate the shower room. She said everyone was responsible for ensuring the trash and linens were taken out properly.During an interview on 2/2/2026 at 12:13 p.m., LVN C said linens should be placed in a bag and taken to the laundry or placed in a gray barrel. She said lines should not ideally be placed on the floor. She said it could contaminate the surface. LVN C said staff should not touch dirty linens with bare hands and gloves should be worn to prevent cross-contamination. She said it could cause contamination if someone touched a resident or something a resident might touch. LVN C said everyone was responsible for ensuring staff were wearing gloves and not placing linens on the floor. LVN C said trash should not be in bags in the hallway and should be placed in yellow barrels.During an interview on 2/2/2026 at 1:15 p.m., the ADON said trash should be bagged and taken to the dumpster out back. She said the trash should not be placed on the floor or in hallways. She said it was a fall risk and potential risk for spreading infection. She said she expected the staff to not place trash on the floor or hallways. She said the nurses were responsible for ensuring the trash was properly placed and not on the floors.During an interview on 2/2/2026 at 1:30 p.m., the DON said trash should not be stored in the hallways or left behind shower doors. She said the trash should be placed in the yellow barrel. The DON said she expected staff to wear gloves and properly bag linens and place them in gray barrels. She said trash should not be placed on the floor in the hallways. She said it was an infection control issue if the staff touched other surfaces or trash fell and contaminated other surfaces. The DON said all staff were responsible for ensuring trash and linens were stored properly.During an interview on 2/2/2026 at 2:45 p.m., the ADM said trash should be placed in the yellow barrels and linens in the gray barrel. The ADM said staff should wear gloves while transferring dirty linens. He said it could cause cross-contamination if residents were provided care after touching dirty linens. He said he expected the staff to follow infection control policies.During an observation on 1/29/2026 at 10:36 a.m., Shower #2's toilet rim was broken on the back of the toilet with exposed rigid edges.During an observation and interview on 1/29/2026 at 3:30 p.m., the toilet rim in Shower # 2 was broken on the back of the toilet with exposed rigid edges and reported to the Corporate Nurse. She said she was not aware the porcelain was broken and would get it fixed immediately.During an interview on 2/2/2026 at 11:20 a.m., Housekeeper E said she reported the broken toilet to maintenance through the mobile QR application. She said she reported it in March 2025. She said the toilet rim was broken for a while and no one told her why it was not fixed. She said a resident could trip and fall or cut themselves on the porcelain. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She said it should be reported immediately to maintenance or ADM when identified.During an interview on 2/2/2026 12:13 p.m., LVN C said she was not aware the toilet was broken in Shower #2. She said a resident could cut or hurt themselves if they fell or bumped into the broken porcelain.During an interview on 2/2/2026 at 1:15 p.m., the ADON said no one reported the porcelain broken on the toilet in Shower #2. She said whoever found it would be responsible for reporting it to maintenance. She said a resident could receive a skin injury from the broken porcelain.During an interview on 2/2/2026 at 1:30 p.m., the DON said she was not aware of the broken porcelain on the toilet in Shower #2. She said a report would need to be made immediately. She said a resident could have leaned back, fell or rubbed against it causing them to be injured or cut. She said all staff were responsible for ensuring equipment was intact. She said she would expect the staff to report immediately to prevent an injury.During an interview on 2/2/2026 at 2:45 p.m., the ADM said he expected the toilet to be fixed immediately due to resident safety. He said there was a possibility of an injury if a resident fell and hit the porcelain. He said everyone was responsible for ensuring the toilet was safe and operational.Record review of the facility's policy, Fundamentals of Infection Control Precautions, undated, stated, .A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions .1. Hand hygiene continues to be the primary means of preventing the transmission of infection.after handling soiled or used linens, dressings, bedpans, catheters or urinals.Gloving.to provide a protective barrier and prevent gross contamination of hands when touching blood, body fluids, secretions, excretions, mucous membranes and nonintact skin. 7. Linen and laundry.soiled linen may be contaminated with pathogenic microorganism, the risk for disease transmission is negligible if it is handled, transported, and laundered in a manner that avoids transfer of microorganisms. Hygienic and common-sense storage and processing of clean and soiled c=linens is recommended. 1. All soiled linen will be doubled bagged at the site that it was generated. All personnel will utilize all personal protective equipment. Soiled linen will be transported to the laundry site by cart.Record review of the facility's policy, Resident Rights, undated, stated, .The resident has a right to a dignified right to existence, self-determination, and communication with and access to persons and services inside and outside the facility.A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.