STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675386	A. Building B. Wing	01/07/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or others for 4 of 21 residents (Resident #16, Resident #24, Resident #37 and Resident #60) reviewed for reasonable accommodations of needs. The facility failed to ensure Resident #16, Resident #24, Resident #37 and Resident #60 had a call light within reach on the memory care and secure unit. This failure could place residents at risk of possible falls, major injuries, hospitalization, and unmet needs.Findings include: Record review of Resident #16's face sheet dated 01/07/26 reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #16 had diagnoses which included: unspecified dementia, severe, with psychotic disturbances (describes a stage of dementia where cognitive decline is significant, and the person experiences severe behavioral issues like hallucinations), severe protein-calorie malnutrition, depression, and unilateral primary osteoarthritis, right knee (the cartilage in only your right knee is wearing down due to age or wear-and year, causing pain, stiffness, swelling, reduced motion and grinding sensations). Record review of Resident #16's MDS, dated [DATE], reflected Resident #16 was usually understood and usually understood by others. Resident #16's BIMs score was a 7, which indicated severe impaired cognition. Resident #16 was dependent on toileting and required partial or moderate assistance with all ADLs. Resident #16 was always incontinent to bowel and bladder. Record review of Resident #16's care plan dated 7/24/24 reflected Resident #16 was a high risk for falls due to her history of fall with fracture prior to admission. The interventions included anticipating and meeting resident's needs, to be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Record review of Resident #24's face sheet dated 01/07/26 reflected a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #24 had diagnoses which included: cerebral ischemia (a serious condition where blood flow and oxygen to the brain are reduced), dysphagia (difficulty swallowing), extrapyramidal movement disorder (medication-induced or disease-related movement disorder affecting the brain's motor system), convulsions (uncontrollable, rapid and repeated tightening and relaxing of muscles, causing body shaking) and vascular dementia (occurs when damaged blood vessels reduce oxygen and nutrient flow to the brain, causing cognitive decline). Record review of Resident #24's MDS, dated [DATE], reflected Resident #24 was understood and was understood by others. Resident #24's BIMs score was a 4, which indicated severe impaired cognition. Resident #24 was substantial or maximal assist on toileting and required partial or moderate assistance with ADLs. Resident #24 was always incontinent to bladder but was frequently incontinent to bowel. Record review of Resident #24's care plan dated 7/28/20 reflected Resident #24 was a risk for falls antipsychotic induced impaired mobility. The interventions included anticipating and meeting resident's needs, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Record review of Resident #37's face sheet dated 01/07/26 reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #37 had diagnoses which included: dementia (a decline in mental ability severe enough to (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interfere with daily life, involving memory loss, thinking problems and behavioral changes), malignant neoplasm of head, face and neck (a cancerous tumor) and major depressive disorder. Record review of Resident #37's MDS, dated [DATE], reflected Resident #37 was understood and was understood by others. Resident #37's BIMs score was a 3, which indicated severe impaired cognition. Resident #37 was independent with ADLs. Resident #37 was occasionally incontinent to bladder and bowel. Record review of Resident #37's care plan dated 10/06/25 reflected Resident #37 was a risk for falls due to his generalized weakness. The interventions included anticipating and meeting resident's needs, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Record review of Resident #60's face sheet dated 01/07/26 reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #37 had diagnoses which included: dementia (a decline in mental ability severe enough to interfere with daily life, involving memory loss, thinking problems and behavioral changes), chronic obstructive pulmonary disease (a progressive lung condition causing airflow obstruction, making breathing difficult) and overactive bladder. Record review of Resident #60's MDS, dated [DATE], reflected Resident #60 was usually understood and was usually understood by others. Resident #60's BIMs score was a 5, which indicated severe impaired cognition. Resident #60 required set-up or clean-up assistance with ADLs. Resident #60 was occasionally incontinent to bladder and bowel. Record review of Resident #60's care plan dated 09/10/25 reflected Resident #60 was at risk for falls due to unsteady gait and balance. The interventions included anticipating and meeting resident's needs, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. During observation and interview on 01/05/26 at 9:01 A.M., revealed Resident #37 was lying in bed watching television. He said he did not know where his call light was; when he needed something he went down the hall and asked the staff for what he needed. Resident #37's call light was on the side of his nightstand on the floor. During observation and interview on 01/05/26 at 9:15 A.M., revealed Resident #16 was lying in bed. Her call light was not within reach and it was tucked behind her nightstand on the opposite side of her bed. Resident #16 was asked if she could reach her call light. She said if she needed to call staff she could not because she could not reach her call light. During observation on 01/05/26 at 9:25 A.M., revealed Resident #60's call light was under her bed. During observation on 01/05/26 at 9:53 A.M., revealed Resident #24 was lying in bed asleep. His call light was on the floor on the other side of the nightstand opposite side of the bed. During observation on 01/06/26 at 9:23 A.M., Resident #37 was lying in bed resting. Her call light was not within reach. During observation on 01/06/26 at 9:27 A.M., revealed Resident #60 was lying in bed asleep. Her call light was not within reach. During observation on 01/06/26 at 9:28 A.M., revealed Resident #16 was not in her room. Her call light was not accessible to the bed. During observation on 01/06/26 at 9:33 A.M., revealed Resident #24 lying in bed asleep. His call light was not within reach; it was on the other side of his nightstand. During an interview on 01/06/26 3:21 P.M. CNA H said the call lights were a way for residents to notify staff if they needed something. She said Resident #37 never used his call light, but she knew the call lights needed to be accessible, so when the residents needed staff they could get a hold of them She said she agreed that a lot of the call lights on the secured unit were not accessible for the residents and she had put the call lights where the residents could get to them that morning. She said everyone was responsible for ensuring that the call lights were accessible for the residents. She said a negative effective of not having a call light accessible was if the residents fell, they could not get help. During an interview on 01/07/26 at 11:50 A.M. LVN G said the call light should be accessible for the residents to use in case of an emergency; the residents may need to contact staff. He said everyone was responsible for ensuring that the call lights were accessible for the residents. He said a negative effect of not having a call light accessible for a resident was that a resident could fall and cause an injury. He said a resident could even die and not be able to call for staff. During an interview on 01/07/2026 at 1:30 P.M., the Assistant Director of Nursing said the call light should be accessible for the residents to make their needs known. She said everyone was responsible for (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ensuring the call lights were accessible to the residents. She said negative effect of not having the call light accessible for the residents was potential falls. During an interview on 01/07/2026 at 2:41 P.M., the Director of Nursing said the call lights should be accessible and working properly for the residents so if they need help, they could get help when needed and not have to struggle to get to the call light. She said any of the staff that go into the residents' rooms were responsible for ensuring the call lights were accessible to the residents. She said negative effect of the call light not being accessible was if the resident needed assistance right away and they did not have a call light right away it could worsen the condition for the resident. During an interview on 01/07/2026 at 3:10 P.M., the Administrator said the call lights should be accessible for the residents if the resident needs help. He said all staff were responsible for ensuring the call lights were accessible for the residents and in working condition. He said a negative effect of the call light not being accessible was that a resident could potentially be in danger if they were not able to call for help. No Call light Policy was given per request.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on interview and record review, the facility failed to ensure their activities program was directed by a qualified professional for 1 of 1 facility reviewed. The facility failed to employ a certified activities director who oversaw the activities program. This failure could place the residents at risk of not receiving a program of activities that meets their assessed activity needs. Findings included: Record review of a personnel file for the Activity Director did not indicate an Activity Director Certification, that the Activity Director had 2 year of experience in a social or recreational program. During an interview on 01/07/2026 at 09:20 AM., the AD said she had been in the position as AD for approximately two months. The AD said she was not certified or completed the required activity director classes. The AD said she had not done any activity assessments, and she had just learned this morning that she was responsible for completing them. The AD said she was not aware of the frequency for completing the activity assessments because she was still learning. The AD said it was important to complete the activity assessments to know the residents and update their likes or dislikes and to prevent them from declining. The AD said, Another lady from a sister facility was going to train her but she had just found out she had a stroke and that is why she had not shown up for training. During an interview on 01/07/2026 at 4:18 PM, the Certified Occupational Therapist Assistant said she was a certified activity director and had volunteered to call bingo only. The Certified Occupational Therapist Assistant said she knew nothing about the assessment requirements, documenting activities and never said she would do those things for the AD or the facility. During an interview on 01/07/2026 at 4:26 PM, the Administrator said he expected the activity assessments to be done quarterly. The Administrator said the AD was responsible for completing the activity assessments. The Administrator said it was important for the activity assessments to be completed to learn the residents likes/dislikes, their religious preferences, and personalize information for them. The Administrator said it was important to have a qualified AD to ensure the residents did not have a decline in their quality of life. The Administrator said he was aware the Activity Director was hired without a certification. Record review of the facility's policy titled, Activity Programming dated 2011, indicated, The Activity Director determines the need for individual programming through the resident assessment process. Individual programs are coordinated by the Activity director and documented in the plan of care. Goals, type of interventions and response are documented and reflected in monthly or quarterly progress notes. The Activity Director and staff regularly (at least quarterly) assess the ability or the interest of the residents. The policy did not indicate the required qualifications for an Activity Director.

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure professional staff were licensed, certified or registered in accordance with applicable state laws for 1 (LVN A) of 4 licensed nursing staff reviewed for staff qualifications.The facility failed to ensure LVN A's license was valid in order to practice as a licensed vocational nurse from [DATE] through [DATE].This failure could place residents at risk of receiving nursing services by an unlicensed nurse.The findings included:Record review of LVN A's employee file revealed the facility verified her unencumbered (no restrictions) license with Nursys Quickconfirm (National database to verify nursing licensures) on [DATE] prior to her hire date of [DATE]. LVN A's employee file included a Job Description for Charge Nurse signed by LVN A on [DATE] acknowledging she had read the qualifications and requirements of the position of Charge Nurse which included being a RN or LVN in good standing. LVN A's employee file also included a handwritten letter from LVN A indicating she was turning in her notice on [DATE] and her last day performing as a charge nurse would be [DATE], but she was open to other positions within the facility.Record review of the website https://txbn.boardsofnursing.org/licenselookup accessed on [DATE], indicated LVN A was listed by the BON as having an expired license as of [DATE]. The verification report included a document with the title of Before the Texas Board of Nursing . in the matter of LVN A . Agreed Order . Terms of Order . it is therefore agreed and ordered that Vocational Nurse License Number . previously issued to LVN A, to practice nursing in the State of Texas is/are herby SUSPENDED and said suspension is ENFORCED until . Respondent's Certification . by my signature on this Order, I agree to the entry of this Order and all conditions of said Order . signed by LVN A on [DATE] . effective this 15th day of [DATE] . signed by the Executive Director on behalf of the BON .Record review of the facility's time punch report obtained [DATE] for LVN A indicated she worked 12.38 hours on [DATE], 11.52 hours on [DATE], 13.62 hours on [DATE], and 12.62 hours on [DATE].Record review of the facility's daily staffing sheets obtained [DATE] indicated LVN A was the Charge Nurse on the 6 AM to 6 PM for Halls C & D on [DATE], [DATE], [DATE], and [DATE].Record review of the facility's daily census obtained on [DATE] indicated the census was 66 on [DATE] with 14 residents on Hall C and 25 residents on Hall D; the census was 66 on [DATE] with 14 residents on Hall C and 25 residents on Hall D; the census was 65 on [DATE] with 14 residents on Hall C and 24 residents on Hall D; and the census was 66 on [DATE] with 14 residents on Hall C and 26 residents on Hall D.Record review of the website https://txbn.boardsofnursing.org/licenselookup of the BON report accessed on [DATE] indicated LVN A's licensed had an Enforced Suspension effective [DATE].During an interview on [DATE] at 5:36 PM, the DON said LVN A was a floor nurse and LVN A came to her in the middle of [DATE] and said she would have to put in her notice but would be able to work until end of December. The DON said LVN A said her past had caught up with her and she would have to do some TPAPN with the BON. The DON said she sent LVN A's written notice to their HR department after she received it. The DON said the week of Christmas, their Corporate HR contacted her via email and said LVN A's license was not good and they immediately removed LVN A from the nursing schedule. The DON said she did not check LVN A's license when she turned in her notice. The DON said she did look at an email LVN A showed her with the BON representative and LVN A had asked if she could work until the end of the month of December and LVN A said the BON representative told her she could work out her two week notice to the end of December. The DON said she did not actually see in the email the BON said LVN A could work until the end of December.During an interview on [DATE] at 10:30 AM, LVN A said her understanding of the form she signed for the BON on [DATE] was just saying she would not go to court. LVN A said she asked in the email to the BON representative if she could give a two week notice to her job and get another check to pay her fees to the BON. LVN A said the BON representative responded to the email and said as long as the form was signed by [DATE]th that would be fine. LVN A said she took it as (continued on next page)

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the BON representative was saying she could work out her two week notice. LVN A said she did not realize her license was suspended effective [DATE] until the DON notified LVN A the week of Christmas and said HR had notified her that LVN A's license had expired [DATE]. LVN A said she was immediately told by the DON she could not work as a nurse or provide any type of patient care. LVN A said she knew she could not work as a nurse once her license was suspended, but she must have misinterpreted the email from the BON representative, because she thought she had approval to work out a two week notice to her job.During an interview on [DATE] beginning at 2:51 PM, the ADM said his understanding was LVN A had come to the DON and explained that her license was going to be suspended at the end of the year, and she turned in her notice. The ADM said then their Corporate HR person emailed them the week of Christmas and informed them LVN A's license expired on [DATE], so they immediately removed her from the schedule. The ADM said he would have expected LVN A to have communicated to them the status of her license. The ADM said the risk of LVN A working with a suspended license included she could get in trouble, it could create potential trouble for the facility, and it could create a potential safety issue for the residents; it was all about the safety of the residents. The ADM said they did not have a policy related to qualified staff and used the job descriptions as requirements for the position.Record review of the facility's Job Description for Charge Nurse dated from the Human Resources Manual 2014, provided by the ADM on [DATE], indicated . The following was a non-exhaustive criteria that relates to the job of a Charge Nurse . These were legitimate measures of the qualifications for a Charge Nurse and were related to the functions that were essential to the job of a Charge Nurse . Knowledge Base . Registered Nurse or Licensed/Vocational Nurse in good standing .

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to promptly resolve grievances for 1 of 6 residents (Resident #12) reviewed for grievances. The facility failed to ensure a grievance was filed when Resident #12 reported to the DON his roommate was loud, and he could not sleep. This failure could place residents at risk for grievances not being addressed or resolved promptly resulting in frustration and sleep deprivation.Findings include: Record review of a face sheet dated 01/08/2026 revealed Resident #12 was [AGE] year-old male admitted on [DATE] with diagnoses including multiple sclerosis (chronic autoimmune disease where the immune system attacks the brain, spinal cord and optic nerves), hypertension (high blood pressure), and chronic pain. Record review of the quarterly MDS dated [DATE] revealed Resident #12 was understood by others and able to understand others. The MDS revealed Resident #12 had a BIMS of 15 which indicated cognitively intact. The MDS revealed Resident #12 required extensive assistance for bed mobility, dressing, toilet use, personal hygiene, transfer and bathing. Record review of Resident #12's care plan with revised date of 12/06/2025 indicated a chronic condition of multiple sclerosis with the following interventions: Discuss with resident/resident and family any concerns, fears, issues regarding diagnosis or treatments, encourage frequent rest periods to help conserve energy. During an interview on 01/05/2026 at 09:25 AM, Resident #12 stated he had spoken with the DON during the Christmas holidays regarding wanting a new roommate because his current roommate hollered out, moaned, and groaned throughout most of the day and night. Resident #12 stated he did not get any rest, and it was becoming very frustrating for him. Resident #12 stated the DON had not followed back up with him to date regarding this matter. During an observation on 01/05/2026 at 01:40 PM revealed while in Resident #12's room, Resident #12's roommate was heard hollering out and talking randomly. During an observation on 01/05/2026 at 02:45 PM revealed while in Resident #12's room, Resident #12's roommate was moaning loudly consistently and reached into the air while lying in bed. During an observation and interview on 01/05/2026 at 03:40 PM, revealed Resident #12 had his television very loud and stated he was trying to drown out the noise from his roommate. Resident #12 inquired about an update and stated he had spoken with the DON again today around lunch time regarding a change in roommate because he had grown more frustrated from lack of rest. During an interview on 01/05/2026 at 04:45 PM, Resident #12 stated he had not heard of any plan or resolution from the DON regarding a change in roommate. Record review of the grievance log dated 12/01/2025 - 01/05/2026 did not indicate any grievances filed by Resident #12. During an interview on 01/05/2026 at 5:01 PM, the DON stated she was aware of Resident #12's grievance of wanting a new roommate and him not being able to rest because of the constant moaning and groaning from his current roommate. The DON said Resident #12 had told her this morning, I am stuck in the mud! The DON explained that Resident #12 felt trapped with the situation of not being able to get another roommate. The DON said Resident #12 wanted a new roommate and she had been working on the matter. The DON stated she first learned of the complaint from Resident #12 during the holidays, probably a couple of weeks ago when she was working on the floor. The DON stated she thought she had made notes and provided them to the Social Worker for follow-up but was not able to locate the documentation. The DON said the Social Worker may have the notes regarding the grievance, but the Social Worker was off work the next few days. The DON said she needed to find a room for Resident #12 and would start working on a resolution with the Administrator at this time. The DON said it was important to log the grievances at the time of occurrence to ensure the timely response and follow up be appropriate to prevent any adverse effects to the residents such as lack of rest and increased frustrations. During an interview on 01/07/2026 at 04:00 PM, the Administrator stated that all grievances should be logged whether they were communicated verbally or written and followed up on timely to ensure an amicable (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resolution to provide the best possible outcome for the residents. The Administrator stated it was important for each resident to be able to rest in their own home. The Administrator said when a resident filed a grievance a resolution was developed and completed within 2-3 days at the very longest. He said if a resolution could not be completed in that time frame of 2-3 days a written update was provided. The Administrator said grievances should be addressed in a timely manner, so the residents delt like they were being heard. He said grievances not being addressed timely could cause residents to have unresolved complaints. The Administration said he was not aware of Resident #12's grievance until now. Record review of a facility Grievance Policy dated 11/02/2016 indicated .The resident had the right to, and the facility must make prompt efforts by the facility to resolve grievances that resident may have.Maintain evidence demonstrating the results of all grievances for a period of no less than 3 years from the issuance of the grievance decision.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene were provided for 2 of 6 residents reviewed for ADLs (Resident #2 and Resident 30). The facility did not provide scheduled showers for Resident #2 on 01/05/2026. The facility failed to provide assistance for Resident # 30 with the removal of facial hair on 01/05/2026. These failures could place residents at risk of not receiving services/care and decreased quality of life.Findings Include: 1. Record review of a face sheet dated 01/08/2026 indicated Resident # 2 was a [AGE] year-old male initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included atherosclerotic heart disease (plaque buildup inside the arteries), malignant neoplasm of prostate (cancer tumor in the prostate gland) , cardiomegaly (enlarged hear), hypertension (high blood pressure), and back pain. Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #2 was understood and understood others. The MDS assessment indicated Resident #2 had a BIMS score of 11 which indicated moderate cognitive impairment. The MDS assessment indicated Resident #2 required supervision and partial assistance for all ADLs. Record review of the care plan with target date 02/17/2026 indicated Resident #2 had an activity of daily living (ADL) self-care performance deficit related to generalized weakness. The care plan indicated interventions included Resident #2 required limited assistance x1 staff for showering. During an interview and observation on 01/05/2026 at 08:30 AM, Resident #2 said he was waiting for the aide because it was his shower day. Resident #2 had a shower bag ready with his bath products inside. During an interview on 01/06/2026 at 08:15 AM, Resident #2 said he did not get a shower on yesterday's date. Resident #2 said the aide never came back to get him. Resident #2 was upset and stated it was important to get assistance with the shower when scheduled to decrease the chances of infection. Resident #2 said he had reminded the aide about the shower throughout the day yesterday, but no one appeared to have time. Record review of Resident #2's electronic health record indicated a completed bath was performed by Student Nursing Aide B on 01/05/2026. During an interview on 01/06/2026 at 08:30 AM, Student Nursing Aide B said she had been employed by the facility for a couple of weeks. Student Nursing Aide B said she was responsible for giving the residents their showers. Student Nursing Aide B said there was a shower schedule posted at the nurse's station to let the CNAs know who needed a shower on what day and shift. Student Nursing Aide B said it was important for residents to receive their showers so staff could observe their skin and to maintain the residents' cleanliness. Student Nursing Aide B said Resident #2 should have received a bath yesterday by the shower aide but the shower aide was pulled to work on another hall. Student Nursing Aide B said she had documented that she gave Resident #2 his shower on yesterday's date, but she must have made a mistake. Student Nursing Aide B said that she was assigned to Resident #2 but had failed to complete the shower as scheduled. Student Nursing Aide B said she would need to be re-educated to only document what task she had completed herself. 2. Record review of a face sheet dated 01/08/2026 indicated Resident #30 was a [AGE] year-old male initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included Alzheimer's disease (decline in memory, thinking, reasoning and eventually hindering daily activities), chronic atrial fibrillation (irregular heartbeat) , subdural hemorrhage (brain bleed, hypertension (high blood pressure), and repeated falls. Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #30 was understood and usually understood others. The MDS assessment indicated Resident #30 had a BIMS score of 05 which indicated severe cognitive impairment. The MDS assessment indicated Resident #30 required substantial and partial assistance for all ADLs. Record review of the care plan with target date 03/31/2026 indicated Resident #30 had an activity of daily living (ADL) self-care performance deficit related to limited range of motion of bilateral upper (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675386	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	extremities. The care plan indicated interventions included Resident #2 required assistance with personal hygiene: hair, shaving and oral care. During an interview on 01/05/2026 at 01:45PM, Resident #30's family member said she had shaved Resident #30 on today's date. Resident #30's family member said she came to the facility on Resident #30's shower days and shaved him. Resident #30's family member said if she did not come to the facility to shave Resident #30, he would not get shaved and have hair stubble. Resident #30's family member said she would like for the facility to shave Resident #30 per the care plan. Resident #30's family member said Resident #30 would never want to have facial hair and appear unkept. During an interview on 01/06/2026 at 02:37 PM, CNA C said she gave Resident #30 a shower or on 01/05/2026. CNA C said she did not shave Resident #30 because she thought his family wanted to shave him. CNA C said Resident #30's family member always shaved him upon her arrival. CNA C said she had just assumed the family wanted to do the shaving and she had not inquired about it. CNA C said it was important to follow the plan of care to prevent infections and allow dignity with being appropriately dressed and groomed. During an interview on 01/07/2026 at 04:15PM, the DON said it was the CNAs responsibility to give the residents their showers and provide personal hygiene. The DON said there was a shower list that identified what resident received a shower on which day and shift. The DON said the CNAs performed showers on the residents, but any of the nursing staff could and should perform showers when needed. The DON said she expected the CNAs to communicate with the charge nurses daily to ensure resident's needs were being met. The DON said if a resident refused she expected staff to try again a couple times or send a different staff member to ask the resident. The DON said if a resident continued to refuse she expected staff to report the refusal to the family and document the refusal. The DON said she was responsible to ensure the oversight of resident ?s being bathed and showered appropriately according to the resident's Plan of Care. The DON said the importance of the residents receiving their scheduled showers was to maintain dignity, hygiene, skin integrity, skin inspections and prevent skin infections. The DON said ultimately it was her responsibility to ensure the showers and personal hygiene were performed for the residents by the staff. The DON said a new system was implemented on yesterday's date to ensure no showers and hygiene were missed. During an interview 01/07/2026 at 4:39 PM, the Administrator said he expected baths/showers as scheduled or as requested by the resident. The Administrator said clinical staff were responsible for making sure the baths/showers were provided for the residents. The Administrator said if the residents refused ADL care, the staff should educated the residents. The Administrator said if a resident refused, he expected staff to try again a couple times or send a different staff member to ask the resident. The DON said if a resident continued to refuse, he expected staff to report the refusal to the family and document the refusal. The Administrator said it was important for the residents to receive baths/showers for hygiene according to the resident's plan of care to make the residents feel good, infection control and dignity. Record review of undated facility policy and procedure titled, Bath, Shower/Tub, Bathing by tub bath or shower is done to remove soil .Procedure.1. The resident will receive assistance with bathing according to their resident centered plan of care.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 2 of 6 residents (Resident #2 and Resident #7) reviewed for activities. The facility failed to ensure quarterly activity assessments were completed for Resident #2. The facility failed to provide consistent and scheduled in-room activities for Resident #7 to meet her needs. These failures 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.Findings included: 1. Record review of a face sheet dated 01/08/2026 indicated Resident #2 was a [AGE] year-old male initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included atherosclerotic heart disease (plaque buildup inside the arteries), malignant neoplasm of prostate (cancer tumor in the prostate gland) , cardiomegaly (enlarged hear), hypertension (high blood pressure), and back pain. Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #2 was understood and understood others. The MDS assessment indicated Resident #2 had a BIMS score of 11 which indicated moderate cognitive impairment. Record review of the care plan with target date 02/17/2026 indicated Resident #2 needs out of room social, spiritual, and stimulus activities and mental stimulation with the following interventions: resident will attend activities of his/her choice, will watch TV, read and socialize with other residents at least 2 times weekly by next update, the activity director will encourage and remind the resident of current activities, the activity director will provide the resident reading material for mental stimulation, the activity director will praise the resident for attending activities of their choice. Record review of Resident #2's electronic health record indicated his last activity assessment was completed on 08/18/2025. During an interview on 01/07/2025 at 11:00 AM, Resident #2 stated he did not get out of his room for facility related activities. Resident #2 stated he enjoyed conversations in his room discussing the Bible. 2. Record review of a face sheet dated 01/08/2026 indicated Resident #7 was a [AGE] year-old female initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included Alzheimer's disease (loss of memory and cognitive abilities), severe protein-calorie malnutrition, osteomyelitis (infection of the bone). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #7 was usually understood and usually understood others. The MDS assessment indicated Resident #7 had a BIMS score of 0, which indicated Resident #7 was severely cognitively impaired. Record review of Resident #7's care plan with a target date of 01/29/2026, indicated Resident #7 needed in room socialization and sensory stimulation with the following interventions: Resident will respond to one on one in room visits with sensory stimulation such as tactile, and visual in room activities, the Activity Director will provide the resident with one on one visits with sensory stimulation at least 3 times per week. During an observation on 01/06/2026 at 08:30 AM, revealed Resident #7 was lying in bed resting. During an observation on 01/06/2026 at 02:10 PM, revealed Resident #7 was lying in bed resting. During an observation on 01/06/2026 at 05:45 PM, revealed Resident #7 was laying bed resting. During an interview on 01/07/2026 at 08:10 AM the AD said she provided 1 on 1 activities to residents who were bedridden. The AD said some residents did better in small groups, and the more outgoing residents did better in larger groups. The AD said she had not documented in the computer charting system or on a log when a resident attended activities or refused to participate. The AD said she was not aware that she was supposed to be documenting who attended activities or when she did a 1:1 activity. The AD stated she was not certified as an AD at this time and was awaiting to take the class. During an interview on 01/07/2026 at 09:20 AM the AD said she had been in the position as AD for approximately two months. The AD said she had not done any activity assessments, and she had just learned this morning that she was responsible for completing them. The AD said she was not aware of the frequency for completing the activity (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessments because she was still learning. The AD said it was important to complete the activity assessments to know the residents and update their likes or dislikes and to prevent them from declining. The AD said, Another lady from a sister facility was going to train her but she had just found out she had a stroke and that is why she had not shown up for training. During an interview on 01/07/2026 at 4:18 PM, the Certified Occupational Therapist Assistant said she was a certified activity director and had volunteered to call bingo only. The Certified Occupational Therapist Assistant said she knew nothing about the assessment requirements, documenting activities and never said she would do those things for the AD or the facility. Record review of the Certified Occupational Therapist Assistant's employee file indicated she had a Certificate of Completion for Nursing Home Activity Director dated November 28, 1994. During an interview on 01/07/2026 at 4:26 PM, the Administrator said he expected the activity assessments to be done quarterly. The Administrator said the AD was responsible for completing the activity assessments. The Administrator said it was important for the activity assessments to be completed to learn the residents likes/dislikes, their religious preferences, and personalize information for them. Record review of the facility's policy titled, Activity Programming dated 2011, indicated, The Activity Director determines the need for individual programming through the resident assessment process. Individual programs are coordinated by the Activity director and documented in the plan of care. Goals, type of interventions and response are documented and reflected in monthly or quarterly progress notes. The Activity Director and staff regularly (at least quarterly) assess the ability or the interest of the residents.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to store all drugs and biologicals in locked compartments for 1 of 4 medication carts reviewed. (Nurse medication cart for the B Hall) LVN D failed to securely lock the nurse medication cart for the B Hall. This failure could place residents at risk of not having their medications available as prescribed or possible drug diversions.Findings included: During an observation on 1/06/26 at 7:56 A.M. revealed the nurse medication cart sitting across the hall from room [ROOM NUMBER] was unlocked. The door was open to room [ROOM NUMBER] and the resident was in the room lying in bed. There was a resident standing at the nurse medication cart leaning on her walker. There were no staff present at the medication cart. The top drawer contained a tray of eye drops, lancets, alcohol pads, 3 insulin pens and a glucometer. The second drawer contained liquid G-tube medications, 34 cards of various medications (including Metoprolol, Metformin, Lisinopril, Keppra, Digoxin), Geri-Lanta, MiraLAX, Tums, Ready Care, 1 bottle of Liquid Protein and 1 bottle of Lactulose. Drawer 3 contained topical medications. Drawer 4 contained oxygen tubing and a supply of plastic cups. During an interview on 1/06/26 at 7:58 A.M. LVN D said the nurse cart was supposed to be in her possession, and the cart was supposed to be locked. She said she was called away by an aide. She said she normally kept the cart locked at all times. During an interview on 1/06/26 at 1:48 P.M. LVN D said she normally had the nursing cart locked when she walked away from it, but the aide caught her off guard by asking her to help her with a resident. The negative effect of leaving a medication cart unlocked was anyone can get into it. She stated she was not normally careless like that. During an interview on 1/07/26 at 10:45 A.M. RN J said when staff walked away from their cart it was always supposed to be locked. She said a negative effect of not locking a medication cart was someone could steal things off the cart and patient information could be exposed. During an interview on 1/07/26 at 1:30 P.M. the ADON said the person who opened the medication cart was responsible for ensuring the cart was locked when they stepped away from the cart. She said a negative effect of an unlocked nursing medication cart was that a resident could potentially get into the cart. During an interview on 1/07/26 at 2:41 P.M. the Director of Nursing said whoever was in charge of the medication cart was responsible for ensuring the medication cart was locked. She said a negative effect of an unlocked medication cart was residents could get in the cart and take something that does not belong to them, and they could be allergic to the item. During an interview on 1/07/26 at 3:10 P.M. the Administrator said he heard about the incident with the nurse leaving the medication cart unlocked. He said the nurses or medication aides were responsible for ensuring the medication carts were locked. He said the negative effect of unlocked medication carts had potential for a resident to pull out something that did not need to be pulled out of the cart. Review of an undated facility Medication Storage in the facility policy indicated, Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.2. Only licensed nurses, the Consultant Pharmacist, and those lawfully authorized to administer medications (e.g. medication aides) are allowed unsupervised access to medications. Medication rooms, carts, and medication supplies are locked or attended to by persons with authorized access.

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	675386	A. Building B. Wing	01/07/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 22 residents (Resident #22), reviewed for infection control practices.1. The facility failed to ensure SNA B and CNA C wore a gown while providing direct care to Resident #22, who was on EBP (infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities), while performing a mechanical lift transfer and incontinent care on 1/05/2026.2. The facility failed to ensure LVN D wore a gown and gloves while providing direct care to Resident #22's feeding tube (medical tube delivering liquid nutrition) and PEG tube (soft tube inserted through the skin and abdominal wall directly into the stomach) on 1/05/2026.These failures could place residents at risk for cross contamination, at an increased risk of infection, and the spread of infection. Findings included:Record review of Resident #22's face sheet dated 1/05/26 indicated he was [AGE] years old and was admitted to the facility on [DATE]. Resident #22 had diagnoses which included Alzheimer's disease (a progressive brain disorder causing irreversible decline in memory, thinking, and reasoning, interfering with daily life) and gastrostomy (also called PEG tube).Record review of Resident #22's quarterly MDS assessment dated [DATE] indicated he was rarely/never understood and was unable to complete the BIMS interview, which indicated he had severe cognitive impairment. Resident #22 was dependent on staff for most ADLs. Resident #22 was always incontinent of bowel and bladder. Resident #22 had a feeding tube/PEG tube.Record review of Resident #22's Care Plan indicated he was on enhanced barrier precautions with interventions of gloves and gown should be donned (put on) if any of the following activities were to occur . transfer . toileting/incontinent care . enteral feeding care . or other high-contact activity. Resident #22 had an ADL self-care performance deficit and was totally dependent on staff for toileting and he required a lift for all transfers. Resident #22 required tube feeding related advanced Alzheimer's and anorexia (not eating).Record review of Resident #22's Order Summary Report dated 1/05/2026 indicated an order for Enhanced Barrier Precautions related to PEG tube with an order date of 1/04/2026. There was also an order for Enteral (delivered directly into the stomach) Feed Order to check placement prior to feeding and medication administration with a start date of 5/13/2025.During an observation on 1/05/2026 beginning at 2:30 PM, LVN D entered Resident #22's room and put on gloves and then reached under the resident's shirt and disconnected the feeding tube from his PEG tube on his stomach. LVN D did not wear a gown as part of EBP. After the PEG tube was disconnected, CNA C and SNA B performed a mechanical lift transfer from the chair to the bed. SNA B leaned against Resident #22's bed, allowing the front of her clothing to come in contact with Resident #22's bedding and grabbed items from the bed and placed them on the bedside table. CNA C then moved Resident #22 to his bed and lowered to bed. CNA C then leaned over Resident #22 and his bed and pulled a blanket from under the resident on the opposite side away from her, allowing her clothing to come in contact with Resident #22 and his bed/bedding. SNA B leaned over bed and Resident #22 to unhook the straps from the mechanical lift, allowing her clothing to come in contact with Resident #22 and his bed/bedding. CNA C then began incontinent care, assisted by SNA B, and neither staff wore gowns as part of EBP while providing incontinent care. CNA C pushed Resident #22's brief down in between his legs, then used wipes to clean his front private area and CNA C was leaning against his bed. CNA C changed gloves, then both staff rolled Resident #22 away from them toward the wall and held him over on his side, removed his brief, then CNA C cleaned his back private area. CNA C changed her gloves, placed a new brief and pushed it and the lift pad under Resident #22, then pulled Resident #22 toward them as CNA C leaned over Resident #22 and pulled the lift pad out from under Resident #22 and pulled the new brief out from opposite side of the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident, allowing their clothing to touch the Resident #22 and his bed/bedding. CNA C then applied Resident #22's heel protectors. SNA B reached over Resident #22's head and grabbed his shoulders and pulled him over in bed and placed a neck pillow around his neck and pillows beside his head, then CNA C and SNA B pulled Resident #22 up in bed and repositioned. CNA C and SNA B did not wear a gown at any time while performing a mechanical lift transfer, incontinent care, or positioning Resident #22 as part of EBP. There was a red sign on the wall and a PPE cart outside of Resident #22's room by his door which indicated Resident #22 was on EBP and staff were required to wear a gown and gloves while providing direct resident care.During an interview on 1/05/2026 at 3:15 PM, Resident #22's RP said she came to the facility every day and watched the camera when she was not there. Resident #22's RP said the staff never wore a gown when providing care for Resident #22 and only wore gloves.During an observation on 1/05/2026 at 3:22 PM, LVN D entered Resident #22's room and lifted Resident #22's shirt and reconnected his feeding tube to his PEG tube. LVN D did not wear a gown or gloves while providing direct care.During an interview on 1/06/2026 at 4:36 PM, SNA B said she had worked at the facility since 9/2025. SNA B said she had been a SNA since 10/13/2025. SNA B said EBP meant the resident was fighting some kind of bacteria. SNA said a resident on EBP was any resident with a red sign on their door. SNA B said if the resident had a red sign that said they were on EBP, then staff should wear gloves, gown, mask, and a face shield, so not to transfer any infections back and forth from staff or other residents. SNA B said if the resident was on EBP, staff should wear the required gloves, gown, mask, and a face shield, anytime when entering the resident's room. SNA B said she and CNA C were not wearing PPE except gloves during Resident #22's mechanical lift transfer, incontinent care, or positioning on 1/5/2026 because it just slipped her mind. SNA B said by not wearing the gown, she could transfer anything from her clothing to another resident or to Resident #22 and they could get sick. SNA B said it would be an infection control issue.During an interview on 1/06/2026 at 4:48 PM, CNA C said she had worked at the facility for about five years.CNA C said she only knew to wear gloves with residents who had feeding tubes and urinary catheters. CNA C said she had received training on infection control. CNA C said the signs on the doors normally said whether the resident was on droplet or contact isolation and the sign said what type of protective equipment was needed. CNA C said she did not know she needed to wear a gown or what EBP was. CNA C said she agreed it could be an infection control issue to not wear the appropriate PPE.During an interview on 1/06/2026 at 5:04 PM, RN E said she had worked at the facility for about seven days. RN E said EBPs was to protect the resident from infections, and focused on residents with wounds, PICC lines, feeding tubes, urinary catheters, and any implanted device. RN E said staff should be wearing gowns and gloves for direct contact with the resident on EBP. RN E said staff should be wearing a gown and gloves to reconnect a feeding tube to a PEG tube to protect both resident and staff. RN E said by not wearing a gown and gloves when providing direct resident care to a resident on EBP, placed the resident at a higher instance of getting an infection.During an interview on 1/06/2026 at 5:10 PM, LVN D said she had worked at the facility for almost two years as a charge nurse. LVN D said EBP was to protect the resident from staff transferring germs/disease to residents with PEG tubes, Foley catheters, PICC lines, and wounds. LVN D said gloves, gown, and mask should be worn when providing direct patient care to a resident on EBP. LVN D said direct care would include touching a resident in any way, putting medications in PEG tube, providing any care, and would require gown and gloves to be worn. LVN D said with EBP, staff should wear gown and gloves during incontinent care and mechanical lift transfers. LVN D said staff should wear a gown and gloves when reconnecting a feeding tube to a PEG tube. LVN D said she was not wearing a gown but thought she was wearing gloves when she reconnected Resident #22's feeding tube to his PEG tube, because she usually did. LVN D said Resident #22 was on EBP. LVN D said by not wearing a gown and gloves while providing direct care, it could cause contamination and cause the resident an infection. During an interview on 1/06/2026 at 5:24 PM, RN F said the purpose of EBP was to prevent the spread of infection to residents with wounds, implanted devices, urinary (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	catheters and to prevent staff from passing infections from a resident to other residents potentially. RN F said staff should wear gloves and a gown during direct resident care to residents on EBP. RN F said staff should wear a gown during mechanical lift transfers and incontinent care. RN F said a gown and gloves should have been worn during reconnection of a feeding tube to a PEG tube. RN F said the feeding tube/PEG tube would have been the reason the resident was on EBP. RN F said by staff not wearing the appropriate PPE with a resident on EBP, placed the resident at risk for infection. During an interview on 1/06/2026 at 5:36 PM, the DON said EBP was to prevent the spread infection especially with residents with catheters, PEG tubes, feeding tubes, IVs (intravenous- inserted into a vein), and wounds. The DON said staff should wear the appropriate gear when providing direct care to the resident to help prevent the spread of infection. The DON said staff should wear gown and gloves during mechanical lift transfers and incontinent care. The DON said staff should definitely wear a gown and gloves when reconnecting a feeding tube to a PEG tube. The DON said not wearing appropriate gear during direct care placed the resident at risk of infection. During an interview on 1/07/2026 at 2:51 PM, the ADM said he expected staff to follow the facility's policies for the safety of the residents and staff. The ADM said EBP was to ensure staff did not carry anything to the residents and vice versa. The ADM said he would absolutely expect staff to wear gown and gloves during direct care such as incontinent care, mechanical lifts and re-connecting a feeding tube to a PEG tube. The ADM said the resident could get something that makes them sick if staff were not wearing the appropriate PPE. Record review of the facility's undated policy titled Fundamentals of Infection Control Precautions received 1/07/2026 indicated . a variety of infection control measures were used for decreasing the risk of transmission of microorganisms in the facility . gloves were worn for three important reasons . 1. To provide protective barrier and prevent gross contamination of the hands when touching blood, body fluids, secretions, excretions, mucous membranes, and nonintact skin . 2. To reduce the likelihood that microorganisms present on the hands of personnel will be transmitted to residents during invasive or other resident-care procedures that involve touching a resident's mucous membranes and nonintact skin. 3. To reduce likelihood that hands of personnel contaminated with microorganisms from a resident or a fomite can transmit these organisms to another resident . 5. Gowns and protective apparel . 1. Gowns and protective apparel are worn to provide barrier protection and reduce the opportunity for transmission of microorganisms in the LTCF (Longterm Care Facility) Gowns are worn to prevent contamination of clothing and to protect the skin of personnel from blood and body fluid exposures . 2. Gowns are also worn by personnel during the care of patients infected with epidemiologically important microorganisms to reduce the opportunity for transmission of pathogens from residents or items in their environment to other residents or environments .Record review of the facility's policy titled Enhanced Barrier Precautions dated 4/01/2024 indicated . Multidrug-resistant organism (MDRO) transmission is common in long-term care (LTC) facilities. Many residents in nursing homes are at increased risk of becoming colonized and developing infections with MDROs . Enhanced Barrier Precautions (EBP) refer to infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities . EBP are used in conjunction with standard precautions and expand the use of PPE (personnel protective equipment) to donning (putting on) of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing . EBP are indicated for residents with any of the following: colonization with CDC (Centers of Disease Control and Prevention) targeted MDRO when Contact Precautions do not otherwise apply or wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO . Indwelling medical device examples include central lines, urinary catheters, feeding tubes . Donning PPE for residents on EBP based on activity provided/assistance while in resident room . gown and gloves . for transfer a resident, changing briefs or assisting with toileting, turn and reposition or assist with bed mobility . device care or use: central line, urinary catheter, feeding tube .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675386	A. Building B. Wing	01/07/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside, for 1 of 6 residents (Resident #12) reviewed for call lights.The facility failed to ensure Resident #12's call light was functioning properly. This failure could place residents at risk of possible falls, major injuries, hospitalization, and unmet needs. Findings include: 1.Record review of a face sheet dated 01/08/2026 revealed Resident #12 was [AGE] year-old male admitted on [DATE] with diagnoses including multiple sclerosis (chronic autoimmune disease where the immune system attacks the brain, spinal cord and optic nerves), hypertension (high blood pressure), and chronic pain. Record review of the quarterly MDS dated [DATE] revealed Resident #12 was understood by others and able to understand others. The MDS revealed Resident #12 had a BIMS of 15 which indicated cognitively intact. The MDS revealed Resident #12 required extensive assistance for bed mobility, dressing, toilet use, personal hygiene, transfer and bathing. Record review of Resident #12's care plan with revised date of 12/06/2025 indicated a chronic condition of multiple sclerosis with the following interventions: Discuss with resident/resident and family any concerns, fears, issues regarding diagnosis or treatments, encourage frequent rest periods to help conserve energy. During an observation and interview on 01/06/2025 at 08:45 AM, Resident #12 said he was waiting for the aide to assist him. He said he had pressed the call light button approximately 15 minutes ago but no one had come to answer the light. The Surveyor asked Resident #12 to press the call light button again. The Surveyor observed the light for the call button did not come on in the hallway area when Resident #12 pushed the call button. Student Nursing Aide B was notified and came into Resident #12's room and attempted turn on the call light without success. She stated that she was not aware the call light was not working. Student Nursing Aide B said she thought the call light was checked when the resident was relocated into the room the night before. Student Nursing Aide B said she was not aware the call light was not working. Student Nursing Aide B said it was important for the call light system to work properly to prevent potential injuries and to be notified of the residents' wants and needs. Student Nursing Aide B said she would notify the charge nurse and maintenance for repairs. During an interview on 01/07/2026 at 2:41 P.M., the Director of Nursing said the call lights should be accessible and working properly for the residents so if they need help, they could get help when needed and not have to struggle to get to the call light. She said any of the staff that go into the residents' rooms were responsible for ensuring the call lights were accessible to and properly working for the residents. She said negative effect of the call light not being accessible or functioning was if the resident needed assistance right away and they did not have a call light right away it could worsen the condition for the resident. During an interview on 01/07/2026 at 3:10 P.M., the Administrator said the call lights should be accessible and fully functioning for the residents if the resident needs help. He said all staff were responsible for ensuring the call lights were accessible to the residents and in working condition. He said a negative effect of the call light not being accessible and functioning were that a resident could potentially be in danger if they were not able to call for help. During an interview on 01/07/2024 at 04:30 PM., the Administrator said there was no policy to address the call light system.