

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  10/03/2024
NAME OF PROVIDER OR SUPPLIER  Whispering Pines Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE  2131 Alpine Rd Longview, TX 75601	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643</b></p> <p>Based on interview and record review, the facility failed to ensure the Pre-Admission Screening and Resident Review (PASRR) Level I assessment accurately reflected the resident's status for 4 of 8 residents (Resident #15 #16, #49, and #52) reviewed for PASRR Level I screenings.</p> <ol style="list-style-type: none"> <li>The facility failed to ensure the accuracy of the PASRR Level 1 screening for Resident #49. The PASRR Level 1 screening did not indicate a diagnosis of mental illness, although the diagnosis (Post Traumatic Stress Disorder, a mental health condition that can develop after a person experiences or witnesses a traumatic event with an onset date of 08/01/21) was present upon Resident #49's re-admitted on 11/16/23.</li> <li>The facility failed to ensure the accuracy of the PASRR Level 1 screening for Resident #15. The PASRR Level 1 screening did not indicate a diagnosis of mental illness, although the diagnosis (Major depressive disorder with an onset date of 06/28/22) was present upon Resident #15's admitted on 06/28/22.</li> <li>The facility failed to ensure the accuracy of the PASRR Level 1 screening for Resident #52. The PASRR Level 1 screening did not indicate a diagnosis of mental illness, although the diagnosis (Major depressive disorder with an onset date of 04/07/22) was present upon Resident #52's re-admitted on 09/12/24.</li> <li>The facility failed to ensure the accuracy of the PASRR Level 1 screening for Resident #16. The PASRR Level 1 screening did not indicate a diagnosis of mental illness, although the diagnosis (Major depressive disorder with an onset date of 12/15/2020) was present upon Resident #16's re-admitted on 2/11/2021.</li> </ol> <p>This failure could place residents who had a mental illness at risk of not receiving a needed assessment (PASRR Evaluation), individualized care, or specialized services to meet their needs.</p> <p>Findings included:</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. Record review of Resident #49's face sheet, dated 08/01/21 reflected a [AGE] year-old female admitted on [DATE]. She was most recently readmitted on [DATE]. The reflected diagnoses that included PTSD (a mental health condition that can develop after a person experiences or witnesses a traumatic event) with an onset date of 08/01/2021, Chronic Systolic Heart Failure (a condition where the left ventricle of the heart is unable to contract properly, resulting in less blood circulating throughout the body), Hyperlipidemia (a condition where there are abnormally high levels of lipids or fats in the blood.)</p> <p>Record review of Resident #49's quarterly MDS assessment, dated 07/31/24, reflected Resident #49 had a BIMS of 10, which indicated moderate cognitive impairment. Shows that Resident #49 received an antianxiety medication during the assessment period.</p> <p>Record review of Resident #49's PASRR Level 1 Screening, dated 08/01/21, reflected in Section C Mental Illness was marked as no, which indicated Resident #49 did not have a mental illness.</p> <p>During an interview on 10/02/24 at 11:21 a.m., MDS Nurse J said she had worked at the facility for two years. She said that when a new resident comes into the facility their PASRR level one needs to be completed or if a level one was completed it needs to be checked for accuracy. She said that PTSD, Schizophrenia, and Major Depressive Disorder all qualify for a mental illness. She said that if one of these diagnoses were present then the resident's PASRR would be marked, Yes to indicate the presence of mental illness. She said that residents #15 and #49 both had mental illnesses that should have been marked as, Yes.</p> <p>2. Record review of Resident #15's face sheet, dated 06/28/22 reflected a [AGE] year-old female admitted on [DATE]. She was most recently readmitted on [DATE]. Revealed diagnoses that included schizoaffective disorder (a chronic mental illness that combines symptoms of schizophrenia and a mood disorder, such as bipolar disorder or depression) onset date of 6/28/2022, Major Depressive Disorder (a serious mental disorder that can affect how someone feels, thinks, and acts) onset date of 6/28/2022, and Hyperthyroidism (occurs when the thyroid gland produces too much thyroid hormone).</p> <p>Record review of Resident #15's significant change MDS assessment, dated 07/14/24, reflected Resident #15 had a BIMS of 10, which indicated moderate cognitive impairment. Resident #15's MDS reflected there was no serious mental illness.</p> <p>Record review of Resident #15's PASRR Level 1 Screening, dated 06/28/22, reflected that in Section C Mental Illness was marked as no, which indicated Resident #15 did not have a mental illness.</p> <p>During an interview on 10/02/24 at 11:21 a.m., MDS Nurse J said she had worked at the facility for two years. She said that when a new resident comes into the facility their PASRR level one needs to be completed or if a level one was completed it needs to be checked for accuracy. She said that PTSD, Schizophrenia, and Major Depressive Disorder all qualify for a mental illness. She said that if one of these diagnoses was present with a resident then their PASRR would be marked, Yes to indicate the presence of mental illness. She said that residents #15 and #49 both had mental illnesses that should have been marked as, Yes.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Record review of Resident #52's face sheet, dated 09/30/24, reflected she was a [AGE] year-old female, admitted to the facility initially on 02/15/22, and readmitted to the facility on [DATE]. Her diagnoses included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) with an onset date of 04/07/22.</p> <p>Record review of Resident #52's quarterly MDS assessment, dated 09/16/24, reflected she had a BIMS score of 15, which indicated intact cognition. She also took an antidepressant medication during the assessment window.</p> <p>Record review of Resident #52's PASRR Level 1 Screening, dated 02/15/22, reflected that in Section C, Mental Illness was marked as no, which indicated Resident #52 did not have a mental illness.</p> <p>During an interview on 10/02/24 at 11:37 AM, the SW A said she had started working in the facility in January 2022. She said Resident #52 should have had a positive PASRR Level 1 screening for mental illness. She said there was a possibility that Resident #52 could have received PASRR services if her PASRR Level 1 had been marked positive for mental illness.</p> <p>4. Review of Resident #16's face sheet dated 10/1/2024 reflected [AGE] year-old female readmitted to the facility on [DATE] diagnosis included Heart Failure (occurs when the heart muscle doesn't pump blood as well as it should causing blood often backs up and fluid can build up in the lungs, causing shortness of breath), Atrial Fibrillation (an irregular and often very rapid heart rhythm and can lead to blood clots in the heart), Major Depressive disorder (a common but serious mood disorder that causes severe symptoms that affect how a person feels, thinks, and handles daily activities, such as sleeping, eating, or working), Pseudobulbar Affect (a condition that's characterized by episodes of sudden uncontrollable and inappropriate laughing or crying), and Anxiety disorder (usually involves a persistent feeling of anxiety or dread, which can interfere with daily life. usually involves a persistent feeling of anxiety or dread, which can interfere with daily life).</p> <p>Review of Resident # 16's MDS Assessment, dated 2/17/2021, reflected a [AGE] year-old female readmitted to the facility on [DATE] diagnoses included anxiety disorder (usually involves a persistent feeling of anxiety or dread, which can interfere with daily life, depression (a common but serious mood disorder that causes severe symptoms that affect how a person feels, thinks, and handles daily activities, such as sleeping, eating, or working) and psychotic disorder (psychosis refers to a collection of symptoms that affect the mind, where there has been some loss of contact with reality).</p> <p>Review of Resident # 16's PASRR Level 1 Screening, dated 12/11/2020, reflected a negative screening for mental illness.</p> <p>During an interview on 10/2/2024 at 11:24 AM, Social Worker A said admissions ensured the PASARR was completed before a resident was admitted to the facility. Social Worker A said she would refer the resident's if they qualified for services and refer them to the local mental health authority if the PASARR was positive.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/2/2024 at 11:30 AM, Social Worker L said Resident # 16 went to the hospital and then returned. He said there was a diagnosis on the readmit from the hospital for depression. Social Worker L said he was not sure if another PASARR should had been completed in February. He said Resident #16 was readmitted with an antidepressant which required the facility to give her a diagnosis of depression. Social Worker L said he did not realize the facility would need to obtain a new PASARR. He said Resident #16 could have been available to receive services. Social Worker L said Resident #16 already had services in place upon return to the facility.</p> <p>During an interview on 10/2/2024 at 2:15 PM, MDS nurse J said all residents should have a PASARR. She said she is currently working on fixing issues from a previous employee. The MDS nurse J said the facility should have completed a form 1012 to send to the physician following the updated diagnosis of major depression on 1/18/2021. She said it was not completed. The MDS nurse said the PASARR update would not have changed Resident #16's care because Resident #16 was already receiving psychiatric services by a visiting psychiatric service that comes to the facility. She said the services started on 3/30/2024 which she admitted was a delay in care of a couple of months.</p> <p>During an interview on 10/2/2024 at 2:20 PM, MDS nurse M said she was currently working on resolving issues identified from a previous employee. She said if a resident were positive for mental illness, the local mental health authority would call the resident on 30/60/90 days and check on them and would offer psychiatric services.</p> <p>During an interview on 10/2/24 at 11:09 a.m. with the DON she said that the MDS nurse was responsible to ensure the accuracy of PASRR level one screenings. She said that PTSD, Major Depressive Disorder, and Schizophrenia would trigger a Yes response on the PASRR level one. Residents could be placed at risk for not receiving the services they require if they are not accurately assessed on their PASRR level one.</p> <p>During an interview on 10/2/24 at 11:09 a.m. the ADM said that the MDS nurse was responsible for completing PASRR for newly admitted residents as well as ensuring that already completed PASRR's from the community are accurate. She said that residents would be placed at risk for not receiving services if they did not have an accurate PASRR.</p> <p>Record review of the facility's policy, PASRR Evaluation PE Policy and Procedure, dated 10/30/2017, reflected: 1. Policy: It is the policy of Creative Solutions in Healthcare facilities to ensure the LIDDA and/or LMHA complete a PE within the appropriate time periods (14 days). Note: this may vary depending on the type of admission and length of stay . The PE is to be printed and closely reviewed to determine if the resident was PASRR POSITIVE and notification to IDT Team is completed if indeed PASRR POSITIVE. The PE is placed in the medical record under the PASRR Tab . Positive PL1 will alert the LA to complete the Pasrr Evaluation. The PE (Pasrr Evaluation) is an evaluation to confirm or deny the suspicion of ID, DD, or MI recorded on the PL1. The evaluation also determines the need for specialized services that may be beneficial to the individual if they are confirmed positive for ID, DD, or MI. The PE is critical because it is the first identification of services an individual's needs.</p> <p>49019</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44933</p> <p>Based on interview and record review, the facility failed to ensure the baseline care plan that included the instructions for resident care needed to provide effective and person-centered care was completed and provided to the resident and/or their representative for 1 of 5 residents reviewed for new admissions (Resident #34).</p> <p>The facility failed to provide Resident #34's RP a copy of the summary of the baseline care plan.</p> <p>This failure could place residents at risk of not receiving care and services to meet their needs.</p> <p>Findings included:</p> <p>Record review of Resident #34's face sheet dated 09/30/24 indicated Resident #34 was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis including dementia (a group of thinking and social symptoms that interferes with daily functioning) with psychotic disturbance (severe mental disorders that cause abnormal thinking and perceptions), paranoid schizophrenia (is a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), and acute embolism (is an obstruction or blockage in a blood vessel) and thrombosis (is a blood clot within blood vessels that limits the flow of blood). The face sheet indicated a family member was Resident #34's responsible party.</p> <p>Record review of Resident #34's quarterly MDS assessment dated [DATE] indicated Resident #34 was usually understood and understood others. Resident #34 had a BIMS score of 03 which indicated severe cognition impairment. Resident #34 required setup for dressing, eating, and putting on footwear, supervision assistance for oral hygiene, partial assistance for shower/bath self and personal hygiene, and dependent for toilet hygiene.</p> <p>Record review of Resident #34 baseline care plan acknowledgement sheet indicated a copy of the baseline care plan was provided to the resident on 05/12/24.</p> <p>During an interview on 09/30/24 at 4:15 p.m., the responsible party of Resident #34 said he did not get a copy of Resident #34's baseline care plan. He said it would have been nice to have a copy of it.</p> <p>During an interview on 10/02/24 at 2:20 p.m., LVN E said LVNs completed certain parts on the baseline care plan and the MDS Coordinator finished it. She said the ADON printed a copy of the resident's baseline care plan then gave it to the nurses to give to the family. She said Resident #34 had a responsible party. She said Resident #34's RP should have also gotten a copy if Resident #34 received a copy. She said it was important for the RP to receive a copy of the baseline care plan, so they knew how the facility was going to care for their family member. She said if family members or RPs did not receive a copy of the baseline care plan, they would not know what was going on with the resident.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/02/24 at 3:21 p.m., MDS Nurse M said the charge nurse and ADON were responsible for baseline care plans. She said the charge nurse gave the baseline care plan acknowledgement form to the resident and/or RPs. She said she did not feel like Resident #34 would have understood her baseline care plan. She said Resident #34's RP should have received a copy. She said it was important for RPs to receive a copy of the resident's baseline care plan, so they understood the treatment and care being provided. She said not giving the resident's RP a copy, could make the family member feel out of the loop.</p> <p>During an interview on 10/03/24 at 10:21 a.m., the DON said the admission nurse was responsible for completing the baseline care plan and giving a copy to the resident and/or RP. She said the RP should get a copy of the baseline care plan and the resident if they wanted a copy. She said the facility provided a copy of the baseline care plan to the resident and/or RP 48 hours after admission. She said it was important to provide the RP with a copy, so they were informed on the resident's care being provided and how the facility was going to deliver the care. She said when a copy of the baseline care plan was not provided, RPs would not know what care was being provided. She said when a copy was not provided to the RPs, the facility could miss getting information like preferences and things that worked better for the resident. She said she did not know why Resident #34 only received a copy of the baseline care plan and not her RP.</p> <p>During an interview on 10/03/24 at 11:00 a.m., the ADM said the charge nurses were responsible for giving a copy of the baseline care plan to the RP and/or resident. She said the nursing administrative staff should ensure a copy of the resident's baseline care plan was given to the RP and/or resident if they were cognitive enough. She said a copy of the baseline care should be provided to the RP and/or resident within 72 hours of admission. She said it was important to provide a copy to the RP to ensure the information was correct, to add any missed information, and get information that could help better care for the resident.</p> <p>Record review of an undated facility's Base Line Care Plans policy indicated .the facility will provide the resident and their representative with a summary of the baseline care plan .</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46929</p> <p>Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment for 3 of 19 residents reviewed for care plans. (Resident #62, Resident #53, and Resident #34)</p> <ol style="list-style-type: none"> <li>The facility failed to ensure that Resident #62's care plan dated 08/15/24 addressed her psychotropic medications that she was prescribed by the physician on 08/02/2024.</li> <li>The facility failed to ensure Resident #34's CAA of behavioral symptoms were on the 08/27/24 care plan.</li> <li>The facility failed to ensure Resident #34's behaviors of incontinence on her and other resident's property was on the 08/27/24 care plan.</li> <li>The facility failed to ensure Resident #53's CAA of limited range of motion of her upper and lower extremities were on the 07/11/24 care plan.</li> <li>The facility failed to ensure Resident #53 activity preference of listening to music and type of preferred music was on the 07/11/24 care plan.</li> </ol> <p>These failures could place residents at risk for not receiving the necessary care or having important care needs identified.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Record review of Resident #62's face sheet, dated 09/30/24, indicated she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included dementia (the loss of cognitive functioning to such an extent that it interferes with a person's daily life and activities), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).</li> </ol> <p>Record review of Resident #62's quarterly MDS assessment, dated 07/05/24, indicated she was sometimes able to make herself understood, and sometimes was able to understand others. She had a BIMS score of 4, which indicated severe cognitive impairment.</p> <p>Record review of Resident #62's order summary report, dated 09/30/24, indicated this order:</p> <p>*Lorazepam oral tablet 0.5mg, Give 1 tablet by mouth one time a day related to dementia and anxiety for 180 days. The start date was 08/02/24. The end date was 01/29/25.</p> <p>Record review of Resident #62's MAR for the month of August 2024, printed on 10/01/24, indicated she was not administered the lorazepam medication during the month of August 2024.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #62's MAR for the month of September 2024, printed on 10/01/24, indicated she was administered the lorazepam medication on 09/11/24, 09/12/24, 09/16/24, 09/17/24, and 09/22/24.</p> <p>Record review of Resident #62's care plan, last revised on 08/15/24, did not contain a care plan for psychotropic medications.</p> <p>During an interview on 10/02/24 at 11:10 AM, the ADON said she expected Resident #62 to have a care plan for psychotropic medications. she said the risk to Resident #62 was that an unfamiliar staff may miss an intervention related to her psychotropic medication.</p> <p>During an interview on 10/02/24 at 11:16AM, the DON said she expected Resident #62 to have a care plan for psychotropic medications. She said the risk was that it was possible a staff unfamiliar with Resident #62's care could miss an intervention.</p> <p>During an interview on 10/02/24 at 11:22AM, the Administrator said she expected Resident #62 to have a care plan for psychotropics. She said the risk to Resident #62 was that her needs were not addressed. She said a staff member that was unfamiliar with her care may miss an intervention.</p> <p>2. Record review of Resident #34's face sheet dated 09/30/24 indicated Resident #34 was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis including dementia (a group of thinking and social symptoms that interferes with daily functioning) with psychotic disturbance (severe mental disorders that cause abnormal thinking and perceptions), paranoid schizophrenia (is a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), and acute embolism (is an obstruction or blockage in a blood vessel) and thrombosis (is a blood clot within blood vessels that limits the flow of blood).</p> <p>Record review of Resident #34's quarterly MDS assessment dated [DATE] indicated Resident #34 was usually understood and understood others. Resident #34 had a BIMS score of 03 which indicated severe cognition impairment. Resident #34 required setup for dressing, eating, and putting on footwear, supervision assistance for oral hygiene, partial assistance for shower/bath self and personal hygiene, and dependent for toilet hygiene. Resident #34 experience other behavioral symptoms not direct toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, or smearing food or bodily wastes, of verbal/vocal symptoms like screaming, disruptive sounds). Resident #34 experienced wandering that occurred daily. Resident #34's MDS assessment indicated SW A and MDS Nurse M completed the sections.</p> <p>Record review of Resident #34's care plan last reviewed completed on 08/27/24 indicated Resident #34 resided in the secure care unit, related to diagnosis of dementia and risk of elopement. Resident #34's care planned did reflect other behavioral symptoms coded on the MDS or behavior charted on the progress notes such as urinating on her and other resident's property.</p> <p>Record review of Resident #34's progress note dated 07/19/24 at 10:51 a.m. by LVN E indicated .Resident #34 wanders in and out of room taking clothing that is not hers and urinating on other resident's beds and putting clothing between her legs for pads after she takes her brief off .</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #34's progress note dated 07/20/24 at 3:31 p.m. by LVN E indicated .Resident #34 goes in and out of other resident's rooms urinating on beds and on clothing that is not hers .</p> <p>Record review of Resident #34's progress note dated 09/01/24 at 4:45 p.m. by LVN E indicated .I [LVN E] found resident [Resident #34] in bed on her back .she [Resident #34] had urinated on the bed from pillow to foot .she [Resident #34] had taken her pants and brief off and urinated on them on the floor .she [Resident #34] opened night chest drawers and took clothing out getting them soiled .</p> <p>Record review of Resident #34's progress note dated 09/04/24 at 3:37 p.m., by LVN E indicated .she [Resident #34] continues to urinate on bedding and clothing when not monitored .</p> <p>3. Record review of Resident #53 face sheet dated 09/30/24 indicated Resident #53 was a [AGE] year-old female admitted on [DATE] with diagnoses including Alzheimer's disease (s a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), cerebral infarction (stroke), major depressive disorder (a persistently low or depressed mood and a loss of interest in activities that you used to enjoy), anxiety (is a feeling of fear, dread, and uneasiness.), and aphasia following cerebral infarction (loss of ability to understand or express speech, caused by brain damage).</p> <p>Record review of Resident #53's quarterly MDS assessment dated [DATE] indicated Resident #53 had unclear speech, was rarely/never understood, and rarely/never understood others. Resident #53 was unable to complete the BIMS assessment. Resident #53 had short-and-long term memory loss and severely impaired cognitive skills for daily decision making. Resident #53 had upper and lower extremities functional limitation in range of motion. Resident #53 was dependent for eating, oral, toilet, and personal hygiene, dressing and shower/bathe self. Resident #53's MDS assessment indicated MDS Nurse J completed all sections.</p> <p>Record review of Resident #53's care plan last review completed on 07/11/24 did not reflect upper and lower extremities functional limitation in range of motion. Resident #53's activity preference of listening to music and type of preferred music.</p> <p>During an observation on 09/30/24 at 9:58 a.m., Resident #53 was lying in bed asleep. Resident #53 had a radio on her dresser playing music. Resident #53 was covered and unable to clear visualize extremities. Resident #53 lower extremities appeared to be bent at the knees without voluntary movement.</p> <p>During an observation and interview on 10/01/24 at 11:10 a.m., Resident #53 was lying in bed asleep. Resident #53 had a radio on her dresser playing loud, pop/ hip hop music. Resident #53 was covered and unable to clear visualize extremities. Resident #53's lower extremities appeared to be bent at the knees without voluntary movement. Resident #53 had unclear speech and non interviewable.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/02/24 at 2:20 p.m., LVN E said the MDS coordinator, ADON and DON were responsible for care plans. She said the nurses reported information to them to be placed on the care plans. She said care plans and interventions could be made for anything. She said Resident #53's music preference could be care planned. She said Resident #53's was in her 60's and probably preferred music from her era. She said she knew she liked country and gospel music. She said Resident #34's behavior issues should also be care planned. She said care plans were important because interventions will not get done if it is not care planned.</p> <p>During an interview on 10/02/24 at 3:03 p.m., CNA D said the facility had a binder in the linen cabinet that let staff know about each resident. She said she did not have access to resident's care plans only what information was in the binder. She said she thought it would be important to care plan Resident #53's limited range of motion limitations and music preference and Resident #34's behavioral symptoms. She said the care plan and interventions would help her know how to take care of the resident. She said when important things were not care planned, they risked doing something the resident did not like or not providing care they needed.</p> <p>During an interview on 10/02/24 at 3:21 p.m., MDS Nurse M said she was responsible for care plan during the admission and OBRA assessment. She said she reviewed the MDS assessment and let each department know which areas they were required to complete. She said each department were then responsible for developing care plan problems and interventions. She said Resident #53's limited range of motion should have been care planned because it triggered a CAA. She said the AD would be responsible for the resident's activity preference if triggered on the MDS assessment. She said the nurses and social service would be responsible for care planning Resident #34's behavioral symptoms.</p> <p>During an interview on 10/02/24 at 4:27 p.m., SW A said she was responsible for implementing new social service issues and updates. She said she was responsible for care planning behavioral symptoms. She said nurses could also implement care plans regarding behavior and interventions. She said she had only heard about Resident #34 urinating on things one time. She said she had not seen Resident #34's behaviors documented in her chart. She said Resident #34's behavioral symptoms should have been care planned to ensure proper interventions and goals were in place.</p> <p>During an interview on 10/03/24 at 10:21 a.m., the DON said she expected resident's triggered CAAs to be care planned. She said she expected Resident #53's limited range of motion and behavioral symptoms to be care planned. She said Resident #53's limited range of motion should have been care planned by the MDS Coordinator or the nurses. She said Resident #34's behavioral symptoms should have been care planned by the MDS Coordinator, nurses, or social worker. She said the AD, nurses, or social services should have done Resident #53's activity preference. She said care plan were important to know what care to provide and let staff and family know how the facility will provide the resident's care. She said when things were not care planned, it risked the resident not getting the care they needed, not knowing their preference and likes, and not knowing what intervention worked best.</p> <p>During an interview on 10/03/24 at 11:00 a.m., the ADM said she expected MDS triggered areas and activity preferences to be care planned. She said the MDS nurses were primarily responsible for care plans. She said when care plans were not implemented, staff did not know what worked and risked them not knowing how to care for the resident. She said nursing administration was responsible for monitoring the completion of care plans by the appropriate departments.</p> <p>Record review of the facility's undated Comprehensive Care Planning policy stated:</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The comprehensive care plan will describe the following -</p> <p>* The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .</p> <p>. Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs .</p> <p>44933</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49019</p> <p>Based on observations, interviews, and record review, the facility failed to provide the necessary services to maintain personal hygiene for 3 of 5 residents reviewed for ADLs (Residents #25, #42, and #61).</p> <p>The facility failed to provide baths as scheduled for Resident #25, #42, and #61.</p> <p>This failure could place residents who required assistance from staff for ADLs at risk of not receiving care and services to meet their needs which could result in poor care, risk for skin breakdown, feelings of poor self-esteem, lack of dignity, and health.</p> <p>Findings included:</p> <p>1. Record review of Resident #25's face sheet, dated 10/01/24, indicated he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included cerebral palsy (a group of conditions that affect movement and posture), and heart failure (occurs when the heart muscle does not pump blood as well as it should).</p> <p>Record review of Resident #25's quarterly MDS assessment, dated 08/06/24, indicated he was able to make himself understood and he was able to understand others. He had a BIMS score of 15 which indicated intact cognition. He did not exhibit behaviors of rejection of care. He required substantial assistance (helper does more than half the effort) with bathing.</p> <p>Record review of Resident #25's care plan, last revised on 08/22/24, indicated a focus of the resident has an ADL self-care performance deficit due to his chronic condition of cerebral palsy. Interventions included:</p> <p>*Assist with personal hygiene as required: hair, shaving, oral care as needed</p> <p>*Bathing: requires staff x2 for assistance</p> <p>*Bathing: the resident is totally dependent on staff to provide a bath how often and as necessary</p> <p>*Personal Hygiene: the resident requires total assistance with personal hygiene care.</p> <p>Record review of a shower sheet, dated 08/24/24, indicated Resident #25 had a bed bath on 08/24/24. It further indicated his shower day was on the Tuesday, Thursday, Saturday schedule.</p> <p>Record review of a shower sheet, dated 09/07/24, indicated Resident #25 had a bed bath on 09/07/24.</p> <p>Record review of Resident #25's bathing documentation report for the month of August 2024, printed on 10/01/24, indicated he received a bed bath on 08/01/24 and 08/10/24. The other scheduled days of the month did not have any documentation marked for whether or not Resident #25 had received a bath.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #25's bathing documentation report for the month of September 2024, printed on 10/01/24, indicated he received a bed bath on 09/10/24, 09/14/24, and 09/19/24. The other scheduled days of the month did not have any documentation marked for whether or not Resident #25 had received a bath.</p> <p>During an interview on 09/30/24 at 09:37 AM, Resident #25 said the facility does not give him baths as he would like. He said he last had a bath about 1 and a half weeks ago.</p> <p>During an interview on 10/01/24 at 03:19 PM, the ADON said if the showers were not documented then it was likely they were not done. She said if she did not have proof than she cannot say they were done.</p> <p>During an interview on 10/02/24 at 11:10 AM, the ADON said Resident #25 was scheduled to have a shower on Tuesdays, Thursdays, and Saturdays. She said the baths were likely missed because the facility had a lot of staff turnover. She said it was also possible that the staff missed some documentation. She said however if the staff did not document it, it was not done. She said the risk to Resident #25 was possible skin breakdown.</p> <p>During an interview on 10/02/24 at 11:16AM, the DON said she expected the staff to bathe Resident #25 as scheduled. She said she also expected the staff to document in the medical record if they were unable to complete the bath. She said the risk was possible infection or skin breakdown.</p> <p>During an interview on 10/02/24 at 11:22AM, the Administrator said she expected Resident #25 to get a bath as scheduled. She said the risk was skin breakdown, body odor, infection, and feeling yucky.</p> <p>2. Record review of Resident #42 's face sheet, dated 9/30/2024, reflected he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included cerebral infarction (occurs when the blood supply to part of the brain was blocked or reduced preventing brain tissue from getting oxygen and nutrients causing brain cells begin to die), peripheral vascular disease (a condition where blood vessels outside the heart become narrowed, blocked, or spasm, leading to reduced blood flow to the arms, legs, or other body parts. It can cause pain, cramping, and increases the risk of heart attack or stroke), Type II Diabetes with hyperglycemia (high blood sugar is when there's too much glucose (sugar) in your bloodstream, typically because your body isn't making or using insulin), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and vascular dementia A condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain. It causes problems with reasoning, planning, judgment, and memory).</p> <p>Record review of Resident #42's quarterly MDS assessment, dated 9/23/2024, reflected he was able to make himself understood and he was able to understand others. He had a BIMS score of 7 which indicated severe cognitive impairment. He required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with bathing.</p> <p>Record review of Resident #42's care plan, initiated on 5/16/2024, reflected a focus of the resident has an ADL self-care performance deficit due to his left BKA Interventions included:</p> <p>*Assist with personal hygiene as required: hair, shaving, oral care as needed</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Bathing: requires staff x 1 for assistance</p> <p>*Bed Mobility: Supervision as needed.</p> <p>*Discuss with resident/family/POA (Power of Attorney) care concerns related to loss of independence, decline in function.</p> <p>*Dressing requires staff x1 for assistance.</p> <p>During an interview on 10/1/2024 at 8:21 AM, Resident # 42 said he had not received a bath on 2 weeks. He said he cleans himself off at the sink. Resident # 42 was not sure when the last time he received a shower.</p> <p>During record review of bathing schedule dated August 2024, reflected Resident # 42 was scheduled for his baths on evening shift from 2:00 PM-10:00 PM and last documented bath was initialed and dated on 8/13/2024. The documentation did not reflect refusal for the month of August 2024. The bath schedule for September 2024 did not indicate Resident #42 received a bath or refused.</p> <p>During record review of bath sheets dated 8/22/2024, 8/24/2024, 8/31/2024, 9/7/2024, did not reflect Resident # 42 received a bath or shower. Resident # 42 had a bath sheet that reflected he did have a shower on 9/24/2024 but was not documented on the bath flowsheet.</p> <p>3. Record review of Resident #61 's face sheet, dated 10/1/2024, reflected he was an [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included Alzheimer's disease (a brain disorder that is the most common cause of dementia with gradual decline in memory, thinking, behavior and social skills that affect a person's ability to function), Chronic atrial fibrillation (A disease of the heart characterized by irregular and often faster heartbeat.), traumatic subdural hemorrhage (a type of bleeding near your brain that can happen after a head injury. Symptoms like a headache and slurred speech can develop right after the injury or days to months later), Type II Diabetes (a group of diseases that affect how the body uses blood sugar (glucose) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>Record review of Resident #61's quarterly MDS assessment, dated 7/23/2024, reflected he was able to make himself understood and he was able to understand others. He had a BIMS score of 4 which indicated severe cognitive impairment. He required set-up or clean up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with bathing.</p> <p>Record review of Resident #61's care plan, revised on 8/7/2024, reflected a focus of the resident has an ADL self-care performance deficit.</p> <p>Interventions included:</p> <p>*Assist with personal hygiene as required: hair, shaving, oral care as needed</p> <p>*Bathing: requires staff x 1 for assistance</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Bathing: check nails and clean on bath day and as necessary. Report any changes to the nurse. If diabetic, the nurse will provide toenail care.</p> <p>*Discuss with resident/family/POA care concerns related to loss of independence, decline in function.</p> <p>*Dressing: The resident requires (x1) staff participation to dress.</p> <p>*Monitor/document/report to MD PRN any changes, any potential for improvement reasons for self-care deficit, expected course, declines in function.</p> <p>During an interview and on 10/2/2024 at 9:42 AM, Resident # 61's RP said she did not know Resident #61 was receiving showers or baths. RP said she was concerned about her spouse being in the shower by himself and wanted to make sure someone was with him during his baths. She said the aides told her Resident #61 was receiving his showers. The RP said she felt of her spouse's hair, and it felt dirty. She said he had dementia and always told her he had bathed. The RP said she would want to know if Resident #61 was not showered or bathed or refusing care.</p> <p>During record review of bath sheets dated August 2024, Resident #61 had documented he was scheduled for baths on 6:00 AM - 2:00 PM. The documentation reflected Resident # 61 had 3 baths in the month of August 2024 and received 1 bath in the month of September 2024.</p> <p>During record review of bath sheets dated 9/24/2024, Resident # 61 had a shower documented but, on the flowsheet, reflected Resident #61's shower did not occur.</p> <p>During record review of bath sheets dated 8/22/2024, 8/24/2024, 8/31/2024, 9/7/2024, did not reflect Resident # 42 received a bath or shower. Resident # 42 had a bath sheet reflected he did have a shower on 9/24/2024 but was not documented on the bath flowsheet.</p> <p>During an interview on 10/2/2024 at 11:11 AM, CNA K said she assisted with bathing residents and works on all the halls. CNA K said residents on the right side of the hall receive their baths on Monday, Wednesday, Friday, and those on the left side of the hall receive their baths on Tuesday, Thursday, Saturday. She said residents in Bed A were scheduled in the morning and B beds were scheduled on the evening shift. CNA K said a resident could refuse 3 times before notifying the nurse. CNA K said she would ask a resident several times and if they continued to refuse after the 3rd time, she would get the nurse and the nurse would notify the family. CNA K said the facility had a few residents who would refuse care. CNA K said would be on their care plan if they refuse care. CNA K said Resident # 61 was very willing and was a positive person and never refused for her. CNA K said he was bathed on the day shift. CNA K said the CNAs were to document on the kiosk if a resident refused or if they received a bath or shower. CNA K said the staff also document on a shower sheet. CNA K said if a resident was not being properly showered or bath, they could develop odors, skin breakdown, and would be a dignity issue. She said having a scheduled shower or bath would make them feel better.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/2/2024 at 11:35 AM, RN H said residents on right side of the hall received their baths on Monday, Wednesday, Friday with A beds in the morning and B beds in the evening. RN H said on Tuesday, Thursday, Saturday the left side of the hall received their baths with A bed scheduled for the morning and B beds scheduled for the evening. RN H said Resident #42 does what he wants to and sometimes he refused baths. RN H said the aides have reported refusal and the nurse would go back in and assist him with a shower. RN H said the aides document in the baths in the kiosk if the resident received or refused a bath. RN H said she notifies the family only if the resident was of sound mind. She said the facility did not require them to notify the family if a resident made their own decisions. RN H said Resident #61 had intermittent confusion and she would notify his Resident #42's RP. RN H said no one had brought up any concerns from the family regarding any concerns. RN H said a resident not receiving a bath could develop dry skin, yeast infection, urinary infection, and cause overall health and comfort related issues. At 4:05 PM, RN H said the charge nurse was responsible for ensuring care plan were followed.</p> <p>During an interview on 10/2/2024 at 2:15 PM, MDS nurse J said everyone assist with the development of the care plan. She said the nurse was responsible for ensuring the plan of care was being followed for residents bathing schedule. MDS J said if a resident were not receiving a bath, it could negatively affect them by causing emotional issues, skin issues or infection.</p> <p>During an interview on 10/3/2024 at 10:17 AM, the ADON said residents were scheduled a bath 3 days a week. She said residents on the right side of the hall would receive their baths on Monday, Wednesday, and Friday with A beds in the morning and B beds on the evening shift. The ADON said on the left side of the hall, residents received their bath on Tuesday, Thursday, and Saturday with A beds in the morning and B beds in the evening. The ADON said the CNAs should be documenting if a resident refused a bath. The ADON said the family should be notified of refusal after a couple of attempts and the facility would try to get the SW involved. The ADON said the CNAs were responsible for giving the baths, the charge nurse was responsible for reporting to the administrative staff and then the ADM staff or SW were responsible for making sure the care plans are being followed. The ADON said the charge nurse was responsible for making sure the care plans are being followed. The ADON said a resident not receiving a bath could negatively affect a resident by causing skin issues, Urinary tract infections and dignity issues if they had body odor.</p> <p>During an interview on 10/3/2024 at 11:11 AM, the DON said she expected the CNAs to notify the charge nurse if a resident was refusing showers and expected them to document. The DON said she would expect the staff to offer several times before notifying the charge nurse. The DON said notifying the family depended on if it was a routine issue. She said the facility would contact the family if a resident continued to refuse baths and became an issue. The DON said a resident not receiving bath could cause skin issues, irritation, odors, and dignity issues. The DON said she expected the CNAs to document the showers and baths. The DON said the CNAs are responsible for the baths being performed, then nursing management was responsible for ensuring the bath are being performed. The DON said she does not look at the percentages daily, but the facility tries to look at them weekly.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/3/2024 at 10:45 AM, the ADM said she expected the CNAs to be documenting the ADL's and the providing the residents with their scheduled baths. The ADM said she looks at the percentages of the residents receiving baths weekly. She said she was not sure how often the ADON and DON reviewed the percentages of baths performed. The ADM said the MDS nurse were starting to look at the bathing schedules. The DON said the facility was going to do education and give opportunity to the staff to improve. The ADM said a resident could negatively be affected if not receiving scheduled baths causing skin issues, infection, body odor and dignity issues.</p> <p>Record review of the facility's undated policy, bath, tub/shower, reflected: Bathing by tub bath or shower is done to remove soil, dead epithelial cells, microorganisms from the skin, and body odor to promote comfort, cleanliness, circulation, and relaxation. A medicated tub bath can also be provided to treat skin conditions. The aging skin becomes dry, wrinkled, thinner and blemished with various aging spots over time and is easily affected by environmental temperature and humidity, sun exposure, soaps, and clothing fabrics. The frequency and type of bathing depends on resident preference, skin condition, tolerance, and energy level. Although a daily bath or shower is preferred and necessary for some, the aging skin can be maintained by bathing every two days or with partial bathing as needed.</p> <p>46929</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44933</p> <p>48958</p> <p>Based on observation, interview, and record review, the facility failed to provide an ongoing program of activities in accordance with the comprehensive assessment to meet the interests and the physical, mental, and psychosocial well-being for 1 of 1 memory care unit reviewed for activities.</p> <p>The facility failed to provide meaningful activities for dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) residents on the memory care unit on 9/30/24-10/1/24.</p> <p>This failure could place residents at risk for not having activities to meet their interests or needs and a decline in their physical, mental, and psychosocial well-being.</p> <p>Findings included:</p> <p>During an observation on 09/30/24 at 9:32 a.m., the dining area had a large television playing a television show in the dining area of the memory care unit. Approximately 20 residents were in the dining area.</p> <p>During an observation on 09/30/24 at 10:50 a.m.-11:55 a.m., the dining and sitting area nor hallways had any memory care/dementia focused activities. Television on in dining area, but residents did not show interest.</p> <p>During observation on 10/01/24 at 2:22 p.m. residents on memory care unit sitting in Dining area with Television on, but residents did not show interest.</p> <p>Record review of the October 2024 Activity schedule reflected:</p> <p>*10/01/24: 9am- Coffee and Friends, 10am- Daily Chronicle, 10:30am- Appetizer 2pm- Bingo with, 3pm- Music Hour.</p> <p>*10/02/24: 9am- Coffee and News, 10am- Daily Chronicle, 10:30am- Appetizer, 2pm- Arts and Crafts, 3pm- [NAME] &amp; River.</p> <p>*10/03/24: 9am- Coffee and Friends, 10am- Daily Chronicle, 10:30am- Appetizer, 2pm- Bingo, 3pm- Movie &amp; Snack.</p> <p>*10/04/24: 9am- Coffee and News, 10am- Daily Chronicle, 10:30am- Appetizer, 2pm- Bingo, 3pm- Snack Pass With A Smile.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Whispering Pines Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE  2131 Alpine Rd Longview, TX 75601	
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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/02/24 at 9:37 a.m., CNA C said the activity director was responsible for doing activities with the residents on the memory care unit. CNA C said some residents loved to play BINGO. She said she was not sure what Resident #67 liked to do. CNA C said she was not sure if the incident and falls were due to the lack in activities for the residents. She said easy activities would be good for dementia residents.</p> <p>During an interview on 10/02/24 at 9:49 a.m., CNA D said the activity director was supposed to do activities with the residents on the memory care unit, but the aides normally do them. CNA D said the activity director came to the memory care unit once or twice a day to deliver snacks, then she leaves right back out. CNA D said some residents did not have a specific activity she liked to do, but they tried to keep them occupied all day. CNA D said the lack of activities on the memory care unit could be a reason why the residents had falls and incidents. She said she felt like if the residents had things to do it would not be as much aggression back here. She said dementia residents should be do different activities. She said some of the residents could do flower arrangements, puzzles and memory card games for activities.</p> <p>During an interview on 10/02/24 at 9:59 a.m., with LVN E she said activity director was the one that tried to put the activity calendars in the resident's rooms on the memory care unit. She said she was not sure if the October activity calendar were up yet, because she had just returned to work. She said the facility had an activity director in the building that was responsible for the activities on the memory care unit, but her and the CNA's tried to do things with the residents: like give snacks, let them watch television and the CNA's paint the resident finger nails. She said some residents loved to watch western shows. She said she thought the falls and incidents occurred due to the resident's disease process. She said she thought activities are good when the activity director stayed with the resident while they worked on activities, because they were easily distracted. She said one of residents on the unit loved to play the piano.</p> <p>During an interview on 10/02/24 at 10:15 a.m., CNA D said the activity director had not brought an updated activity calendar to the memory care unit since July 2024.</p> <p>During an interview on 10/02/24 at 11:22 a.m., DON said the activity director was responsible for the activities on the memory care unit. She said was sure the more activities back there would be better, because the more activities back there would help with the falls and incidents. The DON said coloring, activity boards, music, dancing and crafts were good for dementia residents to do. She said she felt anything was safe that would be good for the residents on the memory care unit to do.</p> <p>During an interview on 10/03/24 at 10:18 a.m., the Administrator stated they had an activity plan for the resident to do more. She said when the activity director was there, and she did activities with the residents. The Administered said the activity director mother had a fall and she had not been there the last 3 days. She said there was an activity closet with games and crafts for the resident to have activities if the activity director was not here, so the aides should be utilizing it. She said the resident's need to have activities. The Administrator said the negative effects of no activities on the memory care unit, the residents do get bored, and the staff should make more of an effort to keep the residents occupied. The Administrator said here was only one main calendar and there was not a specific calendar for the memory care unit.</p> <p>During an observation on 09/30/24 at 4:04 p.m., 15-20 residents in sitting area and dining area on the secured unit with no meaningful activities offered to residents.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 10/01/24 at 11:04 a.m., 15-18 residents in sitting area and dining area on the secured unit with television on, but residents did not show interest.</p> <p>During an observation on 10/01/24 at 3:34 p.m., 11-15 residents in sitting area and dining area on the secured unit with no meaningful activities offered to residents.</p> <p>Record review of a facility's Activity Policy &amp; Procedure Manual policy dated 2011 reflected . the Activity Director and staff will provide individual programming to meet individual needs and interests.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49019</p> <p>Based on observation, interview, and record review, the facility failed to ensure an acceptable parameter of nutritional status was maintained for 3 of 3 residents (Resident # 36, #42 and #61) who was reviewed for nutritional status, in that:</p> <p>1. The facility failed to ensure Resident #36, #42 and # 61 had sufficient fluid intake to maintain proper hydration and health as evidence by Resident #36 said on 10/1/2024 he had dry mouth, on 9/30/2024 Resident #42's said he had to ask for water and ice and on 10/1/2024 Resident #61 did not have any ice and water in his cup .</p> <p>This failure could place residents at risk for dehydration and decline in health due to insufficient fluid intake.</p> <p>Finding included:</p> <p>1. Record review of Resident #36's face sheet dated 10/2/2024, indicated he was a [AGE] year-old male who was admitted on [DATE]. His diagnosis included multiple sclerosis (A disease that affects central nervous system. The immune system attacks the myelin, the protective layer around nerve fibers and causes Inflammation and lesions. This makes it difficult for the brain to send signals to rest of the body), depression ((a mood disorder that causes a persistent feeling of sadness and loss of interest), and essential hypertension (a mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>Record review of Resident # 36's annual MDS dated [DATE] indicated he was able to make himself understood and he was able to understand others. He had a BIMS score of 10 which indicated moderate cognitive impairment. The annual MDS did not indicate any issues with swallowing disorder.</p> <p>Record review of Resident #36's care plan revised on 8/22/2024 indicated resident had potential for nutritional problems due to his history of adult failure to thrive. Interventions included following:</p> <p>Monitor/document/report to MD PRN for signs and symptoms of dysphagia; pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals.</p> <p>Obtain and monitor lab/diagnostic work. Report results to MD and follow-up as indicated.</p> <p>During an observation and interview on 10/1/2024 at 3:26 PM, Resident # 36 observed to have water on his bedside table and Resident #36 said his water was from the evening before. Resident #36 said his mouth gets dry from not having fluids and he enjoyed ice in his water.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Record review of Resident #42 's face sheet, dated 9/30/2024, indicated he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced preventing brain tissue from getting oxygen and nutrients causing brain cells begin to die), peripheral vascular disease (a condition where blood vessels outside the heart become narrowed, blocked, or spasm, leading to reduced blood flow to the arms, legs, or other body parts. It can cause pain, cramping, and increases the risk of heart attack or stroke), Type II Diabetes with hyperglycemia (high blood sugar is when there's too much glucose (sugar) in your bloodstream, typically because your body isn't making or using insulin), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and vascular dementia A condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain. It causes problems with reasoning, planning, judgment, and memory).</p> <p>Record review of Resident #42's quarterly MDS assessment, dated 9/23/2024, indicated he was able to make himself understood and he was able to understand others. He had a BIMS score of 7 which indicated severe cognitive impairment.</p> <p>During an interview and observation on 9/30/2024, Resident # 42 said he had to ask for ice and water. Observed Resident #42 had a cup located on his nightstand with water with no ice and the cup was out of resident's reach.</p> <p>During an observation on 10/1/2024 at 8:16 AM, observed Resident #42's cup on nightstand with water and no ice.</p> <p>During an observation on 10/2/2024 at 10:31 AM, observed no ice in Resident #42's cup sitting on nightstand. The cup appeared to have water remaining but cup sitting in the same spot from previous day.</p> <p>3. Record review of Resident #61 's face sheet, dated 10/1/2024, indicated he was an [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included Alzheimer's disease (a brain disorder that is the most common cause of dementia with gradual decline in memory, thinking, behavior and social skills that affect a person's ability to function), Chronic atrial fibrillation (A disease of the heart characterized by irregular and often faster heartbeat.), traumatic subdural hemorrhage (a type of bleeding near your brain that can happen after a head injury. Symptoms like a headache and slurred speech can develop right after the injury or days to months later), Type II Diabetes (a group of diseases that affect how the body uses blood sugar (glucose) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>Record review of Resident #61's quarterly MDS assessment, dated 7/23/2024, indicated he was able to make himself understood and he was able to understand others. He had a BIMS score of 4 which indicated severe cognitive impairment.</p> <p>During review of Resident #61's care plan revised 4/24/2023 indicated Resident had a diet order other than regular and was at risk for unplanned weight loss or gain, RCS/LCS (Reduced concentrated sweets, low-calorie sweetener) regular texture. Resident had interventions for following:</p> <p>Determine food preferences and provide within dietary limitations.</p> <p>Encourage the resident to drink fluids of choice.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the resident has fluids within reach.</p> <p>Inform the nurse if the resident was refusing to drink fluids.</p> <p>Monitor vital signs as ordered/per protocol and record. Notify MD of significant abnormalities.</p> <p>Monitor/document/report to MD PRN for signs and symptoms of dehydration: decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset of confusion, dizziness, fever, thirst, recent/sudden weight loss, dry sunken eyes.</p> <p>Obtain and monitor labs/diagnostic work as ordered. Report results to MD and follow-up as indicated.</p> <p>During record review of Resident # 61's labs dated 4/24/2024 indicated BUN (Blood urea nitrogen) was elevated at 22.0 with normal ranges between 6-20 mg/dl. An elevated BUN could be caused by dehydration (too little fluid in your body) or other reasons.</p> <p>During an observation on 10/1/2024 at 3:20 PM, Resident # 61 was observed to have no ice or water in his cup that was sitting out of reach on his nightstand.</p> <p>During an interview on 10/2/2024 at 9:42 AM, RP said she had not noticed if Resident # 61 had water or ice in his room. The RP said she placed cokes in Resident #61's refrigerator.</p> <p>During an interview on 10/2/2024 at 10:36 AM, MA S said she will get the residents cups and take it down to the nurse's station to get the residents ice and water every 4 hours. MA S said some residents do not want ice.</p> <p>During an interview on 10/2/2024 at 11:11 AM, CNA K said we pull the ice cart and fill up each resident ice and water whenever we have time during the day. CNA K said we just look during the morning rounds to see if the resident need water and ice. CNA K said the residents could get dehydrated, get an UTI, or have other health problems. CNA K said she was taught that everyone should have ice and water on their bedside table.</p> <p>During an interview on 10/2/2024 at 11:35 AM, RN H said she did not like the current system. RN H said residents come up to the nurse' station for ice and water. RN H said the carts do not roll well. RN H said the CNAs should be passing the ice and water. She said the CNA's do not do it like they should. RN H said she will check on residents once a shift and pass ice and water. RN H said she believed the policy was for the staff to pass ice and water once per shift. RN H said residents could get dehydrated, have low blood pressure, or get an UTI from not having proper fluids.</p> <p>During an interview on 10/3/2024 at 10:17 AM, the ADON said the CNAs are supposed to pass ice and water every shift. She said dietary staff brings out a hydration cart with lemonade and water and the CNAs should be passing the ice. The resident can ask for additional ice if they need ice or water. The ADON said she had no previous reports of ice water pitchers not filled. She said the CNAs are responsible for ensuring every resident has ice and water. The ADON said not having proper fluids throughout the day could affect a resident and potentially cause dehydration or cardiac issues.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/3/2024 at 10:45 AM, the ADM said she expected the nurses and CNAs to provide the residents with fresh ice and water. She said the CNAs are responsible to make sure the residents have water, and they should be checking every 2 hours. The ADM said the residents could get an UTI, become dehydrated and affect their oral health.</p> <p>During an interview on 10/3/2024 at 11:11 AM, the DON said she expected the staff / CNAs to be filling resident water with ice and fresh water. She said it could cause dehydration, UTI.</p> <p>Record review of facility policy dated October 5, 2016, titled Hydration reflected the facility provides each resident with sufficient fluid intake to maintain proper hydration and health. The resident will receive sufficient amounts of fluid based on assessed need to prevent dehydration and promote optimum physiological functions daily. Goals: .1. The resident will maintain adequate hydration. 2. The resident will not experience skin breakdown .3. Vital signs will remain within normal parameters. 4. Fluid intake monitored routinely. 4. The resident will not demonstrate signs or symptoms of dehydration. Procedure: 1. Upon admission, annually and as needed, the resident will be assessed by the registered dietician to calculate minimum fluid needs .2. Staff should offer hydration, unless contraindicated, at the following intervals. 1. Direct care interaction with the resident in the resident room. 2. Prior to, during and following meals. 3. During medication pass. 4. During activities.3. The facility may utilize fine dining programs to encourage fluids .4. Residents who demonstrate a risk for dehydration will be care planned and treated accordingly. 5. Goals and interventions should be directed in a proactive fashion .6. Residents will also be frequently monitored for indications of dehydration. 7. A dehydration screen should be completed upon admission . 8. The MDS comprehensive assessment will assist in identifying residents who are potentially at risk for dehydration. 9. The dietary staff will assess resident fluid preferences. Additional juices and fluids will be encouraged. 10. Resident who are restricted to thickened liquids will be provided with thickened liquids to ordered consistency .</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643</b></p> <p>Based on observation, interview, and record review the facility failed to ensure that residents who need respiratory care are provided with such care, consistent with professional standards of practices for 1 of 22 residents (Resident #49) reviewed for respiratory care.</p> <p>The facility failed to replace the oxygen filter that was damaged for Resident #49.</p> <p>This failure could place residents at risk for of respiratory infections.</p> <p>Findings included:</p> <p>Record review of Resident #49's face sheet, dated 11/16/23 revealed a [AGE] year old female admitted on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - a common lung disease that causes breathing problems and restricted airflow), Chronic Systolic Heart Failure (a condition where the left ventricle of the heart is unable to contract properly, resulting in less blood circulating throughout the body), Hyperlipidemia (a condition where there are abnormally high levels of lipids or fats in the blood.)</p> <p>Record review of Resident #49's quarterly MDS assessment, dated 07/31/24, revealed Resident #49 had a BIMS of 10, which indicated moderate cognitive impairment. The MDS showed that Resident #49 received oxygen therapy during the assessment period.</p> <p>Record review of Resident #49's care plan revealed a problem initiated on 8/3/21, The resident has Emphysema/COPD Give oxygen therapy as ordered by the physician.</p> <p>During an observation and interview on 9/30/24 at 9:52 a.m. Resident #49's oxygen concentrator had an oxygen filter that was 90% missing. An oxygen filter was present but appeared to have been torn off. Approximately 90% of the oxygen concentrator intake did not have a filter in place.</p> <p>During an interview on 10/2/24 at 11:09 a.m., the DON said that residents' oxygen concentrators require a filter on the machine per policy. She said that it was the responsibility of nurses to ensure that residents who use an oxygen concentrator have a clean and functioning filter. She said that not having a filter on the oxygen concentrator puts the residents at risk for the machine to stop functioning properly.</p> <p>During an interview on 10/2/24 at 11:33 a.m., the ADM said they have a system in place to prevent residents from having dirty or missing filters for the oxygen concentrators. She said the maintenance supervisor is supposed to check these daily. She said that residents could be placed at risk of breathing in dust and bacteria if their oxygen concentrator was missing its filter.</p> <p>Record review of facility policy titled Oxygen Administration revised in March of 2023 revealed that, The resident will maintain oxygenation with safe and effective delivery of prescribed oxygen The resident will maintain an effective breathing pattern with administration of oxygen The resident will be free from infection 16. Change or clean oxygen concentrator filters according to manufactures' recommendations.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44933</p> <p>Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate administering of all drugs and biologicals, to meet the needs of 4 of 19 residents reviewed for pharmacy services. (Residents #18, Resident #23, Resident #34, and Resident #68)</p> <p>The facility failed to ensure Resident #18's Niacin-50 (is one of the water-soluble B vitamins), Ativan (is used to treat anxiety) 1 mg, and Nicotine Patch (helps you quit smoking by reducing cravings for nicotine. Nicotine is an addictive substance in tobacco) were available for administration on 08/20/24, 08/21/24, 08/22/24, 08/23/24, 08/24/24, and 08/25/24.</p> <p>The facility failed to ensure Resident #23's Aspirin EC (is used to reduce fever and relieve mild to moderate pain from conditions such as muscle aches, toothaches, common cold, and headaches) 81 mg Delayed Release was not crushed.</p> <p>The facility failed to ensure Resident #34's Lorazepam Oral Tablet 1 MG (treats anxiety) was available for administration on 08/20/24, 08/21/24 and 08/22/24.</p> <p>The facility failed to ensure Resident #68's Lomotil Oral Tablet 2.5-0.025mg (treats diarrhea) was available for administration on 09/05/24 and 09/06/24.</p> <p>These failures could place residents at risk for inaccurate drug administration.</p> <p>Findings included:</p> <p>1. Record review of Resident #18's face sheet dated 09/30/24 indicated Resident #18 was a [AGE] year-old female admitted on [DATE] with diagnoses including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), anxiety disorder (involve repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak within minutes (panic attacks)), depression (is a common mental health condition that causes a persistent feeling of sadness and changes in how you think, sleep, eat and act), and bariatric surgery status (is an operation that makes changes to the digestive system and causes weight loss).</p> <p>Record review of Resident #18's admission MDS assessment dated [DATE] indicated Resident #18 was usually understood and usually understood others. Resident #18 had a BIMS score of 05 which indicated severe cognitive impairment. The MDS indicated Resident #18 received an antianxiety during the last 7 days of the assessment period.</p> <p>Record review of Resident #18's care plan last review completed on 09/27/24 indicated Resident #18 used anti-anxiety medications due to anxiety disorder. Intervention included give anti-anxiety medications ordered by physician.</p> <p>Record review of Resident #18's order summary report dated 08/01/24-08/31/24 indicated:</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*Ativan Tablet 1 mg (Lorazepam), give 1 tablet by mouth at bedtime for anxiety. Start date 08/19/24.</p> <p>*Niacin-50 Oral Tablet (Niacin), give 1 tablet by mouth one time a day for supplement give with breakfast. Start date 08/21/24.</p> <p>*Nicotine Patch 24-hour 21 mg/24 hour, apply 1 patch transdermally one time a day for smoking cessation for 4 weeks. Start date 08/20/24. End date 09/17/24.</p> <p>Record review of Resident #18's MAR dated 08/01/24-08/31/24 indicated:</p> <p>*Ativan Tablet 1 mg (Lorazepam), give 1 tablet by mouth at bedtime for anxiety. Discontinued 09/23/24 at 11:17 a.m. The MAR indicated other/see nurse notes on 08/21/24 (MA AA) and 08/22/24 (MA AA).</p> <p>*Niacin-50 Oral Tablet (Niacin), give 1 tablet by mouth one time a day for supplement give with breakfast. The MAR indicated other/see nurse notes on 08/21/24 (MA O) and 08/23/24 (MA O). The MAR indicated unavailable on 08/22/24 (MA P) and 08/25/24 (MA O).</p> <p>*Nicotine Patch 24-hour 21 mg/24 hour, apply 1 patch transdermally one time a day for smoking cessation for 4 weeks. End date 09/17/24. The MAR indicated not documentation of administration on 08/20/24. The MAR indicated other/see nurse notes on 08/21/24 (MA O). The MAR indicated unavailable on 08/22/24 (MA P).</p> <p>Record review of Resident #18's progress notes dated 05/29/24-09/30/24 indicated:</p> <p>*On 08/21/24 at 12:02 p.m. by MA O. Nicotine Patch 24-hour 21 mg/24 hour, apply 1 patch transdermally one time a day for smoking cessation for 4 weeks. Unavailable.</p> <p>*On 08/21/24 at 12:06 p.m. by MA O. Niacin-50 Oral Tablet (Niacin), give 1 tablet by mouth one time a day for supplement give with breakfast. Unavailable.</p> <p>*On 08/21/24 at 10:12 p.m. by MA AA. Ativan Tablet 1 mg (Lorazepam), give 1 tablet by mouth at bedtime for anxiety. Med on order.</p> <p>*On 08/22/24 at 10:55 a.m. by MA P. Nicotine Patch 24-hour 21 mg/24 hour, apply 1 patch transdermally one time a day for smoking cessation for 4 weeks. Not available.</p> <p>*On 08/22/24 at 10:55 a.m. by MA P. Niacin-50 Oral Tablet (Niacin), give 1 tablet by mouth one time a day for supplement give with breakfast. Not available.</p> <p>*On 08/22/24 at 7:29 p.m. by MA S. Ativan Tablet 1 mg (Lorazepam), give 1 tablet by mouth at bedtime for anxiety. On order.</p> <p>*On 08/23/24 at 11:42 a.m. by MA O. Niacin-50 Oral Tablet (Niacin), give 1 tablet by mouth one time a day for supplement give with breakfast. Med unavailable.</p> <p>*08/24/24 at 5:51 p.m. by MA O. Ativan Tablet 1 mg (Lorazepam), give 1 tablet by mouth at bedtime for anxiety. Med not in emergency box, awaiting delivery.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Whispering Pines Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE  2131 Alpine Rd Longview, TX 75601	
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #18's Ordering Record dated 10/04/24 indicated:</p> <p>*Ativan Tablet 1 mg was ordered on 08/19/24 at 7:43 p.m. The ordering record indicated an error message of message not support: Unsigned new order for Narcotics 2-5 not supported.</p> <p>*Ativan Tablet 1 mg was delivered to facility on 08/24/24 at 6:44 p.m.</p> <p>During an interview and observation on 09/30/24 at 10:09 a.m., Resident #18 was lying in her bed. Resident #18 was confused and rabbled about random things. Resident #18 was not interviewable.</p> <p>2. Record review of Resident #23's face sheet dated 09/30/24 indicated Resident #23 was a [AGE] year-old female admitted on [DATE] and 08/16/24 with diagnoses including anemia (is a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), hypertension (is when the pressure in your blood vessels is too high (140/90 mmHg or higher)), and long term (current) use of anticoagulants (commonly known as a blood thinner, is a chemical substance that prevents or reduces the coagulation of blood, prolonging the clotting time).</p> <p>Record review of Resident #23's significant change MDS assessment dated [DATE] indicated Resident #23 was rarely/never understood and sometimes understood others. Resident #23 was unable to complete the BIMS assessment. Resident #23 had short-and-long term memory problems with severely impaired cognitive skills for daily decision making. The MDS indicated Resident #23 received an antiplatelet the last 7 days during the assessment period.</p> <p>Record review of Resident #23's care plan last review completed on 09/13/24 indicated Resident #23 received an antiplatelet medication. Intervention included monitor/document/report to MD as needed signs and symptoms of anticoagulant complications.</p> <p>Record review of Resident #23's order summary report dated 09/30/24 indicated Aspirin EC Tablet Delayed Release 81mg (Aspirin), give 1 tablet by mouth one time a day related to long term (current) use of anticoagulants. DO NOT CRUSH. Start date 08/02/22.</p> <p>Record review of Resident #23's MAR dated 09/01/24-09/30/24 indicated Aspirin EC Tablet Delayed Release 81mg (Aspirin), give 1 tablet by mouth one time a day related to long term (current) use of anticoagulants. DO NOT CRUSH. Due in AM. Resident #23 received scheduled doses.</p> <p>During an observation and interview on 09/30/24 at 10:05 a.m., Resident #23 did not respond to surveyor during attempted interview. Resident #23 not interviewable.</p> <p>During an observation on 09/30/24 at 10:28 a.m., Resident #23 was sitting at a dining room table. MA O administered crushed medications with a yellow custard substance.</p> <p>3. Record review of Resident #34's face sheet dated 09/30/24 indicated Resident #34 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia (a group of thinking and social symptoms that interferes with daily functioning) with psychotic disturbance (severe mental disorders that cause abnormal thinking and perceptions), paranoid schizophrenia (is a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), and acute embolism (is an obstruction or blockage in a blood vessel) and thrombosis (is a blood clot within blood vessels that limits the flow of blood).</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #34's quarterly MDS assessment dated [DATE] indicated Resident #34 was usually understood and understood others. Resident #34 had a BIMS score of 03 which indicated severe cognitive impairment. The MDS indicated Resident #34 received an antianxiety during the last 7 days of the assessment period.</p> <p>Record review of Resident #34's care plan last review completed on 08/27/24 indicated Resident #34 required anti-psychotic medications due to her diagnosis of paranoid schizophrenia. Interventions included administer medication as ordered, monitor/record occurrence of target behavior symptoms, and monitor/record/report to MD prn side effects and adverse reactions of psychoactive medications: unsteady gait, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficult swallowing, fatigue, loss of appetite, weight loss, behavioral symptoms not usual to the person. Resident #34's care plan did not address antianxiety medication use.</p> <p>Record review of Resident #34's order summary report dated 08/01/24-08/31/24 indicated Lorazepam Oral Tablet 1 mg (Lorazepam), give 1 tablet by mouth three times a day for anxiety/agitation related to unspecified dementia, moderate, with psychotic disturbance. Start date 08/18/24.</p> <p>Record review of Resident #34's MAR dated 08/01/24-08/31/24 indicated Lorazepam Oral Tablet 1 mg (Lorazepam), give 1 tablet by mouth three times a day for anxiety/agitation related to unspecified dementia, moderate, with psychotic disturbance. The MAR indicated other/see nurse notes on 08/20/24 8 p.m. (MA AA) and 08/21/24 8 p.m. (MA S). The MAR indicated unavailable on 08/22/24 2 p.m. (MA P).</p> <p>Record review of Resident #34's progress noted dated 05/29/24-09/30/24 indicated:</p> <p>*On 08/21/24 at 10:18 p.m. by MA AA. Lorazepam Oral Tablet 1 mg (Lorazepam), give 1 tablet by mouth three times a day for anxiety/agitation related to unspecified dementia, moderate, with psychotic disturbance. Med on order.</p> <p>*On 08/22/24 at 1:49 p.m. by MA P. Lorazepam Oral Tablet 1 mg (Lorazepam), give 1 tablet by mouth three times a day for anxiety/agitation related to unspecified dementia, moderate, with psychotic disturbance. Emergency kit empty.</p> <p>*08/22/24 at 9:26 p.m. by MA S. Lorazepam Oral Tablet 1 mg (Lorazepam), give 1 tablet by mouth three times a day for anxiety/agitation related to unspecified dementia, moderate, with psychotic disturbance. On order.</p> <p>Record review of Resident #34's ordering record dated on 10/04/24 indicated:</p> <p>*Lorazepam Oral Tablet 1mg was ordered on 08/18/24 at 3:12 p.m. The ordering record indicated an error message of .Unsigned new order for Narcotics 2-5 not supported .</p> <p>*Lorazepam Oral Tablet 1 mg was reordered on 08/20/24 at 6:34 p.m.</p> <p>*Lorazepam Oral Tablet 1 mg was delivered to the facility on [DATE] at 7:13 p.m.</p> <p>During an observation and interview on 09/30/24 at 10:30 a.m., Resident #34 was in the dining room in a wheelchair. Resident #34 was leaning to the left in her wheelchair and appeared sleepy. Resident #34 smiled but did not respond when addressed by surveyor. Resident #34 was non interviewable.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Record review of Resident #68's face sheet dated 09/30/24 indicated Resident #68 was a 64-years-old female admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (is a short- or long-term change in how your brain functions), aphasia (loss of ability to understand or express speech, caused by brain damage) following cerebral infarction (stroke), and gastric ulcer (are open sores on the inner lining of the stomach and the upper part of the small intestine).</p> <p>Record review of Resident #68's quarterly MDS assessment dated [DATE] indicated Resident #68 was usually understood and usually understood others. Resident #68 had a BIMS score of 01 which indicated severe cognitive impairment.</p> <p>Record review of Resident #68's care plan last review completed on 09/25/24 indicated Resident #68 had potential for fluid deficits related to her history of viral hepatitis (is an infection that causes liver inflammation and damage). Intervention included administer medications as ordered.</p> <p>Record review of Resident #68's order summary dated 09/30/24 indicated Lomotil Oral Tablet 2.5-0.025mg (Diphenoxylate with atropine), give 1 tablet by mouth every 12 hours as needed for diarrhea. Start date 09/10/24.</p> <p>Record review of Resident #68's MAR dated 09/01/24-09/30/24 indicated Lomotil Oral Tablet 2.5-0.025 mg (Diphenoxylate with atropine), give 1 tablet by mouth every 24 hours as needed for diarrhea. Started 09/05/24. End date 09/10/24 at 4:04 p.m. Resident #68 did not receive doses on 09/04/24, 09/05/24 and 09/06/24.</p> <p>Record review of Resident #68's progress notes dated 05/29/24-09/30/24 indicated:</p> <p>*On 09/04/24 at 3:34 p.m. by LVN E indicated .she [Resident #68] continues to have diarrhea daily .new order received for Lomotil every day as need .</p> <p>*On 09/05/24 at 5:49 p.m. by LVN E indicated .Resident #68 had 1 episode of diarrhea this shift .Lomotil not delivered as yet .</p> <p>*On 09/06/24 at 10:17 a.m. by LVN R indicated .Day 2 new order Lomotil 1 tab daily pending pharmacy delivery .</p> <p>Record review of Resident #68's ordering record dated on 10/04/24 indicated:</p> <p>*Lomotil Oral Tablet 2.5-0.025 mg was ordered on 09/10/24. The ordering record indicated an error message of .Unsigned new order for Narcotics 2-5 not supported .</p> <p>*Lomotil Oral Tablet 2.5-0.025 mg was delivered to the facility on [DATE] at 6:16 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/02/24 at 1:55 p.m., MA O said he had been working at the facility off and on since 2006. He said he normally passed medications on C and D hall. He said MAs reordered the medications they administered under the nurse's supervision. He said nurses ordered new admission and PRN medications. He said he typically kept a 5-day supply of medication on hand. He said when medications were ordered, they arrived the same night. He said sometimes they experienced issues with the pharmacy company. He said the pharmacy company did not let the facility know there was going to be a delay until the medications did not show up. He said Resident #18's Niacin was a different mg than the facility had in stock. He said the pharmacy did not have it in stock and the facility had to order the medication online. He said normally the facility had doses of Lorazepam in the Emergency box but there were not any when he needed it for Resident #18. He said the pharmacy was responsible for filling the Emergency kit box. He said the timeframe for Nicotine patches varied because it was OTC. He said the nurses and DON were aware of the missed doses due to the medication not being available. He said he reported to the nurses, and they were supposed to report it to the DON. He said he did not have anything to do with Resident #68's missed medication doses because it was PRN. He said it was important for resident's medication to be ordered timely because if the doctor ordered it then there was a reason for the medication. He said if a resident did not have a nicotine patch or Lorazepam, they could experience anxiety and restlessness. He said he did not know about Niacin. He said he crushed all of Resident #23's medications. He said the facility had chewable and enteric coated Aspirin. He said he crushed Resident #23's Aspirin EC Tablet Delayed Release. He said he did not know Resident #23's order said, Do Not Crush. He said when extended or delayed release medication was crushed, the resident could get the dose all at once.</p> <p>During an interview on 10/02/24 at 2:20 p.m., LVN E said MAs and LVNs ordered medications. She said LVNs ordered PRN medications. She said the MAs normally informed them when doses were missed because medications were unavailable. She said it depended on when the medication was ordered when it arrived at the facility. She said the type of medication determined how soon a refill was reordered. She said LVNs and RNs ordered new admit medications. She said when the nurse inputted the medication order in the EMR, there was an option to send the order to the pharmacy. She said it depended on why the resident was taking Niacin and Lorazepam what symptoms they experienced if they missed doses. She said she did not know what symptoms a resident would experience if they did not have nicotine patches. She said enteric coated, extended, or delayed release medication could not be crushed. She said when medications were crushed and it should not be, the medication could not work right or treat what it was prescribed for.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/03/24 at 10:21 a.m., the DON said LVNs ordered admission resident's medications. She said LVNs and MAs reordered medications. She said medications normally arrived the same or next day. She said if a medication could not be given the day it was ordered to start, an order needed to be obtained to administer when available. She said the facility had STAT medication on stock in the E-Kit machine. She said if a medication was out in the E-kit machine, the staff needed to notify the DON to get it refilled. She said she expected medications to be available the next day when ordered or refilled. She said if the medication was not going to be available the next day, staff should take appropriate steps like reordering or ordering from a different source. She said when a resident missed a dose of Lorazepam, they could experience anxiety. She said it depended on why a resident was taking Niacin what they could experience if they missed doses. She said when a resident did not have nicotine patches, they could experience withdrawal symptoms or want a cigarette. She said when Lomotil was not available, the resident could experience diarrhea or loose stools. She said the nurses should make sure the DON was aware of delayed medication delivery or ordering issues. She said if she was aware the E-kit did not have Lorazepam stocked, she would have called them or ordered it STAT. She said delayed or extended-release medication were not crushable. She said also, a medication should not be crushed if the order said not to. She said if a non-crushable medication was crushed, it placed the resident at risk for getting too much at one time or it not being effective.</p> <p>During an interview on 10/03/24 at 11:00 a.m., the ADM said MAs and charge nurses were responsible for ordering medications and ensuring an adequate supply of OTC medication was in stock. She said it depended on the medication what symptoms the resident could experience when doses were missed. She said when resident missed Lorazepam doses, they could experience anxiety, pacing, and crying. She said missed doses of nicotine patches, the resident could experience withdrawal symptoms and discomfort. She said missed doses of an antiarrhythmia medication, the resident could experience diarrhea resulting in skin breakdown and weight loss. She said the nursing management should ensure LVNs and MAs ordered medications timely. She said she expected nursing staff to not crush non crushable medications. She said she expected nursing staff to follow the administration instruction to not crush the medication.</p> <p>Review of National Library of Medicine: Crushed Tablet Administration for Patients with Dysphagia and Enteral Feeding: Challenges and Considerations (September 14, 2023) by [NAME], [NAME], [NAME], [NAME] Tuders, [NAME], and [NAME] G. Stefanacci, <a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10511598/">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10511598/</a> was accessed on 10/08/24 indicated .although medication crushing is common, prescribing information may not include details on acceptability of crushing medications or how to administer once crushed, and inappropriate medication crushing can have unintended or adverse effects .for example, some medications such as those with extended-release formulations or enteric coating cannot be crushed without substantial alterations to their pharmacokinetic properties .</p> <p>Record review of an undated facility's Ordering Medications policy indicated .medications and related products are received from the pharmacy supplier on a timely basis .reorder medication three to four days in advance of need to assure an adequate supply is on hand .new medication .if needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt .inform pharmacy of the need for prompt delivery and request delivery .use the emergency kit when the resident needs a medication prior to pharmacy delivery .if not in the emergency kit, contact the pharmacy for possible local pharmacy to fill enough of the medication until the next scheduled delivery .</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a facility's Medication Administration Procedures revised on 10/25/2017 indicated .any deviation from specified and recommended procedures in dispensing or administering medications to the resident requires documented approval .and shall be in concurrence with current statutes and regulations .</p>

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<p>F 0758</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure, based on the comprehensive assessment of a resident, the resident who used psychotropic drugs received gradual dose reduction and behavioral interventions, the medication was necessary to treat a specific condition as diagnosed and documented in the clinical records, and/or that PRN orders for psychotropic drugs were limited to 14 days unless the prescribing practitioner documented their rationale in the resident's medical records for 4 of 5 residents (Resident #34, Resident #53, Resident #22, and Resident #62) reviewed for unnecessary medications.</p> <ol style="list-style-type: none"> <li>1. The facility failed to recognize the side effects of the medications Lorazepam (Ativan) and Risperidone (Risperdal) which caused Resident #34 to become lethargic, experience increased falls, had increased episodes of incontinence, behavioral symptoms not usual to the person, and weight loss.</li> <li>2. The facility failed to notify Resident #34's physician of a weight loss of 9.8% or 15 lbs. in less than 30 days.</li> <li>3. The facility failed to relay the correct behaviors to Resident #34's physician for increase dosage of Risperidone. Staff indicated Resident #34 was aggressive with staff and or other resident, instead of exhibiting wandering behaviors.</li> <li>4. The facility failed to ensure Resident #34 had an appropriate diagnosis related to use of Trazadone.</li> <li>5. The facility failed to ensure Resident #34 had an appropriate diagnosis related to use of Lorazepam.</li> </ol> <p>An IJ was identified on 10/02/04. The IJ template was provided to the facility on [DATE] at 12:03 p.m. While the IJ was removed on 10/03/24, the facility remained out of compliance at a scope of pattern and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on abuse, neglect, and exploitation prevention, resident weight, preventative strategies to reduce fall risk, notifying the physician of change in status, and psychotropic drugs.</p> <ol style="list-style-type: none"> <li>6. The facility failed to ensure Resident #53's prescribed prn Lorazepam was limited to 14 days and the prescribing practitioner provided rationale for extended use.</li> <li>7. The facility failed to ensure Resident #62 did not have a PRN order for lorazepam 0.5 mg (a prescription medication used to treat anxiety disorders-feelings of fear, dread, and uneasiness) after 14 days without an evaluation by the physician for continued treatment with a rationale in the resident's medical record and a duration for the PRN order.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>8. The facility failed to ensure Resident #22 had effective monitoring for her prescribed Lorazepam. The Lorazepam order was made for 180 days, and PRN psychotropic medications should be reevaluated every 14 days.</p> <p>These failures could place residents at risk for possible psychotropic medication side effects, adverse consequences, decreased quality of life and dependence on unnecessary medications.</p> <p>Findings included:</p> <p>1. Record review of Resident #34's face sheet dated 09/30/24 indicated Resident #34 was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis including dementia (a group of thinking and social symptoms that interferes with daily functioning) with psychotic disturbance (severe mental disorders that cause abnormal thinking and perceptions), paranoid schizophrenia (is a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), and acute embolism (is an obstruction or blockage in a blood vessel) and thrombosis (is a blood clot within blood vessels that limits the flow of blood).</p> <p>Record review of Resident #34's quarterly MDS assessment dated [DATE] indicated Resident #34 was usually understood and understood others. Resident #34 had adequate hearing, clear speech, and adequate vision. Resident #34 had a BIMS score of 03 which indicated severe cognition impairment. Resident #34 did not exhibit behaviors of hallucinations or delusions. Resident #34 experienced other behavioral symptoms not direct toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, or smearing food or bodily wastes, of verbal/vocal symptoms like screaming, disruptive sounds). Resident #34 experienced wandering that occurred daily.</p> <p>Resident #34 required setup for dressing, eating, and putting on footwear, supervision assistance for oral hygiene, partial assistance for shower/bathing self and personal hygiene, and dependent for toilet hygiene. Resident #34 required supervision for rolling left and right, sitting to lying, lying to sitting on side of bed, sitting to stand, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer, and walking 10 feet.</p> <p>Resident #34 did not have functional limitation in range of motion/impairments. Resident #34 used a wheelchair for mobility. Resident #34 was always incontinent of urine and frequently incontinent of bowel. Resident #34 had one fall with no injury since admission/entry or reentry or the prior assessment. Resident #34 had not experienced weight loss 5% or more in the last month or 10% or more in the last 6 months. The MDS indicated Resident #34 received an antianxiety, antipsychotic, and antidepressant during the last 7 days of the assessment period.</p> <p>Record review of Resident #34's care plan last review completed on 08/27/24 indicated:</p> <p>*Resident #34 required anti-psychotic medications due to her diagnosis of paranoid schizophrenia. Interventions included administer medication as ordered, monitor/record occurrence of target behavior symptoms, and monitor/record/report to MD prn side effects and adverse reactions of psychoactive medications: unsteady gait, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, fatigue, loss of appetite, weight loss, behavioral symptoms not usual to the person.</p> <p>(continued on next page)</p>		

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  10/03/2024
NAME OF PROVIDER OR SUPPLIER  Whispering Pines Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE  2131 Alpine Rd Longview, TX 75601	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0758</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #34's care plan did not address antianxiety medication use.</p> <p>*Resident #34 resided in the secure care unit, related to diagnosis of dementia and risk of elopement. Intervention included notify MD of any changes. Resident #34's care plan did not reflect other behavioral symptoms coded on the MDS or behavior charted on the progress notes such as urinating on her and other resident's property.</p> <p>*Resident #34 was at risk for falls due to unsteady gait, generalized weakness to bilateral lower extremities, and use of psychotropic medications. Interventions included anticipate and meet the resident's needs, the resident needs activities that minimize the potential for falls while providing diversion and distraction, and review information on past falls and attempt to determine cause of falls.</p> <p>*Resident #34 had ADL self-care performance deficit. Intervention included bathing: requires staff x1 for assistance, bed mobility: requires staff x1 for assistance, dressing: requires staff x1 for assistance, eating: supervision as needed, resident uses a wheelchair, toileting: supervision as needed, encourage meal consumption and document amount consumed, and offer substitute.</p> <p>Record review of Resident #34's order summary report dated 08/01/24-08/31/24 indicated:</p> <p>*Lorazepam Oral Tablet 1mg (Lorazepam), give 1 tablet by mouth two times a day for anxiety/agitation related to unspecified dementia, moderate, with psychotic disturbance. Start date 08/15/24. Discontinued.</p> <p>*Lorazepam Oral Tablet 1 mg (Lorazepam), give 1 tablet by mouth three times a day for anxiety/agitation related to unspecified dementia, moderate, with psychotic disturbance. Start date 08/18/24.</p> <p>*Risperidone Oral Solution 1mg/ml (Risperidone), give 1.5ml by mouth two times a day related to paranoid schizophrenia. Start date 08/02/24. Discontinued.</p> <p>*Risperidone Oral Solution 1mg/ml (Risperidone), give 1.5ml by mouth three times a day related to paranoid schizophrenia. Start date 08/15/24. Discontinued.</p> <p>*Risperidone Oral Solution 1mg/ml (Risperidone), give 2ml by mouth three times a day related to paranoid schizophrenia. Start date 08/18/24. Discontinued.</p> <p>Record review of Resident #34's order summary report dated 08/31/24 indicated:</p> <p>*Lorazepam Oral Tablet 1 mg (Lorazepam), give 1 tablet by mouth three times a day for anxiety/agitation related to unspecified dementia, moderate, with psychotic disturbance. Start date 08/18/24.</p> <p>*Risperidone Oral Solution 1mg/ml (Risperidone), give 2ml by mouth three times a day related to paranoid schizophrenia. Start date 08/18/24.</p> <p>*Trazodone HCL Oral Tablet 50mg, give 1 tablet by mouth one time a day related to paranoid schizophrenia. Start date 05/10/24.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Whispering Pines Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE  2131 Alpine Rd Longview, TX 75601	
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<p>F 0758</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>*Behavior Monitoring, enter the code- 0. None, 1. Panic, 2. Agitated, 3. Angry, 4. Anxiety, 5. Biting, 6. Compulsive, 7. Crying, 8. Pacing, 9. Screaming, 10. Pull IV line/tubes, 11. Poor eye contact, 12. Depressed, 13. Extreme fear, 14. False belief, 15. Fighting, 16. Finger painting feces, 17. Hallucinations/paranoia/delusion, 18. Head banging, 19. Insomnia, 20. Jittery, 21. Kicking, 22. Noisy, 23. Pinching, 24. Restless, 25. Scratching, 26. Slapping, 27. Suspiciousness, 28. Throwing objects, 29. Wandering, 30. Other see progress notes every day and night for Risperdal, Trazodone. If any behaviors are noted, document details in a progress note. Start date 05/11/24.</p> <p>*Side Effects- Enter the code- 0. None, 1. Dystonia (is a movement disorder that causes the muscles to contract), 2. Dry mouth, 3. Constipation/urinary retention, 4. Hypotension (low blood pressure), 5. Downiness, 6. Dizziness, 7. Arrhythmias (irregular heart rhythm), 8. Tardive dyskinesia (are involuntary movements of the tongue, lips, face, trunk, and extremities), 9. Rash, 10. Headache, 11. Urine retention, 12. Weak, 13. Cogwheel (a type of rigidity that typically affects the limbs, causing them to move in small increments, similar to how gears move), 14. Tremors, 15. Appetite Changes, 16. Insomnia, 17. Confusion, 18. Sore throat, 19. Seizure, 20. Photosensitivity (a condition in which the skin becomes very sensitive to sunlight or other forms of ultraviolet light and may burn easily), 21. Suicidal ideations, 22. GI disturbance, 23. Ataxia (poor muscle control that causes clumsy movements) every day and night shift for Risperdal, Trazodone. If any side effects are noted, document details in a progress note. Start date 05/11/24.</p> <p>Record review of Resident #34's order summary report dated 09/30/24 indicated:</p> <p>*Lorazepam Oral Tablet 1 mg (Lorazepam), give 1 tablet by mouth three times a day for anxiety/agitation related to unspecified dementia, moderate, with psychotic disturbance. Start date 08/18/24.</p> <p>*Risperidone Oral Solution 1mg/ml (Risperidone), give 2ml by mouth three times a day related to paranoid schizophrenia. Start date 08/18/24.</p> <p>*Trazodone HCL Oral Tablet 50mg, give 1 tablet by mouth one time a day related to paranoid schizophrenia. Start date 05/10/24.</p> <p>*Behavior Monitoring, enter the code- 0. None, 1. Panic, 2. Agitated, 3. Angry, 4. Anxiety, 5. Biting, 6. Compulsive, 7. Crying, 8. Pacing, 9. Screaming, 10. Pull IV line/tubes, 11. Poor eye contact, 12. Depressed, 13. Extreme fear, 14. False belief, 15. Fighting, 16. Finger painting feces, 17. Hallucinations/paranoia/delusion, 18. Head banging, 19. Insomnia, 20. Jittery, 21. Kicking, 22. Noisy, 23. Pinching, 24. Restless, 25. Scratching, 26. Slapping, 27. Suspiciousness, 28. Throwing objects, 29. Wandering, 30. Other see progress notes every day and night for Risperdal, Trazodone, Lorazepam. If any behaviors are noted, document details in a progress note. Start date 09/18/24.</p> <p>*Side Effects- Enter the code- 0. None, 1. Dystonia, 2. Dry mouth, 3. Constipation/urinary retention, 4. Hypotension, 5. Downiness, 6. Dizziness, 7. Arrhythmias, 8. Tardive dyskinesia, 9. Rash, 10. Headache, 11. Urine retention, 12. Weak, 13. Cogwheel, 14. Tremors, 15. Appetite Changes, 16. Insomnia, 17. Confusion, 18. Sore throat, 19. Seizure, 20. Photosensitivity, 21. Suicidal ideations, 22. GI disturbance, 23. Ataxia every day and night shift for Risperdal, Trazodone, Lorazepam. If any side effects are noted, document details in a progress note. Start date 09/18/24.</p> <p>Record review of Resident #34's MAR dated 08/01/24-08/31/24, printed 10/08/24 indicated:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Whispering Pines Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE  2131 Alpine Rd Longview, TX 75601	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0758</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>* Lorazepam Oral Tablet 1 mg (Lorazepam), give 1 tablet by mouth one times a day for anxiety/agitation related to unspecified dementia, moderate, with psychotic disturbance. The MAR indicated Resident #34 was administered 15/15 doses. Discontinued 08/15/24 at 12:56 p.m.</p> <p>*Lorazepam Oral Tablet 1mg (Lorazepam), give 1 tablet by mouth two times a day for anxiety/agitation related to unspecified dementia, moderate, with psychotic disturbance. The MAR indicated Resident #34 was administered 6/6 doses. Discontinued 08/18/24 at 3:11 p.m.</p> <p>*Lorazepam Oral Tablet 1 mg (Lorazepam), give 1 tablet by mouth three times a day for anxiety/agitation related to unspecified dementia, moderate, with psychotic disturbance. The MAR indicated Resident #34 was administered 35/40 doses.</p> <p>*Risperdal Oral Tablet 1mg (Risperidone), give 1 tablet by mouth two times a day related to paranoid schizophrenia. The MAR indicated Resident #34 was administered 3/3 doses. Discontinued 08/02/24 at 5:22 p.m.</p> <p>*Risperidone Oral Solution 1mg/ml (Risperidone), give 1.5ml by mouth two times a day related to paranoid schizophrenia. The MAR indicated Resident #34 was administered 26/26 doses. Discontinued 08/15/24 at 12:58 p.m.</p> <p>*Risperidone Oral Solution 1mg/ml (Risperidone), give 1.5ml by mouth three times a day related to paranoid schizophrenia. The MAR indicated Resident #34 was administered 9/10 doses. Discontinued 08/18/24 at 3:09 p.m.</p> <p>*Risperidone Oral Solution 1mg/ml (Risperidone), give 2ml by mouth three times a day related to paranoid schizophrenia. The MAR indicated Resident #34 was administered 38/40 doses. Discontinued 10/02/24 at 5:31 p.m.</p> <p>*Trazodone HCL Oral Tablet 50mg, give 1 tablet by mouth one time a day related to paranoid schizophrenia. The MAR indicated Resident #34 was administered 31/31 doses. Discontinued 10/03/24 at 12:38 p.m.</p> <p>*Behavior Monitoring, enter the code- 0. None, 1. Panic, 2. Agitated, 3. Angry, 4. Anxiety, 5. Biting, 6. Compulsive, 7. Crying, 8. Pacing, 9. Screaming, 10. Pull IV line/tubes, 11. Poor eye contact, 12. Depressed, 13. Extreme fear, 14. False belief, 15. Fighting, 16. Finger painting feces, 17. Hallucinations/paranoia/delusion, 18. Head banging, 19. Insomnia, 20. Jittery, 21. Kicking, 22. Noisy, 23. Pinching, 24. Restless, 25. Scratching, 26. Slapping, 27. Suspiciousness, 28. Throwing objects, 29. Wandering, 30. Other see progress notes every day and night for Risperdal, Trazodone. If any behaviors are noted, document details in a progress note. Start date 05/11/24. Discontinued 09/18/24. The MAR indicated Resident #34 displayed behaviors of compulsive, anxiety, agitated, screaming/yelling, pacing, panic, wandering, and restlessness. The MAR did not indicate aggressive behaviors. Resident #34 did not display behaviors 21/62 shifts.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>*Side Effects- Enter the code- 0. None, 1. Dystonia, 2. Dry mouth, 3. Constipation/urinary retention, 4. Hypotension, 5. Downiness, 6. Dizziness, 7. Arrythmias, 8. Tardive dyskinesia, 9. Rash, 10. Headache, 11. Urine retention, 12. Weak, 13. Cogwheel, 14. Tremors, 15. Appetite Changes, 16. Insomnia, 17. Confusion, 18. Sore throat, 19. Seizure, 20. Photosensitivity, 21. Suicidal ideations, 22. GI disturbance, 23. Ataxia every day and night shift for Risperdal, Trazodone. If any side effects are noted, document details in a progress note. Start date 05/11/24. The MAR indicated Resident #34 did not experience side effects except for 08/03/24 (dry mouth).</p> <p>Record review of Resident #34's MAR dated 09/01/24-09/30/24 indicated:</p> <p>*Lorazepam Oral Tablet 1 mg (Lorazepam), give 1 tablet by mouth three times a day for anxiety/agitation related to unspecified dementia, moderate, with psychotic disturbance. The MAR indicated Resident #34 was administered 88/89 doses.</p> <p>*Risperidone Oral Solution 1mg/ml (Risperidone), give 2ml by mouth three times a day related to paranoid schizophrenia. The MAR indicated Resident #34 was administered 88/89 doses.</p> <p>*Trazodone HCL Oral Tablet 50mg, give 1 tablet by mouth one time a day related to paranoid schizophrenia. The MAR indicated Resident #34 was administered 29/29 doses.</p> <p>*Behavior Monitoring, enter the code- 0. None, 1. Panic, 2. Agitated, 3. Angry, 4. Anxiety, 5. Biting, 6. Compulsive, 7. Crying, 8. Pacing, 9. Screaming, 10. Pull IV line/tubes, 11. Poor eye contact, 12. Depressed, 13. Extreme fear, 14. False belief, 15. Fighting, 16. Finger painting feces, 17.</p> <p>Hallucinations/paranoia/delusion, 18. Head banging, 19. Insomnia, 20. Jittery, 21. Kicking, 22. Noisy, 23. Pinching, 24. Restless, 25. Scratching, 26. Slapping, 27. Suspiciousness, 28. Throwing objects, 29. Wandering, 30. Other see progress notes every day and night for Risperdal, Trazodone, Lorazepam. If any behaviors are noted, document details in a progress note. The MAR indicated Resident #34 displayed behaviors of compulsive, anxiety, agitated, screaming/yelling, pacing, panic, wandering, restlessness, and other see progress note. The MAR did not indicate aggressive behaviors. Resident #34 did not display behaviors 16/59 shifts.</p> <p>*Side Effects- Enter the code- 0. None, 1. Dystonia, 2. Dry mouth, 3. Constipation/urinary retention, 4. Hypotension, 5. Downiness, 6. Dizziness, 7. Arrythmias, 8. Tardive dyskinesia, 9. Rash, 10. Headache, 11. Urine retention, 12. Weak, 13. Cogwheel, 14. Tremors, 15. Appetite Changes, 16. Insomnia, 17. Confusion, 18. Sore throat, 19. Seizure, 20. Photosensitivity, 21. Suicidal ideations, 22. GI disturbance, 23. Ataxia every day and night shift for Risperdal, Trazodone, Lorazepam. If any side effects are noted, document details in a progress note. The MAR indicated Resident #34 did not experience side effects.</p> <p>Record review of Resident #34's progress notes dated 05/29/24-09/30/24 indicated:</p> <p>*06/17/24 at 12:39 p.m. by LVN E, .day 6 follow room change from B hall to the C hall secure unit .resident has adjusted well .</p> <p>*07/07/24 at 9:09 a.m., by LVN E, .resident continues behaviors from previous shift .she will not accept redirection from staff .received order from MD T for Lorazepam 1mg every morning for anxiety .</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>*07/08/24 at 8:58 a.m. by LVN R, .Day 2 Ativan 1mg every morning with no adverse reaction noted .less intrusive now than before Ativan was given .</p> <p>*07/16/24 at 8:44 a.m. by LVN E, .day 10/14 Lorazepam 1 mg every morning .Resident #34 cannot be redirected .attempts to walk .her gait is very unsteady a fall risk .resident is redirected many times during the shift .</p> <p>*07/19/24 at 10:51 a.m. by LVN E, .Day 13/14 Lorazepam 1 mg every morning .Resident #34 continues to be extremely difficult to redirect .she wanders in and out of rooms taking clothing that is not hers and urinating on other resident's beds and putting clothing between her legs for pads after takes her brief off .</p> <p>*07/24/24 at 1:35 p.m. by RN V, .Patient [Resident #34] having urinary frequency .MD T notified .new orders for urinalysis .</p> <p>*07/25/24 at 7:45 p.m. by LVN HH, .talked to MD T .reviewed the lab results . MD T recommended to start Cipro .</p> <p>*07/29/24 at 1:18 p.m. by LVN E, .Resident #34 continues to wander and pilfer thru other resident's things and their rooms . she will not accept any direction at all .goes into rooms and urinates on the floors and beds and clothing if she is allowed to wander alone .</p> <p>*08/02/24 at 6:01 p.m. by LVN E, .received order to increase Risperdal 1mg/ml to 1.5mg.ml .Resident #34 has been closely monitored by staff today to prevent behaviors .resident continues to repeat questions and behaviors with no regard for redirection .</p> <p>*08/05/24 at 10:40 p.m. by RN U, .resident cont. on Risperdal Elixir without s/s of adverse reactions noted . once resident in bed usually stays in bed without wandering .</p> <p>*08/07/24 at 4:23 p.m. by LVN E, .Day 5/14 Risperdal elixir .Resident #34 has rested some today but continues to be extremely difficult to redirect .continues to wander in and out of other rooms pulling out their clothing .</p> <p>*08/12/24 at 3:09 p.m., by LVN E, .Resident #34 has been extremely hard to redirect . she will not accept direction .she has had no adverse reaction related to the Risperdal Elixir but it does not seem to keep her calm and control the anxiety for very long periods of time .</p> <p>*08/13/24 at 5:07 p.m., by LVN E, .Day 10/14 Risperdal Elix [sic] .the medication is only effective for short periods of time .Resident #34 cannot be redirected and cannot be left without monitoring related to her unruly and destructive nature in the unit .</p> <p>*08/14/24 at 11:02 a.m. by LVN R, .Day 11/14 Risperdal Elixir .it is difficult to determine if medication is working as there is not a notable change in behavior .</p> <p>*08/15/24 at 2:45 p.m. by LVN E, .MD T in the facility today and gave the following new orders .1. Increase Risperidone Elixir 1.5ml from BID to TID .2. Increase Ativan 1mg every day to 1 mg BID .</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>*08/18/24 at 3:19 p.m. by LVN E, .Resident #34 has been awake and have different behaviors during this shift .she will not be redirected and continues to attempt to go into other resident's rooms .MD T gave new order as follow 1. Increase Risperdal Elixir from 1.5 ml TID to 2ml TID . 2. Increase Ativan 1mg from BID to Ativan 1mg TID .</p> <p>*08/22/24 at 4:16 p.m. by LVN E, .Resident #34 is day 4/14 Risperdal elix [sic] increased to 2ml TID and Ativan increased to 1mg TID .she has been calm and quiet most of this shift .</p> <p>*08/22/24 at 4:21 p.m. by LVN E, .Resident #34 is day 3 post fall with injury to face and bridge of nose .</p> <p>*08/24/24 at 3:30 p.m. by LVN R, .Day 6/14 increase Risperdal 2ml TID and Ativan 1mg TID no benefit noticed from increase in medication .patient [Resident #34] is extremely difficult to redirect, is constantly trying to get up from her wheelchair and unlocks the chair, rolls and stands up .patient must be 1:1 at all times .</p> <p>*08/27/24 at 5:11 p.m. by LVN E, .Resident #34 was given 30ml milk of magnesium (is used for a short time to treat occasional constipation) per MD T's standing orders .</p> <p>*08/28/24 at 9:40 p.m. by LVN R, .Day 10/14 increase in Risperdal to 2ml TID and Ativan to 1 mg TID . Resident is very drowsy today, laying her head on dining room table and sleeping .</p> <p>*08/29/24 at 3:17 p.m. by LVN R, .Day 11/14 increase in Risperdal to 2ml TID and Ativan to 1 mg TID . Resident #34 moves slowly and when she does get up from wheelchair (against staff instruction) her gait is very unsteady and she stumbles around almost falling several times today .</p> <p>*08/30/24 at 2:19 p.m. by LVN E, .Resident #34 given 30 ml milk of magnesium .Resident #34 noted to be passing hard stool today with some straining noted .</p> <p>*08/30/24 at 6:19 p.m. by LVN E, .Resident #34 is day 12/14 increase .resident continues to be difficult to redirect and gets out of wheelchair and attempts to walk .she is unsteady on her feet .resident will ask same questions over and over and laugh .must be monitored at meal times to prevent her from taking food out of other trays .</p> <p>*09/01/24 at 4:45 p.m., by LVN E, .Resident #34 had urinated on the bed from pillow to foot .she had taken her pants and brief off and urinated on them on the floor .</p> <p>*09/04/24 at 3:37 p.m., by LVN E, .Resident #34 continues to have an extremely unsteady gait and leans forward when she walks .she cannot be redirected and must be monitored very closely .she continues to urinate on bedding and clothing when not monitored .</p> <p>*09/10/24 at 2:45 p.m. by LVN E, .Resident #34 continued to walk as I [LVN E] was trying to get to her . Resident #34 fell before I [LVN E] reached her .she fell on her side and did not hit her head .</p> <p>*09/10/24 at 4:41 p.m. by LVN E, .Resident #34 continues to be belligerent and impossible to redirect . Resident #34 gets out of chair and stumbles and wavers when she walks and has to be assisted back into the chair to keep her from falling .</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>*09/15/24 at 7:45 a.m. by LVN E, .CNA called this nurse [LVN E] into resident's room .upon entering resident was laying on the floor on her left side .assessment revealed no injuries related to this fall .</p> <p>*09/15/24 at 10:09 a.m. by LVN E, .as Resident #34 turned and started to the other table she was bent forward and started falling into the table .the nurse [LVN E] attempted to keep her from falling unsuccessfully . I [LVN E] was able to break her fall but not prevent it .</p> <p>*09/16/24 at 10:03 a.m. by LVN R, .Day 1 post fall x2, Resident #34 seems to lean to the left when sitting in her wheelchair . no complaints pain or discomfort and no further post fall injuries noted at this time .</p> <p>*09/18/24 at 2:30 p.m. by LVN E, .Resident #34 is Day 3 post falls with no injuries noted at this time .the resident has been very restless this shift continuing to attempt to stand from a sitting position in her wheelchair .as she attempts this she leans forward with her face down causing her to stumble as she gets up .to prevent this the resident has been walking in the hallway holding to the handrail .</p> <p>*09/19/24 at 4:52 p.m. by LVN E, .Resident #34 is day 4 post fall with no injuries .Resident #34 has been restless this shift with numerous unsuccessful attempts to redirect her .she is extremely unsteady and is a fall risk when she rises from the chair bent over toward the floor .</p> <p>*09/20/24 at 8:25 a.m. by LVN R, .Resident #34 is day 5 post fall with no injuries .she is restless and getting up and down from wheelchair .very unsteady gait .nurse [LVN R] continues to try to redirect .</p> <p>*09/23/24 at 2:13 p.m. by LVN E, .Resident #34 is Day 1 follow up fall in resident room .resident has been alert and has been in dining room watching TV with other residents .</p> <p>*09/24/24 at 7:30 a.m. by LVN E, .Resident #34 was assessed this morning some light colored bruising noted to right hip and right chin .resident holding head to the left side .unable to assist this nurse and CNA get her from the commode to the wheelchair .resident answering questions .speaking slower than is her norm . informed administrative staff and informing MD T .</p> <p>*09/24/24 at 2:20 p.m. by LVN E, .Received a call from staff at [hospital] ER .she reported that our resident will be returning to the facility .she stated that imaging, labs, and UA had been completed .no fracture, no brain bleed were found .labs and UA are normal .hospital staff further states that the resident continues to be very lethargic and holds her head down and to the left .they can find no explanation for either even though it is evident and continuing at this time .the ER is returning her with no treatable condition .</p> <p>*09/27/24 at 3:22 p.m. by LVN E, .Resident #34 has been very tired today and has rested in bed most of this shift .she has been lethargic at times .</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Whispering Pines Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE  2131 Alpine Rd Longview, TX 75601	
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<p>F 0758</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #34's physician progress note dated 08/15/24 at 9:10 p.m. by MD T indicated . Physician Progress Note .Assessment .Schizophrenia, Bipolar disorder, Pulmonary embolism (is a blockage in a lung artery caused by a blood clot or other substance that travels from another part of the body through the bloodstream), Generalized anxiety disorder, Hypertension (high blood pressure) .Plan: Increase risperidone to three times a daily, increase lorazepam to twice a daily, implement fall precautions, consider increasing medication as needed in the next few days if behavior issues persist .Subjective: Resident #34, a [AGE] year-old lady in the memory care unit, was seen due to increasing behavioral issues .she history of schizophrenia .the nurse staff report worsening behavioral issues despite current medication regimen of risperidone twice daily and lorazepam daily .during the visit, she appeared anxious, repeatedly attempting to stand from her chair without assistant despite instruction to remain seated .Psych: anxious, euthymic (is a normal, tranquil mental state or mood) .</p> <p>Record review of Resident #34's fall event notes reflected:</p> <p>*On 08/09/24, Resident #34 had a fall in the dining room.</p> <p>*On 09/10/24, Resident #34 had a fall in hallway.</p> <p>*On 09/15/24, Resident #34 had a fall in the resident's room.</p> <p>*On 09/15/24, Resident #34 had a fall in the dining room.</p> <p>*On 09/22/24, Resident #34 had a fall in the resident's room.</p> <p>Record review of Resident #34's hospital records dated 09/24/24 indicated .apparently the patient fell 2 days ago at the nursing home and was sent here for evaluation .we did call the nursing home and they said she has been acting more lethargic lately just not moving as much normally she will take a few steps but now she is not doing that no other abnormality .patient feels a little better now she is actually able to communicate more she is just repeating what I say she is more awake .the workup here was negative .</p> <p>Record review of Resident #34's weight record reviewed 10/02/24 indicated Resident #34 weighed 153 lbs. on 09/10/24 and 138 lbs. on 10/02/24. This was a 9.8% weight loss in less than one month.</p> <p>During an observation on 09/30/24 at 9:43 a.m., Resident #34 was in the dining room in a wheelchair. Resident #34 was leaning to the left in her wheelchair and with her head down and eyes closed.</p> <p>During an observation and interview on 09/30/24 at 10:30 a.m., Resident #34 was in the dining room in a wheelchair. Resident #34 was leaning to the left in her wheelchair and with her head down and eyes closed. CNA C brought a pillow to help prop Resident #34 more upright. Staff placed a snack and magazine in front of Resident #34, but she did not touch either item. Resident #34 smiled but did not respond when addressed by surveyor. Resident #34 was non interviewable.</p> <p>During an observation on 09/30/24 at 12:03 p.m., Resident #34 was in the dining room in a wheelchair. Resident #34 was leaning to the left in her wheelchair and was asleep. Resident #34's lunch tray was in front of the resident untouched. Staff kept attempting to wake Resident #34 to eat her lunch. LVN R fed Resident #34 a few bites.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an observation on 09/30/24 at 4:04 p.m., Resident #34 was in the dining room in a wheelchair. Resident #34 was leaning to the left in her wheelchair and was asleep.</p> <p>During an interview on 09/30/24 at 4:15 p.m., a family member of Resident #34 said Resident #34 was not on the secure unit when she was admitted . He said Resident #34 started wandering and going in other people's rooms. He said the facility placed her on the secured unit. He said Resident #34 had dealt with mental illness her whole life and did not take medications. He said Resident #34 did not like how the medications made her drowsy and sleepy. He said Resident #34 was on the medication she did not like and was very sleepy.</p> <p>During an observation on 10/01/24 at 8:14 a.m., Resident #34 was in the dining room in a wheelchair. Resident #34 was leaning to the left in her wheelchair and appeared sleepy. Resident #34's breakfast tray was untouched in front of her. The DON encouraged Resident #34 to take a bit of her oatmeal. Resident #34 took one bite with the DON's assistance.</p> <p>During an observation on 10/01/24 at 11:04 a.m., Resident #34 was in the dining room in a wheelchair. Resident #34 was leaning to the left in her wheelchair and was asleep.</p> <p>During an interview on 10/02/24 at 9:03 a.m., LVN E said Resident #34 was in the general population then placed on the secured unit for wandering. She said Resident #34 never really walked very steady and liked to lean forward. She said Resident #34 had schizophrenia and was not redirectable. She said Resident #34 was a hard resident t[TRUNCATED]</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933</b></p> <p>Based on observation, interview and record review, the facility failed to ensure that it was free of medication error rate of 5 percent or greater. The facility had a medication error rate of 61.76%, based on 21 errors out of 34 opportunities, which involved 4 of 4 residents (Resident #15, Resident #20, Resident #53, and Resident #73) reviewed for medication administration.</p> <ol style="list-style-type: none"> <li>1. MA O administered Buspirone 10mg (is commonly used to treat anxiety disorders), Lorazepam 1mg (treats anxiety), and Tramadol 50mg (a pain relief medication, specifically indicated for moderate-to-severe pain) at 10:49 a.m.-11:21 a.m. instead of 8:00 a.m. as ordered on 09/30/24 for Resident #53.</li> <li>2. MA O administered Divalproex 250mg (is used to treat certain types of seizures (epilepsy)), Senna-Plus (is used to treat constipation), Levetiracetam 500mg (is a medicine used to treat epilepsy), and Sertraline 100mg (used to treat depression, obsessive-compulsive disorder, panic disorder, anxiety and more) at 10:49 a.m.-11:21 a.m. instead of liberalized policy time of 6:30 a.m.-10:30 a.m. on 09/30/24 for Resident #53.</li> <li>3. MA O administered Acetaminophen 500 mg (is used to treat many conditions such as headache, muscle aches, arthritis, backache, toothaches, colds and fevers) at 11:24 a.m. instead of 8:00 a.m. as ordered on 09/30/24 for Resident #20.</li> <li>4. MA O administered Arginaid 4.5g (is an arginine-based powder designed to support the unique nutritional needs of people with chronic wounds (e.g pressure injury)), Vitamin C 500mg, Chewable Aspirin 81mg (is a type of nonsteroidal anti-inflammatory drug (NSAID) that can treat mild to moderate pain, inflammation or arthritis), Bzotropine 1mg (is used with other medicines to treat Parkinson's disease), Haloperidol 5mg (is used to treat nervous, emotional, and mental conditions (eg, schizophrenia)), Levetiracetam 500mg (is a medicine used to treat epilepsy), Lithium Carbonate 150mg (is used to treat manic-depressive disorder (bipolar disorder)), Multi Vitamin with minerals, Pro-Mod 15g 30ml (ready-to-drink medical food providing 15 grams of enzyme-hydrolyzed complete protein and 100 calories), and Vitamin D3 1000mg at 11:24 a.m. instead of liberalized policy time of 6:30 a.m.-10:30 a.m. on 09/30/24 for Resident# 20.</li> <li>5. LVN N administered Resident #73's Cefazolin (is used to treat bacterial infections in many different parts of the body (eg, lungs, bladder, skin, bone and joints, and more)) 2gm/100ml IV over 30 minutes (200ml/hr) instead of 1 hour (100ml/hr) as directed by the physician's order on 10/01/24 at 7:57 a.m.</li> <li>6. GVN Q administered Ferrous Sulfate 325mg (is a type of iron that's used as a medicine to treat and prevent iron deficiency anemia) at 08:27 a.m. instead of 6:30 as ordered on 10/01/24 for Resident #15.</li> <li>7. GVN Q did not administer Resident #15's Lidocaine Patch (is a topical anesthetic that numbs pain by blocking the nerve signals in your skin) due at 8:00 a.m. on 10/01/24.</li> </ol> <p>These failures could place residents at risk for not receiving the intended therapeutic benefit of their medications or receiving them as prescribed, per physician orders.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Findings included:</p> <p>1. Record review of Resident #53 face sheet dated 09/30/24 indicated Resident #53 was a [AGE] year-old female admitted on [DATE] with diagnoses including Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), cerebral infarction (stroke), major depressive disorder (a persistently low or depressed mood and a loss of interest in activities that you used to enjoy), anxiety (is a feeling of fear, dread, and uneasiness.), and aphasia following cerebral infarction (loss of ability to understand or express speech, caused by brain damage).</p> <p>Record review of Resident #53's quarterly MDS assessment dated [DATE] indicated Resident #53 had unclear speech, was rarely/never understood, and rarely/never understood others. Resident #53 was unable to complete the BIMS assessment. Resident #53 had short-and-long term memory loss and severely impaired cognitive skills for daily decision making. Resident #53 had upper and lower extremities functional limitation in range of motion. Resident #53 was dependent for eating, oral, toilet, and personal hygiene, dressing and shower/bathe self. Resident #53 received scheduled pain medication regimen. Resident #53 received an antianxiety, antidepressant, and opioid during the last 7 days of the assessment period.</p> <p>Record review of Resident #53's care plan last review completed on 07/11/24 indicated:</p> <p>*Resident #53 required antidepressant medication. Intervention included give antidepressant medications ordered by physician.</p> <p>*Resident #53 used anti-anxiety medications. Intervention included give anti-anxiety medications ordered by physician.</p> <p>*Resident #53 required psychotropic medications. Intervention included administer medications as ordered.</p> <p>*Resident #53 had chronic condition of multiple sclerosis (a chronic disease of the central nervous system). Intervention included give medications as ordered.</p> <p>*Resident #53 had a chronic condition of seizure disorder (is abnormal electrical activity in your brain that temporarily affects your consciousness, muscle control and behavior). Intervention included give seizure medication as ordered by doctor.</p> <p>Record review of Resident #53's order summary dated 09/30/24 indicated:</p> <p>*Buspirone HCL Oral Tablet 10mg, give 1 tablet by mouth three times a day related to anxiety. Start date 04/03/23.</p> <p>*Depakote Sprinkles Oral Capsule Delayed Release 125 mg (Divalproex Sodium), give 2 capsules by mouth two times a day related to dementia with agitation. Start date 05/16/23.</p> <p>*Keppra Tablet 500mg (Levetiracetam), give 1 tablet by mouth two times a day related to convulsions (is a medical condition where the body muscles contract and relax rapidly and repeatedly, resulting in uncontrolled shaking). Start date 11/20/23.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*Lorazepam Oral Tablet 1mg, give 1 tablet by mouth three times a day related to anxiety disorder. Start date 05/16/23.</p> <p>*Senna-Plus Oral Tablet 8.6-50mg, give 1 tablet by mouth one time a day related to constipation. Start date 06/19/24.</p> <p>*Sertraline HCL Oral tablet 100mg, give 1 tablet by mouth one time a day related to major depressive disorder. Start date 04/01/23.</p> <p>*Tramadol HCL Oral Tablet 50mg, give 1 tablet by mouth three times a day related to multiple sclerosis. Start date 08/08/24.</p> <p>Record review of Resident #53's MAR dated 09/01/24-09/30/24 indicated:</p> <p>*Buspirone HCL Oral Tablet 10mg, give 1 tablet by mouth three times a day related to anxiety. Due at 8:00 a. m. The medication was administered on 09/30/24.</p> <p>*Depakote Sprinkles Oral Capsule Delayed Release 125 mg (Divalproex Sodium), give 2 capsules by mouth two times a day related to dementia with agitation. Due in the AM and PM. The medication was administered on 09/30/24.</p> <p>*Keppra Tablet 500mg (Levetiracetam), give 1 tablet by mouth two times a day related to convulsions (is a medical condition where the body muscles contract and relax rapidly and repeatedly, resulting in uncontrolled shaking). Due in the AM and PM. The medication was administered on 09/30/24.</p> <p>*Lorazepam Oral Tablet 1mg, give 1 tablet by mouth three times a day related to anxiety disorder. Due at 8:00 a.m. The medication was administered on 09/30/24.</p> <p>*Senna-Plus Oral Tablet 8.6-50mg, give 1 tablet by mouth one time a day related to constipation. Due in the AM. The medication was administered on 09/30/24.</p> <p>*Sertraline HCL Oral tablet 100mg, give 1 tablet by mouth one time a day related to major depressive disorder. Due in the AM. The medication was administered on 09/30/24.</p> <p>*Tramadol HCL Oral Tablet 50mg, give 1 tablet by mouth three times a day related to multiple sclerosis. Due at 8:00 a.m. The medication was administered on 09/30/24.</p> <p>During an observation on 09/30/24 from 10:49 a.m.-11:21 a.m., MA O prepared and administered Resident #53's, 6 tablets (Tramadol, Sertraline, Senna-Plus, Lorazepam, Buspirone, and Keppra and 2 capsules. MA O crushed 6 tablets and added the medications in individual medicine cups with a yellow custard substance. MA O separated 2 capsules (Depakote Sprinkles) and placed the sprinkles in a medicine cup with a yellow custard substance.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Record review of Resident #20's face sheet dated 10/08/2024 indicated Resident #20 was a 68-years-old male admitted to the facility on [DATE] with diagnoses including cerebral ischemia (is a common mechanism of acute brain injury that results from impaired blood flow to the brain), low back pain, extrapyramidal and movement disorders (also called drug-induced movement disorders, describe the side effects caused by certain antipsychotic and other drugs), convulsions (a condition in which muscles contract and relax quickly and cause uncontrolled shaking of the body), Vitamin D deficiency (means you don't have enough of this vitamin in your body), mood disorder (is a mental health condition that primarily affects your emotional state), schizophrenia (is a serious mental health condition that affects how people think, feel and behave), bipolar disorder (is a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), and vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain).</p> <p>Record review of Resident #20's quarterly MDS assessment dated [DATE] indicated Resident #20 was usually understood and usually understood others. Resident #20 had a BIMS score of 02 which indicated severe cognitive impairment. Resident #20 received an antipsychotic and antiplatelet during the last 7 days of the assessment period.</p> <p>Record review of Resident #20's care plan last review completed on 07/15/24 indicated:</p> <p>*Resident #20 required psychotropic medications: antipsychotic/antimanic at risk for complications. Intervention included administer medications as ordered.</p> <p>*Resident #20 had seizure disorder. Intervention included give medication as ordered.</p> <p>*Resident #20 had history of transient ischemic attack (is a brief period of stroke-like symptoms caused by a temporary lack of blood flow to the brain). Intervention included give medications as ordered by physician.</p> <p>Record review of Resident #20's order summary dated 10/01/24 indicated:</p> <p>*Arginaid packet, two times a day for wound care. Start date 02/07/24.</p> <p>*Ascorbic Acid (Vitamin C) Tablet 500mg, give 1 tablet by mouth two times a day for wound care. Start date 02/07/24.</p> <p>*Aspirin Tablet Chewable 81mg, give 1 tablet by mouth one time a day related to transient cerebral ischemic attack. Start date 01/22/19.</p> <p>*Benzotropine Mesylate Tablet 1mg, give 1 tablet by mouth two times a day related to extrapyramidal and movement disorders. Start date 01/10/19.</p> <p>*Haloperidol Tablet 5mg, give 1 tablet by mouth two times a day related to schizophrenia. Start date 08/02/22.</p> <p>*Levetiracetam Tablet 500mg, give 1 tablet by mouth two times a day related to convulsions. Start date 01/10/19.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*Lithium Carbonate Capsule 150mg, give 1 capsule by mouth two times a day related to schizophrenia, bipolar disorder. Start date 08/02/22.</p> <p>*Multivitamin Adult (Minerals) Oral Tablet (Multi Vitamins with Minerals), give 1 tablet by mouth one time a day for wound healing. Start date 02/07/24.</p> <p>*ProMod Oral Liquid (Nutritional Supplements), give 30ml by mouth one time a day for wound care. Start date 02/07/24.</p> <p>*Tylenol Extra Strength Tablet 500mg (Acetaminophen), give 1 tablet by mouth three times a day for back pain. Start date 07/12/22.</p> <p>*Vitamin D3 Capsule 1000 Unit (Cholecalciferol), give 2 capsules by mouth one time a day for supplement (2 capsule=2000 Units). Start date 01/11/19.</p> <p>Record review of Resident #20's MAR dated 09/01/24-09/30/24 indicated:</p> <p>*Arginaid packet, two times a day for wound care. Due in the AM and PM. The medication was administered on 09/30/24.</p> <p>*Ascorbic Acid Tablet (Vitamin C) 500mg, give 1 tablet by mouth two times a day for wound care. Due in the AM and PM. The medication was administered on 09/30/24.</p> <p>*Aspirin Tablet Chewable 81mg, give 1 tablet by mouth one time a day related to transient cerebral ischemic attack. Due in the AM. The medication was administered on 09/30/24.</p> <p>*Benztropine Mesylate Tablet 1mg, give 1 tablet by mouth two times a day related to extrapyramidal and movement disorders. Due in the AM and PM. The medication was administered on 09/30/24.</p> <p>*Haloperidol Tablet 5mg, give 1 tablet by mouth two times a day related to schizophrenia. Due in the AM and PM. The medication was administered on 09/30/24.</p> <p>*Levetiracetam Tablet 500mg, give 1 tablet by mouth two times a day related to convulsions. Due in the AM and PM. The medication was administered on 09/30/24.</p> <p>*Lithium Carbonate Capsule 150mg, give 1 capsule by mouth two times a day related to schizophrenia, bipolar disorder. Due in the AM and PM. The medication was administered on 09/30/24.</p> <p>*Multivitamin Adult (Minerals) Oral Tablet (Multi Vitamins with Minerals), give 1 tablet by mouth one time a day for wound healing. Due in the AM. The medication was administered on 09/30/24.</p> <p>*ProMod Oral Liquid (Nutritional Supplements), give 30ml by mouth one time a day for wound care. Due in the AM. The medication was administered on 09/30/24.</p> <p>*Tylenol Extra Strength Tablet 500mg (Acetaminophen), give 1 tablet by mouth three times a day for back pain. Due at 8:00 a.m., 2:00 p.m., and 8:00 p.m. The medication was administered on 09/30/24.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*Vitamin D3 Capsule 1000 Unit (Cholecalciferol), give 2 capsules by mouth one time a day for supplement (2 capsule=2000 Units). Due in the AM. The medication was administered on 09/30/24.</p> <p>During an observation on 09/30/24 at 11:24 a.m., MA O prepared and administered Resident #20's 7 tablets (Aspirin, Benztropine, Haloperidol, Levetiracetam, Multivitamin, Tylenol, and Vitamin C) 2 capsule (Lithium and Vitamin D (2)), and 2 liquid medications (Arginaid in water and Pro-Mod).</p> <p>3. Record review of Resident #73's face sheet dated 10/03/24 indicated Resident #73 was a 50-years-old male admitted to the facility on [DATE] with diagnoses including bacteremia (is the presence of viable bacteria in the circulating blood), sepsis (is your body's extreme reaction to an infection), and acute hematogenous osteomyelitis, right ankle, and foot (is an infection caused by bacterial seeding from the blood).</p> <p>Record review of Resident #73's admission MDS assessment dated [DATE] indicated Resident #73 was understood and understood others. Resident #73 had a BIMS score of 14 which indicated intact cognition. Resident #73 received an antibiotic in the last 7 days during the assessment period. Resident #73 received IV medication and had IV access while a resident in the facility, within the last 14 days.</p> <p>Record review of Resident #73's care plan dated 09/11/24 indicated:</p> <p>*Resident #73 had osteomyelitis. Intervention included give antibiotics as ordered.</p> <p>*Resident #73 had intravenous (IV) access. Intervention included administer IV medications as ordered.</p> <p>Record review of Resident #73's order summary dated 10/01/24 indicated Cefazolin Sodium Injection Solution Reconstituted 2gm, use 2 grams intravenously every 8 hours related to acute hematogenous osteomyelitis, right ankle, and foot until 10/16/24 11:59 p.m., Administer 100ml/hr. Start date 09/20/24.</p> <p>Record review of Resident #73's MAR dated 10/01/24-10/31/24 indicated Cefazolin Sodium Injection Solution Reconstituted 2gm, use 2 grams intravenously every 8 hours related to acute hematogenous osteomyelitis, right ankle, and foot until 10/16/24 11:59 p.m., Administer 100ml/hr. Due at 12:00 a.m., 8:00 a.m., and 4:00 p.m. The medication was administered on 10/01/24.</p> <p>During an observation and interview on 10/01/24 at 7:57 a.m., LVN N reconstituted and administered Resident #73's IV medication. LVN N placed the dial on the tubing on 200ml/hr. LVN N said the medication would run for 30 mins.</p> <p>4. Record review of Resident #15's face sheet dated 10/03/24 indicated Resident #15 was a 64-years-old female admitted to the facility on [DATE] and 07/01/24 with diagnoses including Huntington's disease (is an inherited disorder that causes nerve cells (neurons) in parts of the brain to gradually break down and die) and iron deficiency anemia (a condition in which blood lacks adequate healthy red blood cells).</p> <p>Record review of Resident #15's significant change MDS assessment dated [DATE] indicated Resident #15 was understood and understood others. Resident #15 had a BIMS score of 10 which indicated moderate cognitive impairment. Resident #15 received scheduled pain medication regimen.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #15's care plan dated 10/08/2024 indicated Resident #15 had a nutritional problem or potential nutritional problem. Intervention included administer medications as ordered.</p> <p>Record review of Resident #15's order summary dated 10/01/24 indicated:</p> <p>*Ferrous Sulfate oral Tablet 325 (65 Fe), give 1 tablet enterally one time a day related to anemia. Start date 07/17/24.</p> <p>*Lidocaine Pain Relief Patch 4%, apply to lower back topically one time a day for pain, remove after 12 hours and remove per schedule. Start date 03/13/24.</p> <p>Record review of Resident #15's MAR dated 10/01/24-10/31/24 indicated:</p> <p>*Ferrous Sulfate oral Tablet 325 (65 Fe), give 1 tablet enterally one time a day related to anemia. Due at 6:30 a.m. The medication was administered on 10/01/24.</p> <p>*Lidocaine Pain Relief Patch 4%, apply to lower back topically one time a day for pain, remove after 12 hours and remove per schedule. Due remove 7:59 a.m. and apply 8:00 a.m. The MAR did not indicate administration on 10/01/24.</p> <p>During an observation on 10/01/24 at 8:27 a.m., GVN Q administered one tablet of Ferrous Sulfate 325 mg to Resident #15. GVN Q did not apply Resident #15's Lidocaine Pain Relief Patch 4%.</p> <p>During an interview on 10/02/24 at 1:55 p.m., MA O said if a medication was due at 8am, it had to be administered by 9am. He said if it was administered after 9am, it was considered late. He said if a medication was scheduled for AM, if was due by 11:30 a.m. He said after 11:30 a.m., the medication was considered late. He said on 09/30/24, he had gotten behind which caused him to administer several medications late. He said when he got behind, LVNs did not assist him to catch up. He said it was important to administer medications as ordered so the effects worked better.</p> <p>During an interview on 10/02/24 at 3:44 p.m., LVN N said Resident #73 was admitted on antibiotics. She said the medication order from the hospital did not specify the rate of administration. She said the medication order was sent to the pharmacy and they sent the appropriate fluid to reconstitute the antibiotic with. She said the nurse was supposed to call the MD to confirm the correct medication was ordered and what rate to run it over. She said the pharmacy returned Resident #73's medication with an administration rate of 30 minutes. She said the nurse who ordered the medication received an order for 30 minutes. She said a nurse put special direction on the order for 100ml/hr. She said before administering a medication, she was responsible to verify the medication label matched the physician's order. She said she did not notice the physician order rate was 100ml/hr. She said when a medication was administered too fast, the resident could experience fluid overload and adverse reaction to the medication.</p> <p>On 10/02/24 at 4:15 p.m., call GVN Q but was unable to leave a message.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/03/24 at 10:21 a.m., the DON said if a medication was due at 8am, staff had an hour before and after to administer it. She said if a medication was scheduled for AM, it was due between 6:30 a.m.-10:30 a.m. She said after those time ranges, those medications were considered late. She said MAs were responsible for administering medications on schedule. She said LVNs and the nursing administration should be ensuring MAs were giving medication on schedule. She said when medications were given late, it placed residents at risk for getting doses too close together. She said staff had to document when a medication was administered. She said if a medication administration was not documented, it could imply it was not given. She said if IV medications were administered too long, the medication could become ineffective. She said if an IV medication was run too fast, it could cause unwanted effects.</p> <p>During an interview on 10/03/24 at 11:00 a.m., the ADM said MAs and charge nurse were responsible for administering medication on time. She said charge nurse should use the 5 rights and ensure the medication label and physician order match. She said it depended on the type of medication how it would affect the resident if administered late. She said when medications were administered late, it affected the next scheduled doses. She said the resident could experience a negative outcome if a medication was administered too fast. She said the nurse managers should be ensuring nursing staff administered medications as ordered.</p> <p>Record review of an undated facility's Liberalized Medication policy indicated .AM time code=maybe given from 5:30 am until 10:30 am .medications that require a certain amount of time, i.e. 12 hours in between doses will continue to have scheduled times .if a physician's order specifically states the time of day a medication is to be given, then the facility must administer it at the times specified .</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933</b></p> <p>Based on interview, and record review, the facility failed to ensure that residents were free of significant medication errors for 2 of 5 residents (Resident #23 and Resident #34) reviewed for pharmacy services.</p> <p>The facility failed to ensure Resident #23's losartan (blood pressure medication) was not administered when her blood pressure (is a measure of how forcefully your blood goes through your arteries) and heart rate (is how many times your heart beats in 60 seconds) was outside of the ordered parameters on 09/01/24, 09/02/24, 09/09/24, 09/17/24, and 09/26/24.</p> <p>The facility failed to ensure Resident #34's losartan (blood pressure medication) was not administered when her blood pressure was outside of the ordered parameters on 9/08/24, 9/09/24, 9/10/24, 9/17/24, 9/26/24, and 9/30/24.</p> <p>These failures could place residents at risk of medical complications and not receiving the therapeutic effects of their medications.</p> <p>Findings included:</p> <p>1. Record review of Resident #23's face sheet dated 09/30/24 indicated Resident #23 was a [AGE] year-old female admitted on [DATE] and 08/16/24 with diagnoses including anemia (is a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), hypertension (is when the pressure in your blood vessels is too high (140/90 mmHg or higher)), and long term (current) use of anticoagulants (commonly known as a blood thinner, is a chemical substance that prevents or reduces the coagulation of blood, prolonging the clotting time).</p> <p>Record review of Resident #23's significant change MDS assessment dated [DATE] indicated Resident #23 was rarely/never understood and sometimes understood others. Resident #23 was unable to complete the BIMS assessment. Resident #23 had short-and-long term memory problems with severely impaired cognitive skills for daily decision making.</p> <p>Record review of Resident #23's care plan last review completed on 09/13/24 indicated Resident #23 had hypertension. Intervention included give anti-hypertensive medications (blood pressure medications) as ordered.</p> <p>Record review of Resident #23's order summary report dated 09/30/24 indicated Losartan Potassium Tablet 50mg, give 1 tablet by mouth one time a day related to essential (primary) hypertension. Hold for SBP (is the first number. It measures the pressure your blood is pushing against your artery walls when the heart beats) below 110, DBP (is the second number. It measures the pressure your blood is pushing against your artery walls while the heart muscle rests between beats) below 60 or Heart Rate less than 60. Start date 08/17/24.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #23's MAR dated 09/01/24-09/30/24 indicated Losartan Potassium Tablet 50mg, give 1 tablet by mouth one time a day related to essential (primary) hypertension. Hold for SBP below 110, DBP below 60 or Heart Rate less than 60. The MAR indicated administration on 09/01/24 Hear Rated 54 (MA O), 09/02/24 Heart Rate 57 (MA O), 09/09/24 BP 106/70 (MA P), 09/17/24 HR 59 (MA P), and 09/26/24 HR 58 (MA O).</p> <p>2. Record review of Resident #34's face sheet dated 09/30/24 indicated Resident #34 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia (a group of thinking and social symptoms that interferes with daily functioning) with psychotic disturbance (severe mental disorders that cause abnormal thinking and perceptions), acute embolism (is an obstruction or blockage in a blood vessel) and thrombosis (is a blood clot within blood vessels that limits the flow of blood), and hypertension (high blood pressure).</p> <p>Record review of Resident #34's quarterly MDS assessment dated [DATE] indicated Resident #34 was usually understood and understood others. Resident #34 had a BIMS score of 03 which indicated severe cognitive impairment.</p> <p>Record review of Resident #34's care plan last review completed on 08/27/24 indicated Resident #34 had a chronic condition of hypertension. Intervention included give anti-hypertensive medications as ordered.</p> <p>Record review of Resident #34's order summary report dated active as of 08/31/24 indicated Losartan Potassium Oral Tablet 50mg, give 1 tablet by mouth one time a day related to hypertensive urgency (is an acute, severe elevation in blood pressure without signs or symptoms of end-organ damage). Hold for SBP less than 110, DBP less than 60, HR less than 55. Start date 05/11/24.</p> <p>Record review of Resident #34's MAR dated 09/01/24-09/30/24 indicated Losartan Potassium Oral Tablet 50mg, give 1 tablet by mouth one time a day related to hypertensive urgency. Hold for SBP less than 110, DBP less than 60, HR less than 55. The MAR indicated administration on 09/08/24 BP 104/84 (MA P), 09/09/24 BP 109/75 (MA O), 09/10/24 BP 109/75 (MA O), 09/17/24 BP 108/67 (MA P), 09/26/24 BP 104/63 (MA O), and 09/30/24 BP 108/67 (MA O).</p> <p>During an interview on 10/02/24 at 1:55 p.m., MA O said blood pressure medication parameters were on the medication order. He said if the blood pressure or heart rate were out of range, he notified the nurse. He said he normally did what the nurse told him after he notified them of the low vital signs. He said if the blood pressure or heart rate was less than the parameters, the medication should be held. He said when he held a medication, he notified the nurse and documented held on the MAR. He said if the hold parameters said and then all parameters had to be low to hold the medication. He said if the hold parameters said or, then only one parameter had to be low to hold the medication. He said on the C hall, the nurses got the resident's blood pressure and heart rate. He said the nurses charted those vital signs in the eMAR. He said normally the nurse would tell him if the resident's vital signs were too low to administer the blood pressure medication. He said giving a resident a blood pressure medication when their blood pressure or heart rate was already low, could cause it to drop more. He said residents could experience drowsiness. He said he had not realized he had given Resident # 23 and Resident #34 blood pressure medication when their vital signs met the hold parameters.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/02/24 at 2:20 p.m., LVN E said the nurses did the blood pressure and heart rate on the secured unit (C hall). She said some MAs did their own vital signs. She said if the blood pressure hold parameter said or then only one parameter had to be low to hold the medication. She said if a resident's blood pressure got too low, they could get dizzy, weak, or sick. She said the facility had not instructed the nurse to monitor the MAs to ensure they did not give blood pressure medications when the resident's vital signs were too low.</p> <p>During an interview on 10/03/24 at 10:21 a.m., the DON said she expected MAs to hold blood pressure medications when the resident's vital signs met the hold parameters. She said the MAs should notify the nurses when the vital signs were low, and the medication was held. She said if a blood pressure medication was held, staff should document held and parameters not within range on the MAR. She said the nurse should assess the resident, recheck the blood pressure and notify the physician if the vital signs are still out of range. She said the charge nurse should ensure blood pressure medications were not given when they should not be. She said a resident's blood pressure could drop too low. She said when the blood pressure and heart rate were too low, residents could fall or pass out.</p> <p>During an interview on 10/03/24 at 11:00 a.m., the ADM said she expected the nursing staff to hold medications when they were supposed to. She said that was why the parameters were placed on the order. She said she was not a nurse but knew it was not good for the resident to have a low blood pressure or heart rate.</p> <p>Record review of a facility's Medication Administration Procedures policy revised 10/25/2017 indicated .the 10 rights of medication should always be adhered to .1. Right patient .2. Right medication .3. Right dose .4. Right route .5. Right time .6. Right patient education .7. Right documentation .8. Right to refuse .9. Right assessment .10. Right evaluation .</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure safe and sanitary storage of residents' food items for 2 of 12 resident personal refrigerators reviewed for food safety (Resident #37 and Resident #38).</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure the refrigerator for Resident #37 did not have expired protein drinks.</li> <li>2. The facility failed to ensure the refrigerator for Resident #38 was cleaned and free from a brown and black substance with black dead gnats.</li> </ol> <p>This failure could place resident at risk for food borne illnesses.</p> <p>Findings include:</p> <p>1. Record review of Resident #37's face sheet, dated [DATE] revealed an [AGE] year old male admitted on [DATE]. He was most recently readmitted on [DATE]. The face sheet revealed diagnoses that included Cerebral Infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), Essential Hypertension (abnormally high blood pressure that's not the result of a medical condition), Insomnia (a sleep disorder that makes it hard to fall asleep, stay asleep, or get quality sleep).</p> <p>Record review of Resident #37's Quarterly MDS assessment, dated [DATE], revealed Resident #37 had a BIMS of 02, which indicated severe cognitive impairment. The MDS showed that Resident #37 required substantial assistance with their ADLs.</p> <p>Record review of a care plan for Resident #37 dated [DATE] revealed a problem initiated on [DATE]: The resident has an ADL Self Care Performance Deficit . Resident may require more or less assistance throughout the day/shift due to generalized weakness or disease processes.</p> <p>During an interview and observation on [DATE] at 8:19 a.m., Resident #37 was sitting in a wheelchair looking outside his window. Resident #37 had a personal refrigerator on his side of the room. Upon surveyor looking inside the refrigerator two bottles of protein drink with an expiration date of 2023 were discovered. Resident #37 said he both ate and drank from his refrigerator. Resident #37 said he did not know if anyone cleaned out his refrigerator. Resident #37 said he did not look at expiration dates on the items in his refrigerator.</p> <p>During an interview on [DATE] at 11:09 a.m., the DON said that housekeeping and CNAs are responsible to ensure that resident's personal refrigerators were clean and did not have expired food in them. She said Resident #37 could have been placed at risk of harm from drinking a protein drink that expired in 2023. She said that staff are responsible for the safety of residents.</p> <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 11:36 a.m. with the ADM she said that housekeeping was responsible for removing expired food from a resident's personal refrigerator. She said that housekeeping is also responsible to ensure that residents' refrigerators are clean if their family or responsible party was not cleaning it out. She said that resident's family or responsible party may not be at the facility enough to ensure their personal refrigerators were clean.</p> <p>2. Record review of a face sheet dated [DATE] indicated Resident #38 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, bipolar type (a rare mental health condition that involves both schizophrenia and a mood disorder, with manic episodes), abnormal weight loss (when you lose weight without trying and it's not due to normal circumstances like dieting or exercising) and unspecified protein-calorie malnutrition (a condition that occurs when a person doesn't get enough calories or the right amount of nutrients, such as proteins carbohydrates, fats, vitamins, and minerals).</p> <p>Record review of a quarterly MDS assessment dated [DATE] indicated Resident #38 usually understood others and usually made himself understood. The MDS indicated Resident #38 had intact cognition with a BIMS score of 13. The MDS indicated Resident #38 needed supervision with ADL's.</p> <p>Record review of a care plan for Resident #38 dated [DATE] revealed Resident #38 had impaired cognitive function or impaired thought processes bi-polar disorder: use the residents preferred name, identify yourself at each interaction. Face the resident when speaking, make eye contact. Reduce any distractions turn off TV, radio, close door etc. The resident understands consistent, simple, directive sentences. Provide the resident with necessary cues-stop and return if agitated. Monitor/document/report to MD any changes in cognitive function, specifically.</p> <p>During an observation on [DATE] at 10:45 a.m., in Resident #38's personal refrigerator it was observed not clean and had a brown and black substance with dead gnats in bottom of it with 2 glass containers of chip dips .</p> <p>During an observation on [DATE] at 8:22 a.m., Resident #38's personal refrigerator had a brown and black substance with dead gnats.</p> <p>During an observation on [DATE] at 9:22 a.m., Resident #38's personal refrigerator had a brown and black substance with dead gnats.</p> <p>During an observation on [DATE] at 3:04 p.m., Resident #38's personal refrigerator had a brown and black substance with dead gnats.</p> <p>During an interview on [DATE] at 9:31 a.m., with CNA B she said housekeeping was responsible for keeping the resident's refrigerators clean. She said Resident #38's refrigerator looked nasty. She said the refrigerator could be a hazard to Resident #38's health if he were to eat out of it and she would not want to eat out of it.</p> <p>During an interview on [DATE] at 10:19 a.m., with Housekeeper F she said no one told her she needed to clean out the refrigerators in resident's rooms. She said she did know housekeeping was responsible to ensure the resident's refrigerators were cleaned. Housekeeper F said she cleaned Resident #38's refrigerator on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 10:22 a.m., with Resident #38 he said he did not know staff was supposed to clean out his refrigerator. He said he ate his chip dip in the refrigerator when he got hungry. He said he knew the refrigerator was nasty.</p> <p>During an interview on [DATE] at 10:27 a.m., CNA G said housekeeping should ensure the residents' refrigerators are clean. CNA G thought the refrigerator would be a hazard to the resident, because if he were to accidentally rub the bottom of the refrigerator before he ate, he could get sick.</p> <p>During an interview on [DATE] at 11:12 a.m., RN H said she was not sure who was responsible for cleaning the resident's refrigerators. She said she thought his Resident #38's refrigerator could be a hazard to him, because if he ate something out of the refrigerator it could make him sick. RN H said Resident #38's refrigerator looked like it had not been cleaned in more than a couple of days.</p> <p>During an interview on [DATE] at 11:22 a.m., with the DON, she said their policy said family members were responsible to ensure the residents' refrigerators were clean, but if they did not have family the facility staff was responsible. DON said housekeeping staff and CNAs were responsible to clean out the resident's refrigerators. She said Resident #38 could get sick if he ate from the refrigerator.</p> <p>During an interview on [DATE] at 10:18 a.m., with the Administrator she said it is the responsibility of all staff to clean out the resident's refrigerators. She said there was no excuse for the resident's refrigerator to look like that. She said the staff on that hall should do a better job and she would work on that.</p> <p>Record review of facility policy titled Personal Refrigerator's Policy dated 2012 revealed that, Residents of the facility may place a personal or dormitory size refrigerator in their room if space permits and under Life Safety Code regulations, that the resident room has an adequate electrical system, such as proper outlets, to allow the connection of a refrigerator without overloading the electrical system The care and maintenance of any refrigerator is the responsibility of the resident and/or responsible party. It is also the responsibility of the resident and/or resident representative to properly store non-facility supplied foods that require refrigeration in their personal refrigerator. If food is expired or appears spoiled or moldy, the facility reserves the right to discard it. Housekeeping can assist the resident and/or family member by inspecting the refrigerators at least weekly and assist with removal of outdated food items and cleanliness. Food should be stored in the refrigerator/freezer as determined by the food item. Commonly Used Dates Sell by date - indicates that a product should not be sold after that date if the buyer is to have it at its best quality Best by or Use by date -the maker's estimate of how long a product will keep at its best quality. They are quality dates only, not safety dates. If stored properly, a food product should be safe, wholesome and of good quality after its Use by or Best by date. Expired date - the food items should not be consumed and should be discarded if not eaten by the expiration date</p> <p>48958</p>		

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  10/03/2024
NAME OF PROVIDER OR SUPPLIER  Whispering Pines Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE  2131 Alpine Rd Longview, TX 75601	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49019</p> <p>Based on observations, interviews, 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 1 of 4 residents (Resident #40) reviewed for Covid-19 infection control practices.</p> <ol style="list-style-type: none"> <li>The facility failed to ensure MA S wore an N95 mask when entering a Covid positive resident room.</li> <li>The facility failed to ensure MA S changed her mask after leaving a Covid positive resident room.</li> <li>The facility failed to ensure MA S wore proper PPE (Personal Protective Equipment) in Resident #40's room on 10/2/2024. Resident #40 was COVID-19 positive. MA S wore surgical mask only when entering and exiting Resident #40's Covid-19 positive room.</li> </ol> <p>These failures could place residents at risk of exposure to communicable diseases, cross-contamination, and infections.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Record review of Resident #40's face sheet, dated 10/2/2024, indicated she was an [AGE] year-old female, readmitted to the facility on [DATE]. Her diagnoses included dementia (A group of symptoms that affects memory, thinking and interferes with daily life), paroxysmal atrial fibrillation (is an irregular heart rhythm), type II diabetes (a condition results from insufficient production of insulin, causing high blood sugar) and Covid-19 (illness caused by a virus).</li> </ol> <p>Record review of Resident #40's care plan dated 8/1/2024 indicated focus of care on Resident #40's enhanced barrier precautions due to MDRO (Multidrug-resistant organisms) and surgical incision with interventions as follows:</p> <p>Gloves and gown should be donned if any of the following activities are to occur; linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or high contact activity.</p> <p>Perform hand sanitation before entering the room and prior to leaving the room.</p> <p>Posting at the resident's room entrance indicating the resident was on enhanced barrier precautions.</p> <p>Therapy should use gown and gloves, when transfer training, mobility training or other high contact activity.</p> <p>Record review of Resident #40's care plan revised on 9/23/2024 did not indicate a plan of care for Covid-19 and precautions related to infection control.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #40's progress note, dated 9/24/2024, indicated that Resident #40 tested positive for covid-19 on 9/24/2024.</p> <p>Record review of Resident #40's progress note, dated 9/24/2024, indicated she was placed on isolation precautions and moved to a different room related to a positive covid-19 test.</p> <p>During an observation on 10/2/2024 at 10:36 AM, MA S entered Resident #40's room and closed the door behind her. Resident #40 had a PPE (Personal Protective Equipment) container and a sign posted on the door indicating she was in droplet precautions and the sign indicated PPE was required to enter. MA S was observed wearing a surgical mask entering Resident # 40's room and closing the door behind her. MA S then came out of Resident #40's room and did not remove the surgical mask. MA S was interviewed , and she said she was only standing in the door. She said she was going into Resident #40's room to check on her. MA S said she was supposed to have on full PPE (N95, gown, gloves, face shield) prior to entering the room and did not provide a reason she did not don PPE. MA S said she could get Covid-19 if she was not wearing appropriate PPE.</p> <p>During an interview on 10/2/2024 at 11:11 AM, CNA K said the staff should be wearing appropriate PPE before entering a warm zone (Covid exposure) or hot zone (Covid positive) room. She said prior to exiting a warm or hot zone, the PPE should be removed and placed in a proper box in the resident room and hand care should be performed after leaving a resident room. CNA K said a resident in a warm room requires mask and full PPE only if providing care. She said full PPE should be worn in a hot zone room and follow protocols. She said she has been in-serviced on infection control.</p> <p>During an interview on 10/2/2024 at 11:35 AM, RN H said she could wear a surgical mask unless she was providing care. She said full PPE should be worn in the hot zone and not a surgical mask. RN H said PPE should be disposed in the resident's room and then hand care should be performed after leaving the room.</p> <p>During an interview on 10/2/2024 at 2:15 PM, MDS nurse J said residents in isolation or on enhanced barrier precautions require staff to be wearing PPE and signs posted on the resident's door.</p> <p>During an interview on 10/3/2024 at 10:17 AM, the ADON said if a staff member was entering a warm zone room, the staff should be wearing full PPE (N95, gown, gloves, face shield). The ADON said facility staff should be wearing full PPE when entering a hot zone room and should not be wearing a surgical mask. The ADON said staff should be disposing the PPE in the room and washing their hands after exiting the room. The ADON said the Infection Preventionist was the DON. The ADON said the staff was in-serviced on infection control. The ADON said not wearing appropriate PPE could negatively affect residents by potentially spreading infection. The ADON said the facility was made aware of the staff member and sent her home immediately. The ADON said MA S was educated prior to the incident.</p> <p>During an interview on 10/3/2024 at 11:11 AM, the DON said she had in-serviced staff on warm and hot zones. She said the staff were all supposed to adhere to the precautions on the door and wear full PPE (N95, gown, gloves, face shield) for Covid. The DON said the staff should dispose PPE in the resident's room. The DON said the staff should not be wearing just a surgical mask inside a hot zone room. She said the staff member who was not wearing appropriate PPE could spread infection. She said they did a one on one and sent the nurse home.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/3/2024 at 10:45 AM, the ADM said she expected the nurse and staff to wear appropriate PPE (full PPE) while entering the warm/hot zone resident rooms. She said the staff should not wear just a surgical mask while entering a resident room. The ADM said the staff should dispose of PPE prior to leaving the room and perform proper hand care by using hand sanitizer or washing hands. The ADM said residents could negatively be affected if the staff member carried an infection to someone who was not infected.</p> <p>Record review of the facility's undated signage titled Sequence for putting on personal protective equipment (PPE) indicated the type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet, or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE. 1. Gown: fully cover torso from neck to knees, arms to the end of wrist and wrap around back. Fasten behind neck and waist. 2. Mask or respirator: secure ties or elastic bands at the head and neck, fit flexible band to nose bridge, fit snug to face and below the chin, fit-check respirator. 3. Goggles or face shield: place over face and eyes and adjust to fit. 4. Gloves: extend to cover wrist of isolation gown. The sign posted indicated for staff to use safe work practices to protect yourself and limit the spread of contamination such as:</p> <p>Keep hands away from face,</p> <p>Limit surfaces touched.</p> <p>Change gloves when torn or heavily contaminated.</p> <p>Perform hand hygiene.</p> <p>The sign posted provided information on how to safely remove personal protective equipment (PPE). 1. Gown and Gloves . 2. Goggles or face shield .3. Mask or Respirator .4. Wash hands or use an alcohol-based hand sanitizer immediately after removing PPE.</p> <p>Record review of the facility's Interim Infection Prevention and control recommendations for healthcare personnel during the Coronavirus Disease 2019 Pandemic policy dated 5/8/2023 stated:</p> <p>.1. Recommended routine infection prevention and control practices during the Covid- 19 pandemic . Establish a process to identify and manage individuals with suspected or confirmed SARS-Covid infection . Ensure everyone was aware of recommended infection prevention and control (IPC) practices in the facility. Post visual alerts (signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) .Implementing source control measures .refers to use of respirators or well-fitting facemask or cloth mask to cover a person's mouth and nose to prevent the spread of respiratory secretions .</p> <p>.In the event of a suspected or confirmed COVID-19 infection, staff will promptly implement appropriate interventions and a management plan based on the Center for Disease Control's (CDC) guidelines, state, and federal regulations, and/or guidance from the local health authority to prevent the spread of infection .</p> <p>.3. Implement Source Control (masks) Measures</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>* Source control options for HCP (Healthcare personnel) include:</p> <ul style="list-style-type: none"> <li>* A NIOSH Approved particulate respirator with N95 filters or higher.</li> <li>* A respirator approved under standards used in other counties that are similar to NIOSH (National Institute for occupational safety and health) Approved N95 filtering facepiece respirators .</li> <li>. *A barrier face covering that meets ASTM( America Society for testing and materials) F3502-21 requirements including Workplace Performance and Workplace Performance Masks; or</li> <li>*A well-fitting facemask</li> </ul> <p>* Any of the above options used solely for source control can be used for an entire shift unless they become soiled, damaged, or hard to breathe through.</p> <p>* If using a NIOSH Approved Particulate respirator with N95 filter or higher during the care of a patient with COVID-19 infection, it should be removed and discarded after the patient care encounter and a new one should be donned .</p>