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	02/20/2026

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives for 1 of 2 (Resident #1) reviewed for quality of life. The facility failed to ensure LVN A performed basic life support measures per AHA, BCLS guidelines when Resident #1 was in distress and choking on 2/7/26. The facility failed to ensure RN B performed basic life support per AHA guidelines for Resident #1 on 2/7/26. The facility failed to ensure MA C performed basic life support per AHA guidelines for Resident #1 on 2/7/26. The facility failed to ensure LVN A, RN B, and MA C, CPR trainings were up to date. These failures resulted in Resident #1 not receiving basic life support while choking on 2/7/26. While appropriate, back blows nor the Heimlich maneuver were performed for over a minute. The failure to follow AHA BCLS guidelines delayed initiation of CPR by a approximately 2 minutes. An Immediate Jeopardy (IJ) was identified on 2/19/26. The IJ template was provided to the facility on 2/19/26 at 4:13 p.m. While the IJ was removed on 2/20/26 at 4:18 p.m., the facility remained out of compliance at a scope of isolated and a severity level no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to monitor and evaluate the effectiveness of their corrective systems.Findings included: Record review of Resident #1's face sheet, dated 2/18/26, indicated she was an [AGE] years old female admitted to the facility on [DATE] with diagnoses including senile degeneration of the brain, CHF (Congestive Heart Failure, a chronic, progressive condition where the heart muscle is too weak or stiff to pump blood efficiently) type 2 diabetes and AFIB (atrial fibrillation is a serious irregular heart beat that can lead to complications such as blood clots, stroke and/or heart failure). Record review of the admission MDS, dated [DATE], indicated Resident #1 had clear speech, usually made herself understood and understood others. The MDS reported Resident #1 had severe cognitive impairment (BIMS of 03). The MDS indicated Resident #1 needed set up or clean-up assistance with meal and oral hygiene. The MDS indicated Resident #1 required partial/moderate assistance with toileting, sit to stand transfers and walking ten feet. The MDS reported Resident #1 required supervision or touching assistance with toilet transfers. The MDS indicated Resident #1 required partial/moderate assistance with locomotion in her manual wheelchair. The MDS indicated Resident #1 was frequently incontinent of bowel and always incontinent of bladder. The MDS reported Resident #1 had active diagnoses of senile degeneration of the brain, respiratory failure, muscle weakness and the presence of cardiac pacemaker. The MDS indicated Resident #1 had a mechanically altered diet while a Resident in the facility. Record review of Resident #1's care plan, dated 1/21/26, indicated Resident #1 had a diet other than a regular diet. The care plan did not address risk for choking. During an interview on 2/19/26 at approximately 10:00 a.m., the Administrator said the facility did have video of the (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	incident on 2/7/26. During an interview on 2/19/26 at approximately 10:30 a.m., RN D (corporate compliance nurse) said while observing the video footage a timeline of events would be documented and then a copy supplied to the surveyor. During an observation on 2/19/26 at 10:40 a.m., with the Administrator and RN D (corporate compliance nurse) present, the video footage was observed. The Administrator and RN D confirmed the identification of Resident #1 on the video footage. During the footage Resident #1 sat in the dining room in her wheelchair. Resident #1 was served her breakfast tray. While she ate Resident #1 began to choke. LVN A responded promptly to Resident #1 and began to lightly tap her on her back repetitively after Resident #1 communicated by hand gesture to tap her back (occurred at 07:18:12 [7:18 am 12 second mark]). LVN A continued to lightly pat Resident #1 on the back as Resident #1 violently shook her head back and forth communicating a response of ‘no' (occurred at 07:18:17).With the footage zoomed in on Resident #1, Resident #1 appeared to vomit (occurred at 07:18:48), then Resident #1 nods her head in up and down motion communicating ‘yes' (occurred at 07:19:04). Resident LVN A appeared to be yelling for help and continuously lightly patting Resident #1 on the back (occurred at 07:19:10). Resident #1's body becomes limp and she was unresponsive (occurred at 07:19:25). LVN A walked to the edge of the dining room (occurred at 07:19:27) as Resident #1's limp body remained in her wheelchair. LVN A returned to Resident #1 (occurred at 07:19:34). RN B entered the dining room (occurred at 07:19:37). LVN A resumed lightly patting Resident #1 on the back as her limp body sat in the wheelchair, (occurred at 07:19:40). LVN A quickly assessed Resident #1 and then ran out of dining room (occurred at 07:19:44). LVN A positioned Resident #1's limp body forward (Resident #1's head appeared to rest on the dining table in front of her) and LVN A began to aggressively pat Resident #1 on the back (occurred at 07:19:53). MA C attempted the Heimlich maneuver (an emergency first-aid procedure used to attempt to clear a blocked airway in a choking conscious victim. The maneuver is performed by standing behind the victim, placing a fist just above their navel with the thumb side in, grasping it with the other hand, and delivering quick, upward thrusts to force air from the lungs) (occurred at 07:20:08). RN B returned to Resident #1's side and additional staff were noted in the dining room (CNA E and Housekeeper F). The staff moved Resident #1 away from the table (occurred at 07:20:18). After the wheelchair was moved away from the dining room table, RN B attempted the Heimlich maneuver (occurred at 07:20:22). Resident #1's body remains limp in the wheelchair. RN B attempted to shake Resident #1's shoulder while MA C appeared to perform a sternal rub (painful stimulus technique used by healthcare professionals to assess the neurological responsiveness of an unconscious or unresponsive person) occurred at 07:20:34. RN A began to push Resident #1 in the wheelchair but her (Resident #1's) feet began to drag on the floor impeding movement. CNA E immediately picked her feet up (Resident #1's) as RN B pushed the wheelchair out of the dining room. Resident #1 was out of video frame (out of the dining room) at 07:20:45. During an interview on 2/19/26 at 10:50 a.m., RN D said staff moved Resident #1 to the nearest empty room to initiate CPR. During an interview on 2/19/26 at 11:25 a.m., LVN A said when she saw Resident #1 raise her head in an upward motion, and initially thought Resident #1 was going to sneeze. LVN A said Resident #1 began coughing and went over to her. LVN A said she asked Resident #1 if she was ok and she shook her head no and asked her if she was choking and she nodded her head yes. LVN A said she started slapping Resident #1 on the back to get the object she was choking on loose. LVN A said she remembers she was trying to yell to get assistance from other staff. LVN A said when the resident went unconscious, she started to go out of the dining room to get help but RN B was on her way to the dining room. LVN A said it felt like an eternity and she was scared but felt hitting Resident #1 on the back was the right thing since she suspected she was choking. During an interview on 2/19/26 at 11:42 a.m., RN B said (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	when she had gotten to the dining room Resident #1 was already blue and purple. RN B said Resident #1 was not responsive. RN B said she knew Resident #1 was gone and ran to check her code status. RN B said she noted Resident #1 was a full code and called 911, then ran back to the dining room. RN B said she remembered LVN A saying she (Resident #1) choked. RN B said she quickly attempted the Heimlich maneuver, but Resident #1 remained unresponsive. RN B said they (staff) moved Resident #1 to the nearest empty resident room to initiate CPR because she did not want to traumatize the other residents in the dining room. RN B said they (LVN A and RN B) continued CPR until EMS arrived. RN B said she knew that Heimlich maneuver was to be performed on a choking victim but that if the victim became unconscious CPR was to be initiated. RN B said she panicked and attempted the Heimlich maneuver even though Resident #1 was unconscious at that point. Record review of LVN A's BCLS certificate from the AHA, dated 11/9/2023, indicated her certification in BCLS had expired 11/30/25. Record review of RN B's BCLS certificate from the AHA, dated 12/18/23, indicated her certification in BCLS expired 12/31/25. During an interview on 2/19/26 at 11:50 a.m., RN D said MA C was not currently certified in BCLS. During an observation on 2/19/26 at approximately 2:50 p.m., the Administrator walked quickly from the left entrance of the dining room (where staff were observed to have exited with Resident #1) to the nearest resident room (identified as the room where Resident #1 was taken by staff to initiate CPR). RN B kept record of the time. Walking briskly to the room took the Administrator 15.51 seconds. Record review of the hospital emergency department note dated 2/7/26 at 8:16 am for Resident #1 stated chief complaint.Respiratory Arrest.per EMS, patient had lots of eggs in her mouth/throat-possible aspiration (inhaling foreign material [including food] into the airway and lungs instead of swallowing it into the esophagus). The emergency department note reported Resident #1 was shocked with defibrillator (a medical device that delivers a high-energy electric shock to the heart to stop dangerous, irregular rhythms (arrhythmias) or to restart the heart during cardiac arrest) five times and three rounds of epinephrine and amiodarone (critical drugs used together during advanced cardiovascular life support [ACLS] for cardiac arrest) were administered enroute to the Emergency Department. Record review of the Emergency Department diagnoses dated 2/7/26 at 8:17 am listed Cardiopulmonary arrest (the sudden cessation of effective heart function and breathing, leading to an abrupt halt in blood circulation to the body and brain) Aspiration into airway, and Death. Record review of the Emergency Department provider note dated 2/7/26 at 8:20 a.m., stated .Patient pronounced with death at 8:11 AM with no respiratory effort and no pulse or heart sounds. Record review of the undated facility policy and procedure titled Choking/Aspiration indicated a Resident had four minutes to live and instructed signs a resident may be choking included hand on neck, cannot speak or breathe, turns blue, collapses. The policy and procedure indicated to perform Heimlich and also provided instruction for performing abdominal thrusts if the resident laid on their back. The policy and procedure did not address guidelines if the resident became unconscious or non-responsive. Record review of the undated facility policy and procedure titled Cardiopulmonary Resuscitation stated, Cardiopulmonary resuscitation (CPR) is a method of providing systemic circulation by manual chest compression and oxygen by mouth-to-mouth or providing breathing or providing air to the lungs via ambu bag (handheld, manual resuscitator device used to provide positive pressure ventilation to individuals who are not breathing or are breathing inadequately). The procedure is performed to prevent death. The procedure is performed to prevent death following cardiac or pulmonary arrest.The facility will have at least 1 (one) staff member who is trained in CPR/BCLS at all times in the facility. Trained staff must maintain current CPR certification for Healthcare Providers through a CPR provider whose training includes a hands-on session either in physical or virtual instructor-led setting in accordance with (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	accepted national standards. The American Heart Association BCLS guidelines accessed at, https://www.ahajournals.org/doi/full/10.1161/CIR.0000000000001372 on 2/19/26, at 3:10 p.m., stated. Adult Basic Life Support Part 7 of the 2025 Guidelines, Adult Basic Life Support, provides recommendations for adults experiencing cardiac arrest, respiratory arrest, and FBAO ((foreign body obstruction of airway) .Significant New and Updated Recommendations-Foreign Body Airway Obstruction-Based on additional evidence of effectiveness and safety, the use of back blows is now recommended as the initial step for conscious adults with FBAO (foreign body obstruction [of airway]), followed by abdominal thrusts (Heimlich Manuever). As in 2020, once the person becomes unresponsive, the recommendation is to initiate CPR . with inspection of the mouth for presence of a foreign body prior to delivery of breaths . A new algorithm for treatment of FBAO ((foreign body obstruction of airway)for adults is included. The Administrator was notified on 2/19/26 at 4:10 p.m. that an Immediate Jeopardy situation was identified due to the above failures. The Administrator was provided with the Immediate Jeopardy template via email on 2/19/26 at 4:13 p.m. The Plan of Removal was accepted on 2/19/26 at 7:00 p.m., and detailed the following: Interventions: 1. An audit was conducted on 2/19/26 by Regional Compliance Nurse on all residents that expired in the facility during the last 30 days, to ensure that CPR was performed according to AHA and BCLS guidelines to include the Heimlich Maneuver. No residents were identified. No additional findings were noted. 2. An audit was conducted on 2/19/26 by Human Resource of all charge nurses in facility for current CPR certifications. Completed 2/19/26. 3. Regional Compliance Nurse will conduct CPR classes for all charge nurses in the facility to ensure current certifications with return demonstration to include the Heimlich Maneuver. Completed 2/20/26. The Administrator and ADON were in-serviced 1:1 by the ADO and Regional Compliance Nurse on 2/19/26 on the following and comprehension was verified by a post test a. Abuse and Neglect Policy: to include failure to perform the Heimlich maneuver according to AHA and BCLS guidelines or initiating CPR timely to a resident that is unresponsive could be considered neglect. b. Cardio-Pulmonary Resuscitation - to include initiating CPR immediately when a resident is identified as unresponsive with no pulse. c. Choking- Heimlich Maneuver - to include the universal signs of choking and the Heimlich Maneuver according to the AHA and BCLS guidelines 1. LVN A, RN B, and MA C were in-serviced 1:1 by the ADO and Regional Compliance Nurse on 2/19/26 on the following and comprehension was verified by posttest. a. Abuse and Neglect Policy: to include failure to perform the Heimlich maneuver according to AHA and BCLS guidelines or initiating CPR timely to a resident that was unresponsive could be considered neglect. b. Cardio-Pulmonary Resuscitation - to include initiating CPR immediately when a resident is identified as unresponsive with no pulse. c. Choking- Heimlich Maneuver - to include the universal signs of choking and performing the Heimlich Maneuver according to the AHA and BCLS guidelines The Medical Director was notified of the immediate jeopardy citation on 2/19/26 by the Administrator. 1. An ADHOC QAPI meeting was completed on 2/19/26 to review the immediate jeopardy citations and subsequent plan of removal. In-services: 1. The Regional Compliance Nurse, ADO, Administrator, and ADON will in-service all medication aides and CNAs on the following topics below. All staff not present for the in-services will not be allowed to work their next shift until the in-services are complete. All new hires will be in-serviced during orientation prior to working their shift. All agency staff will be in-serviced prior to assuming scheduled shift. Comprehension will be verified by a post-test. a. Abuse and Neglect Policy: to include failure to perform the Heimlich maneuver according to AHA and BCLS guidelines or initiating CPR timely to a resident that is unresponsive could be considered neglect. b. Notification of a change in condition - including the universal signs of choking and the Heimlich maneuver to be completed immediately according to AHA and BCLS Guidelines. Staff should respond (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	immediately and the nurse should be notified. 2. The Regional Compliance Nurse, ADO, Administrator, and ADON will in-service all charge nurses on the following topics below. All staff not present for the in-services will not be allowed to work their next shift until the in-services are complete. All new hires will be in-serviced during orientation prior to working their shift. All agency staff will be in-serviced prior to assuming scheduled shift. Comprehension will be verified by a post test. a. Abuse and Neglect Policy: to include failure to perform the Heimlich maneuver according to AHA and BCLS guidelines or initiating CPR timely to a resident that is unresponsive could be considered neglect. b. Notification of a change in condition - including the universal signs of choking and the Heimlich maneuver to be completed immediately according to AHA and BCLS Guidelines. Staff should respond immediately and the nurse should be notified. c. Cardio-Pulmonary Resuscitation - to include initiating CPR immediately when a resident is identified as unresponsive with no pulse. d. Choking-Heimlich Maneuver - to include the universal signs of choking and performing the Heimlich Maneuver according to the AHA and BCLS guidelines On 2/20/25 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: Record review of the audit document dated 2/19/26 verified an audit was performed by the Regional Compliance Nurse (RN B) on all residents that expired in the facility during the last 30 days. Record review of the untitled audit record dated 2/19/26 found all facility nurses were audited by human resources for BCLS certification and 16 nurses were found with expired or missing BCLS certifications. During an interview on 2/20/26 at 9:19 a.m., RN B confirmed no residents in the facility required BCLS intervention prior to hospital transfer. RN B also said as a result of the audit performed by human resources many staff had expired BCLS certifications. RN B said she would be teaching BCLS per AHA guidelines to bring expired staff up to date in their certifications. RN B clarified all nurses would be required to have BCLS certification. RN B added that many CNAs and MAs will also be completing the class for certification. RN B stated she would be holding a class at 10:00 a.m. and 3:00 p.m on 2/20/26. During an observation on 2/20/26 at 10:57 a.m., RN B was conducting BCLS training course with AHA material. Record review of the Iin-service training reports dated 2/19/26 confirmed the Administrator and ADON were in-serviced over the following items: *Abuse and Neglect Policy: to include failure to perform the Heimlich maneuver according to AHA and BCLS guidelines or initiating CPR timely to a resident that is unresponsive could be considered neglect. *Cardio-Pulmonary Resuscitation - to include initiating CPR immediately when a resident is identified as unresponsive with no pulse. *Choking- Heimlich Maneuver - to include the universal signs of choking and the Heimlich Maneuver according to the AHA and BCLS guidelines Record review of the posttests dated 2/20/26 confirmed the Administrator's and ADON's comprehension of the in-services listed above. Record review of the individual in-service training reports dated 2/19/26 confirmed LVN A, RN B, and MA C were in-serviced 1 on 1 by RN B over the following items: *Abuse and Neglect Policy: to include failure to perform the Heimlich maneuver according to AHA and BCLS guidelines or initiating CPR timely to a resident that is unresponsive could be considered neglect. *Cardio-Pulmonary Resuscitation - to include initiating CPR immediately when a resident is identified as unresponsive with no pulse. *Choking- Heimlich Maneuver - to include the universal signs of choking and the Heimlich Maneuver according to the AHA and BCLS guidelines. Record review of the posttests dated 2/20/26 confirmed LVN A's, RN B's, and MA C's comprehension of the in-services listed above. Record review of the facility document titled Off Cycle (ADHOC) QA Meeting Document confirmed the Medical Director was notified of the Immediate Jeopardy and attended by phone the ADHOC QAPI meeting on 2/19/26 addressing the identification of Immediate Jeopardy. The document outlined the facilities plan of removal and the plan for the Administrator and DON or ADON monitor (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	weekly, with any identification during monitoring to be addressed for immediate change. During interviews on 2/20/26 from 1:20 p.m. to 4:10 p.m. The surveyor confirmed all direct care staff present on the evening shift or night shift of 2/19/26 (MAs worked 8- hour shifts, nurses and CNAs worked 12-hour shifts) and all clinical staff on the day shifts for 2/20/26 (MAs worked 8-hour shifts, nurses and CNAs worked 12-hour shifts) had received in-services as outlined in the Plan of Removal. Additional staff present for the 10am class that had completed the hands-on skills check-off portion of the AHA BCLS training were also interviewed. All staff interviewed (LVN A, RN B, MA C, LVN G, CNA H, CNA I, CNA J, CNA K, CNA L, CNA M, CNA N, CNA O, CNA P, CNA Q, CNA R, CNA S, RN T, CNA U, LVN V, MA W, MA X, MA Y, MA Z, MA AA, CNA AB) named signs a resident may be choking including the Universal Sign (clutching the throat with one or both hands; Coughing [forced, violent, or silent cough indicates a severe blockage]; Breathing - Noisy Breathing: High-pitched, squeaky, or wheezing noises, or absent breathing; Inability to Speak: The person cannot talk, or make sound; Panic: A panicked, terrified, or shocked facial expression. Color Change: Skin, lips, or fingernails turn blue, gray, or pale. The staff said they understood that a resident may not display all of these signs. They also said they understood resident vomiting did not mean the resident could breathe and was not necessarily reassuring. All staff said BCLS intervention would be initiated immediately for a choking resident, including immediate call to 911 for EMS services. The MAs and CNAs said if they saw these signs they would immediately call for the nurse but would attempt back blows five times alternated with Heimlich mauver 5 times. The MAs and CNAs said when the nurse arrived to take over, they would immediately call EMS if the nurse had not yet done so. The staff said failing to provide alternating back blows and Heimlich to a choking resident could be considered neglect. Nurses said choking residents would be administered BCLS intervention which included for a conscious victim, 5 blows to the back alternated with 5 attempts of Heimlich maneuver, until the item was dislodged or the victim became unresponsive. If the victim became unresponsive during these attempts, CPR was to be initiated immediately. The staff said failing to initiate CPR when a choking resident became unresponsive could be considered neglect. On 2/20/25 at 4:18 p.m., the Administrator was informed the IJ was removed; however, the facility remained out of compliance no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.