STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675527	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whisperwood Nursing & Rehabilitation Center	5502 W 4th St Lubbock, TX 79416

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on interviews and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse and neglect for 2 of 10 residents (Resident #1, and #2) reviewed for abuse. The ADM (Abuse Preventionist) and the DON failed to follow the facility's abuse policy by not reporting the allegation of abuse to HHSC regarding the Resident-to-Resident inappropriate sexual activity between residents (Resident #1 kissed Resident #2) that occurred on an unknown date. The ADM (Abuse Preventionist) and the DON failed to follow the facility's abuse policy by not notifying the family representative regarding the Resident-to-Resident inappropriate sexual activity between residents (Resident #1 kissed Resident #2) that occurred on an unknown date. The ADM (Abuse Preventionist) and the DON failed to follow the facility's abuse policy by not conducting a thorough investigation and documenting regarding the Resident-to-Resident inappropriate sexual activity between residents (Resident #1 kissed Resident #2) that occurred on an unknown date. These failures could place residents as risk for abuse and neglect. Findings included: Record review of Resident #1's face sheet, dated 03/19/25, revealed an [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include dementia (memory loss), major depressive disorder, and anxiety. Record review of Resident #1's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 08, which indicated the resident's cognition was moderately impaired. Section B Hearing, Speech and Vision revealed that Resident #1 had clear speech, had the ability to make himself understood and had the ability to understand others. Record review of Resident #5's care plan, dated 10/01/24, revealed the following: Focus (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675527	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Sexually inappropriate AEB: was witnessed kissing a female resident on the lips in the dining room initiated 1/21/25. Goal Resident will have no episodes of sexually inappropriate behavior in the next 90 days initiated 1/21/25. Interventions Evaluate the resident ability to understand behavior and the consequences of that behavior initiated 1/21/25. Explain to the resident the acceptable expressions of sexuality based on the cognitive evaluation initiated 1/21/25. Listen/talk to the resident-see if they will tell you why they do the behavior initiated 1/21/25. Psychiatric Services consult as needed initiated 1/21/25. Reinforce with staff that clear, firm limits are healthy and required when resident makes inappropriate gestures or statements initiated 1/21/25. Report incidents of inappropriate sexual behavior to charge nurse and if other resident are involved, immediately intervene to protect the safety of all residents involved initiated 01/21/25 Record review of Resident #1's progress notes dated 01/18/25-01/19/25 revealed: There was no progress note related to Resident #1 kissing Resident #2. An interview was not conducted with Resident #1 because he was not actively in the facility on 03/19/25. Record review of Resident #2's face sheet, dated 03/19/25, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include dementia (memory loss), and chronic hepatitis C. Record review of Resident #2's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 03, which indicated the resident's cognition was severely impaired. Section B Hearing, Speech and Vision revealed that Resident #2 had clear speech, usually made herself understood and usually had the ability to understand others. Record review of Resident #5's care plan, dated 02/10/25, revealed the following: Focus (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cognitive Function: Resident #2 has impaired cognitive function/dementia or impaired thought processes Dementia, impaired decision making initiated 2/13/23. Goal The resident will maintain current level of cognitive function initiated 02/13/23. Interventions/Task Discuss concerns about confusion, disease process, nursing home placement with the resident/family and care givers initiated 02/13/23. Record review of Resident #2's care plan, 2/10/25, did not address a desire to be in a relationship or incidents of inappropriate sexual behavior. Record review of Resident #2's progress notes dated 01/18/25-01/19/25 revealed there was no progress note related to Resident #2 being kissed by Resident #1. During an interview on 03/19/25 at 2:09 PM, Resident #2 stated she had a boyfriend. She said she did not know his name but that he was at the facility on 03/19/25. She said she did not remember if she kissed anyone. After asking why she was being questioned, she said she could kiss if she wanted to and felt safe in the facility. During an interview on 03/19/25 at 11:59 AM, the DON said that the Activity Director reported to her a few days after the incident (Resident #1 and Resident #2 kissed) occurred. She was unable to report the date the incident occurred. She stated it was reported to her that it was a peck on the lips. She said she was told that the residents were separated. She said Resident #2 had a BIMS of 3. The DON said she was unsure if anything else was done regarding the incident. She said the only person she spoke with was the Activity Director about the incident, and she would have more information. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/19/25 at 12:02 PM, the Activity Director stated that approximately 2 months ago, Resident #1 and Resident #2 kissed. The Activity Director stated that Resident #1 resided in the male-locked unit, and he would come out and assist her with activities. She stated that Resident #1 would shake hands and hug other residents, and Resident #1 was friendly. She said that because he was out of the male-locked unit, he was with her and helped her gather supplies, gather residents, and deliver items. The Activity Director stated they were near the nurse's station when he kissed Resident #2. Before she knew it, she observed Resident #1 and Resident #2 pecking each other on the lips. The Activity Director stated she separated both residents and explained to Resident #1 that he could not do that because of illnesses he could be exposed to. She stated Resident #1 joked and said, They were both grown. The Activity Director stated she spoke with Resident #2, but she did not understand at that moment and did not recall the incident. The Activity Director stated she believed Resident #2 had dementia. The Activity Director stated she did not think any other staff observed the incident. The Activity Director stated she reported the incident to the ADM and DON the same day the incident occurred. She said it was discussed the next morning in the morning meeting but did not remember the details of the meeting. She said that neither of the residents had a history of inappropriate sexual behaviors. The Activity Director stated she did not document the incident in either of the resident's progress notes. She stated she did not have a reason for not documenting the incident. She stated moving forward, she had just reminded Resident #1 of the best way to greet people. She stated the incident did not happen again. She stated she did not pass the information about the incident to the male-locked unit staff. During an interview on 03/19/25 at 1:15 PM, Family Member E stated she was not notified by facility staff about Resident #1 kissing another resident, but that Resident #1 told her about it. She said he told her he was told not to do it anymore. She could not remember if the kiss was on the lips or cheeks. She referred to the incident by saying, It was just a kiss! The interview ended abruptly because she said she was out with her grandchildren and would call back. During an interview on 03/19/25 at 1:30 PM, the Assistant Activity Director stated she had no first-hand information about Resident #1 kissing Resident #2. She stated that she heard about it but was not given specific instructions related to Resident #1 regarding the matter. She said that Resident #1 had never displayed behavior like that before. She said neither resident had the cognitive ability to make decisions independently. An attempt to interview Family Member F was unsuccessful on 03/19/25 at 1:18 PM. During an interview on 03/19/25 from 12:13 PM to 2:22 PM with LVN A, LVN B, C, and D revealed that they had provided care for Resident #1. They were all unaware of Resident #1 kissing Resident #2. They had not been given specific instructions regarding Resident #1's inappropriate behavior. They had never witnessed him having inappropriate behavior. They all expressed that Residents #1 and #2 could not make decisions cognitively. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/19/25 at 2:34 PM, the ADM stated that HR had told her that Resident #1 had kissed Resident #2. The ADM stated Resident #1 greets everyone and the ladies at the facility and swoons over him. ADM stated that she once was told by Family Member E that while in the community, he (Resident #1) oversaw completing shopping for the ladies in his apartment complex. She said that after HR told her she went and spoke with the Activity Director, she (the Activity Director) told her (The ADM) both residents (Resident #1 and #2) greeted each other and pecked each other on the lips. She said The Activity Director pulled both Residents apart. The ADM stated it was unusual but not an issue. She said she (The ADM) did not see it as inappropriate. She said they discussed the incident in the morning meeting and lightly mentioned that they should plan it because it could be inappropriate. She said she assumed that was why the DON care planned it as inappropriate behavior. The ADM stated Resident #2 was not cognitively able to make her own decisions, and neither was Resident #1. She said she had spoken with Resident #2, and she did not remember. She said she did not talk with Resident #1. She said Resident #1 greets people in this manner. She showed the investigator that he would give a side hug, press his face to other residents, and made a kissing sound. She said he was not asking permission of the residents to greet them in that manner. The ADM stated she did not think there was anything to it. She said she did have a surveillance system, but where the incident occurred, it would not have been an unobstructed view for the cameras. She said she did not even think to look at the camera because she did not think Resident #1 meant to do it. The ADM stated she did not report it to Resident #1's family, and Resident #1 does not have family. The ADM stated Resident #2's family representative was her boyfriend, who did not answer phone calls. She stated when she spoke with Resident #2, she (Resident #2) was not upset. She said she was not sure if an incident like this would necessarily be reported to the family, depending on the resident. She said it was something that they needed to watch but did not consider it an issue because Resident #2 was not upset and could not remember. She said it was reported to her that Resident #2 was pecking him back. She said Resident #2 could let her feelings be known. She said HR was not in the facility today because she was out attending a funeral. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/19/25 at 3:04 PM, the DON stated she was familiar with the facility's abuse policy, specifically reporting to HHSC , notifying the family representative, and conducting a thorough investigation. She said the purpose of reporting to HHSC was so that HHSC could come and investigate. She said the purpose of notifying the family representative was because that was the policy. She said the purpose of conducting a thorough investigation and documenting it was to determine if they needed to substantiate, figure out what happened, and what could have been done to prevent it. She stated they usually get witness statements from all the people who were involved. She stated they typically would try to interview the staff and residents as soon as it happens so that the information was fresh on their minds. She said the longer they wait, the more the residents could forget. She said the PNO of not following the facility's abuse policy was that the facility would be cited for deficiencies. She said the PNO of not notifying the family representative was the family may have further questions and would not know what was going on with the resident's care. She said she did not notify the families of the residents who were involved. She said the PNO of not conducting a thorough investigation and documenting it was then they could not prevent it from happening again and the lack of documenting would make it difficult for others to know about the incident. She said the incident should have been documented in the resident progress notes. She said she did not know it was not documented in the progress notes. She said she was aware that the facility did not report the incident to HHSC, investigate, or contact the family members of both residents involved. She said she was unaware that the incident between Resident #1 and #2 should have been investigated, but in hindsight, she could see where they should have been investigated. She said the system for monitoring that the facility's abuse policy was being followed was using the provider letter and policies to determine if the incident needed to be reported to HHSC. She said her system to monitor family notifications was she would review risk management. She said the system to monitor investigations was if they had a self-report, they would follow the self-report protocol based on what occurred. She said that this was generated in their computer system. She said she would review all documentation. She said she had been trained to report all reportable incidents to HHSC. She said she had been trained to notify family representatives of any significant incidents that involve residents. She said she had been trained to conduct a thorough investigation regarding allegations of abuse. She said she had been trained to conduct a thorough investigation and document regarding ANE. She said she expected all reportable incidents to be reported to HHSC. She said she expected all family representatives to be notified if there was an incident that involved any resident. She said she expected all allegations of ANE reported to be documented and thoroughly investigated. She said she and the ADM were responsible for reporting reportable incidents to HHSC. She said the charge nurse was typically responsible for notifying the resident's family when they were involved in an incident. She said she and the ADM were responsible for investigating and the documentation of the investigation. She said the incident was not reported to HHSC because it was a peck, and she was not troubled by it. She said he was supervised every time Resident #1 was out of the male-locked unit. She said he greeted a lot of people but did not kiss them on the lips. She said she had never seen him make contact with any other resident on the lips. She said the family was not notified because they did not perceive it as concerning or find out about the incident until several days later. She said Resident #2 was not troubled. She said that the reason the incident was not thoroughly investigated or documented was because they did not perceive the incident as ANE. She said she did not customize the care plan but used a template. She stated all staff were trained to notify if there was an allegation of ANE. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/19/25 at 3:36 PM, the ADM stated she was familiar with the facility's abuse policy, specifically reporting to HHSC, notifying the family representative, and conducting a thorough investigation. She said the purpose of reporting ANE to HHSC was to protect the resident and to have a second set of eyes. It ensured that nothing was not missed. She said the purpose of notifying the family representative was to let the family know what was going on with their care. She said conducting a thorough investigation and documenting was to ensure they did not miss anything and get the whole story. She said an investigation would involve interviewing other residents to see if it was a pattern. She said she would also interview the residents involved. She said they would interview any witnesses. She only interviewed Resident #2, HR, and the Activity Director. She said she did not document the interviews because she did not think about it. She said she did not perceive the incident between Resident #1 and Resident #2 as an incident. She said that the PNO of not reporting to HHSC was when the incidents that should have been reported may not have been investigated. She said the PNO of not notifying family representatives was the family needed to know what was going on, and if they did not notify the family, they could fail to do something they (the family) wanted them to do regarding the residents. She said she was aware that the incident where Resident #1 kissed Resident #2 was not reported to HHSC. She said she was aware that the family was not notified and did not notify the family of Residents #1 and #2. She said she does not believe that anyone would have done a notification because an incident report was not completed. She said she was aware an investigation was not completed because they did not feel it was a reportable incident, and she failed to report it. She said the system to monitor reportable incidents to HHSC was they always reviewed incidents. She said they typically reported incidents to the corporate office, and they all came to an agreement. She said if one person agreed that the incident should be reported, they should report it to HHSC. She said they did not report the incident between Resident #1 and #2 to the corporate nurse and operation manager. She said she did not consider it a reportable incident when it was reported to her. She said she heard it from HR, and she told her they (Resident #1 and Resident #2) were kissing. She said the system to monitor family notifications was to ensure that the DON would complete the notification if it were a reportable incident. If it was the charge nurse, she should also be checking behind the incident reports. She said the system they used to monitor investigations was that she and the DON drive the process and get interviews. She said she was unsure if she would have expected the incident to be documented in the resident progress notes. She said she had been trained to report reportable incidents to HHSC. She said she had been trained to notify family members if the resident was involved in a reportable incident. She said she had been trained to conduct a thorough investigation and document that investigation. She said she had been trained to report reportable incidents to HHSC. She said she expected family representatives to be notified if there were any incidents, new orders, or behaviors. She said she expected all reportable incidents to be thoroughly investigated and documented. She said she typically reported incidents to HHSC but that the DON could do it in her absence. She said the DON typically would report incidents to the corporate office. She said that depending on the incident would determine who was responsible for notifying the family representative. She said it would be the charge nurse or nurse present during the incident. She said she, as the ADM, was responsible for conducting a thorough investigation and documenting the investigation. She said she did not report the incident to HHSC because she felt it was accidental. She said there was no harm or intent. She said the family was notified because they did not feel it was an incident or harmful behavior between the two. She said the incident (Resident #1 and Resident #2 kissing) was not investigated and documented because they genuinely did not feel it was reportable. She said she mentioned in the morning meeting on an unknown date that the incident needed to be care planned with the DON being new care planned the incident as inappropriate sexual behavior, but she did not feel that the behavior was sexually inappropriate. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/24/25 at 2:58 PM, she said she did not witness Resident #1 and Resident #2 kiss, but she was told about the incident on an unknown date by the Activity Director while they were doing work for Meals on Wheels. She said although she did not remember the day she was told, she knew she was not told about the incident the same day the incident occurred because the Activity Director just casually mentioned the incident. She said the Activity Director told her that while they (The Activity Director and Resident #1) were bringing other residents to have an appetizer, Resident #1 and Resident #2 kissed. She said it was like a greeting and that the Activity Director joked about the incident. HR stated she did not get the impression as if it was a bad thing. She said she had never seen Resident #1 do this (kiss or greet other residents) before. She said Resident #1 was friendly and felt like he worked at the facility. She said she reported the incident to the ADM in casual conversation. She said she and the ADM were talking about Resident #2's boyfriend dumping her at the facility and being difficult to contact. HR stated she joked with the ADM and said, Oh, he better behave because Resident #2 was kissing boys. She said the ADM stopped and said, Oh God, what? We should probably get that care planned. HR said the ADM spoke about it in the morning meeting the following day. She said they should care plan it just in case it came up or happened again, and they would have a reference. She said both residents have memory issues where they cannot remember very well, but Resident #2 was verbal enough to express if she did not want something, she would let it be known. She said Resident #2 would wink and flirt a little. Record review of the facility policy, Abuse/Neglect, date revised 03/29/18, revealed: The resident has the right to be free from abuse . Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents . The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, and situations that may constitute abuse or neglect to any resident in the facility. Prevention The facility will provide the residents, families, and staff an environment free from abuse and neglect. All reports of abuse or suspicion of abuse/neglect or potentially criminal behavior will be investigated as per facility protocol. Investigations will be reviewed by the facility administrator and/or Abuse Preventionist within 24 hours of complaint. Appropriate notification to state and home office will be the responsibility of the administrator and per policy. Reporting Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and/or adult protective services. State law mandates that citizens report all suspected cases of abuse, neglect or financial exploitation of the elderly and incapacitated persons. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When a suspected abused, neglected, exploited, mistreated or potential victim of misappropriation of property comes to the attention of any employee, that employee will make an immediate verbal report to the Abuse Preventionist or designee. If the discovery occurs outside of normal business hours, the Abuse Preventionist and/or designee will be called. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 dated 7/10/19. If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation. Investigation Comprehensive investigations will be the responsibility of the administrator and/or Abuse Preventionist. All allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injuries of unknown source will be investigated. The administrator in consultation with the Risk Management Department will be responsible for investigating and reporting cases to the HHSC. After receipt of the allegation the Abuse Preventionist and administrator in conjunction with Risk Management will immediately evaluate the resident's situation using the criteria as stated in this policy. Determination will be made for required reporting to HHSC per reporting guidelines found in Provider letter 19-17. A report to the appropriate agency will include the following: The name and address of the suspected victim. The name and address of the suspected victim's care giver, if known. Resident to Resident The above policy will apply to potential resident-to-resident abuse. Provider letter 19-17 will be reviewed to determine if resident-to-resident abuse occurred.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on interviews and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours if the alleged violation involved abuse or neglect and resulted in bodily injury, to other officials (including the State Agency) and the administrator of the facility for 2 of 10 residents (Resident #1 and #2) reviewed for reporting abuse, in that: The ADM (Abuse Preventionist) and the DON failed to follow the facility's abuse policy by not reporting the allegation of abuse to HHSC regarding the Resident-to-Resident inappropriate sexual activity between residents (Resident #1 kissed Resident #2) that occurred on an unknown date. These failures could place residents as risk for abuse and neglect. Findings included: Record review of Resident #1's face sheet, dated 03/19/25, revealed an [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include dementia (memory loss), major depressive disorder, and anxiety. Record review of Resident #1's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 08, which indicated the resident's cognition was moderately impaired. Section B Hearing, Speech and Vision revealed that Resident #1 had clear speech, had the ability to make himself understood and had the ability to understand others. Record review of Resident #5's care plan, dated 10/01/24, revealed the following: Focus Sexually inappropriate AEB: was witnessed kissing a female resident on the lips in the dining room initiated 1/21/25. Goal Resident will have no episodes of sexually inappropriate behavior in the next 90 days initiated 1/21/25. Interventions Evaluate the resident ability to understand behavior and the consequences of that behavior initiated 1/21/25. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Whisperwood Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5502 W 4th St Lubbock, TX 79416	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Explain to the resident the acceptable expressions of sexuality based on the cognitive evaluation initiated 1/21/25. Listen/talk to the resident-see if they will tell you why they do the behavior initiated 1/21/25. Psychiatric Services consult as needed initiated 1/21/25. Reinforce with staff that clear, firm limits are healthy and required when resident makes inappropriate gestures or statements initiated 1/21/25. Report incidents of inappropriate sexual behavior to charge nurse and if other resident are involved, immediately intervene to protect the safety of all residents involved initiated 01/21/25 Record review of Resident #1's progress notes dated 01/18/25-01/19/25 revealed: There was no progress note related to Resident #1 kissing Resident #2. An interview was not conducted with Resident #1 because he was not actively in the facility on 03/19/25. Record review of Resident #2's face sheet, dated 03/19/25, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include dementia (memory loss), and chronic hepatitis C. Record review of Resident #2's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 03, which indicated the resident's cognition was severely impaired. Section B Hearing, Speech and Vision revealed that Resident #2 had clear speech, usually made herself understood and usually had the ability to understand others. Record review of Resident #5's care plan, dated 02/10/25, revealed the following: Focus Cognitive Function: Resident #2 has impaired cognitive function/dementia or impaired thought processes Dementia, impaired decision making initiated 2/13/23. Goal The resident will maintain current level of cognitive function initiated 02/13/23. Interventions/Task Discuss concerns about confusion, disease process, nursing home placement with the resident/family and care givers initiated 02/13/23. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's care plan, 2/10/25, did not address a desire to be in a relationship or incidents of inappropriate sexual behavior. Record review of Resident #2's progress notes dated 01/18/25-01/19/25 revealed there was no progress note related to Resident #2 being kissed by Resident #1. During an interview on 03/19/25 at 2:09 PM, Resident #2 stated she had a boyfriend. She said she did not know his name but that he was at the facility on 03/19/25. She said she did not remember if she kissed anyone. After asking why she was being questioned, she said she could kiss if she wanted to and felt safe in the facility. During an interview on 03/19/25 at 11:59 AM, the DON said that the Activity Director reported to her a few days after the incident (Resident #1 and Resident #2 kissed) occurred. She was unable to report the date the incident occurred. She stated it was reported to her that it was a peck on the lips. She said she was told that the residents were separated. She said Resident #2 had a BIMS of 3. The DON said she was unsure if anything else was done regarding the incident. She said the only person she spoke with was the Activity Director about the incident, and she would have more information. During an interview on 03/19/25 at 12:02 PM, the Activity Director stated that approximately 2 months ago, Resident #1 and Resident #2 kissed. The Activity Director stated that Resident #1 resided in the male-locked unit, and he would come out and assist her with activities. She stated that Resident #1 would shake hands and hug other residents, and Resident #1 was friendly. She said that because he was out of the male-locked unit, he was with her and helped her gather supplies, gather residents, and deliver items. The Activity Director stated they were near the nurse's station when he kissed Resident #2. Before she knew it, she observed Resident #1 and Resident #2 pecking each other on the lips. The Activity Director stated she separated both residents and explained to Resident #1 that he could not do that because of illnesses he could be exposed to. She stated Resident #1 joked and said, They were both grown. The Activity Director stated she spoke with Resident #2, but she did not understand at that moment and did not recall the incident. The Activity Director stated she believed Resident #2 had dementia. The Activity Director stated she did not think any other staff observed the incident. The Activity Director stated she reported the incident to the ADM and DON the same day the incident occurred. She said it was discussed the next morning in the morning meeting but did not remember the details of the meeting. She said that neither of the residents had a history of inappropriate sexual behaviors. The Activity Director stated she did not document the incident in either of the resident's progress notes. She stated she did not have a reason for not documenting the incident. She stated moving forward, she had just reminded Resident #1 of the best way to greet people. She stated the incident did not happen again. She stated she did not pass the information about the incident to the male-locked unit staff. During an interview on 03/19/25 at 1:15 PM, Family Member E stated she was not notified by facility staff about Resident #1 kissing another resident, but that Resident #1 told her about it. She said he told her he was told not to do it anymore. She could not remember if the kiss was on the lips or cheeks. She referred to the incident by saying, It was just a kiss! The interview ended abruptly because she said she was out with her grandchildren and would call back. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/19/25 at 1:30 PM, the Assistant Activity Director stated she had no first-hand information about Resident #1 kissing Resident #2. She stated that she heard about it but was not given specific instructions related to Resident #1 regarding the matter. She said that Resident #1 had never displayed behavior like that before. She said neither resident had the cognitive ability to make decisions independently. An attempt to interview Family Member F was unsuccessful on 03/19/25 at 1:18 PM. During an interview on 03/19/25 at 2:34 PM, the ADM stated that HR had told her that Resident #1 had kissed Resident #2. The ADM stated Resident #1 greets everyone and the ladies at the facility and swoons over him. ADM stated that she once was told by Family Member E that while in the community, he (Resident #1) oversaw completing shopping for the ladies in his apartment complex. She said that after HR told her she went and spoke with the Activity Director, she (the Activity Director) told her (The ADM) both residents (Resident #1 and #2) greeted each other and pecked each other on the lips. She said The Activity Director pulled both Residents apart. The ADM stated it was unusual but not an issue. She said she (The ADM) did not see it as inappropriate. She said they discussed the incident in the morning meeting and lightly mentioned that they should plan it because it could be inappropriate. She said she assumed that was why the DON care planned it as inappropriate behavior. The ADM stated Resident #2 was not cognitively able to make her own decisions, and neither was Resident #1. She said she had spoken with Resident #2, and she did not remember. She said she did not talk with Resident #1. She said Resident #1 greets people in this manner. She showed the investigator that he would give a side hug, press his face to other residents, and made a kissing sound. She said he was not asking permission of the residents to greet them in that manner. The ADM stated she did not think there was anything to it. She said she did have a surveillance system, but where the incident occurred, it would not have been an unobstructed view for the cameras. She said she did not even think to look at the camera because she did not think Resident #1 meant to do it. She said she was not sure if an incident like this would necessarily be reported to the family, depending on the resident. She said it was something that they needed to watch but did not consider it an issue because Resident #2 was not upset and could not remember. She said it was reported to her that Resident #2 was pecking him back. She said Resident #2 could let her feelings be known. During an interview on 03/19/25 at 3:04 PM, the DON stated she was familiar with the facility's abuse policy, specifically reporting to HHSC. She said the purpose of reporting to HHSC was so that HHSC could come and investigate. She said the PNO of not following the facility's abuse policy (reporting to HHSC) was that the facility would be cited for deficiencies. She said she was aware that the facility did not report the incident to HHSC. She said the system for monitoring that the facility's abuse policy was being followed was using the provider letter and policies to determine if the incident needed to be reported to HHSC. She said she had been trained to report all reportable incidents to HHSC. She said she expected all reportable incidents to be reported to HHSC. She said she and the ADM were responsible for reporting reportable incidents to HHSC. She said the incident was not reported to HHSC because it was a peck, and she was not troubled by it. She said he was supervised every time Resident #1 was out of the male-locked unit. She said he greeted a lot of people but did not kiss them on the lips. She said she had never seen him make contact with any other resident on the lips. She stated all staff were trained to notify if there was an allegation of ANE. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/19/25 at 3:36 PM, the ADM stated she was familiar with the facility's abuse policy, specifically reporting to HHSC. She said the purpose of reporting ANE to HHSC was to protect the resident and to have a second set of eyes. It ensured that nothing was not missed. She said she did not perceive the incident between Resident #1 and Resident #2 as an incident. She said that the PNO of not reporting to HHSC was when the incidents that should have been reported may not have been investigated. She said she was aware that the incident where Resident #1 kissed Resident #2 was not reported to HHSC. She said the system to monitor reportable incidents to HHSC was they always reviewed incidents. She said they typically reported incidents to the corporate office, and they all came to an agreement. She said if one person agreed that the incident should be reported, they should report it to HHSC. She said they did not report the incident between Resident #1 and #2 to the corporate nurse and operation manager. She said she did not consider it a reportable incident when it was reported to her. She said she heard it from HR, and she told her they (Resident #1 and Resident #2) were kissing. She said she had been trained to report reportable incidents to HHSC. She said she typically reported incidents to HHSC but that the DON could do it in her absence. She said she did not report the incident to HHSC because she felt it was accidental. She said there was no harm or intent. She said she mentioned in the morning meeting on an unknown date that the incident needed to be care planned with the DON being new care planned the incident as inappropriate sexual behavior, but she did not feel that the behavior was sexually inappropriate. During an interview on 03/24/25 at 2:58 PM, she said she did not witness Resident #1 and Resident #2 kiss, but she was told about the incident on an unknown date by the Activity Director while they were doing work for Meals on Wheels. She said although she did not remember the day she was told, she knew she was not told about the incident the same day the incident occurred because the Activity Director just casually mentioned the incident. She said the Activity Director told her that while they (The Activity Director and Resident #1) were bringing other residents to have an appetizer, Resident #1 and Resident #2 kissed. She said it was like a greeting and that the Activity Director joked about the incident. HR stated she did not get the impression as if it was a bad thing. She said she had never seen Resident #1 do this (kiss or greet other residents) before. She said Resident #1 was friendly and felt like he worked at the facility. She said she reported the incident to the ADM in casual conversation. She said she and the ADM were talking about Resident #2's boyfriend dumping her at the facility and being difficult to contact. HR stated she joked with the ADM and said, Oh, he better behave because Resident #2 was kissing boys. She said the ADM stopped and said, Oh God, what? We should probably get that care planned. HR said the ADM spoke about it in the morning meeting the following day. She said they should care plan it just in case it came up or happened again, and they would have a reference. She said both residents have memory issues where they cannot remember very well, but Resident #2 was verbal enough to express if she did not want something, she would let it be known. She said Resident #2 would wink and flirt a little. Record review of the facility policy, Abuse/Neglect, date revised 03/29/18, revealed: The resident has the right to be free from abuse . Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents . The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, and situations that may constitute abuse or neglect to any resident in the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reporting Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and/or adult protective services. State law mandates that citizens report all suspected cases of abuse, neglect or financial exploitation of the elderly and incapacitated persons. When a suspected abused, neglected, exploited, mistreated or potential victim of misappropriation of property comes to the attention of any employee, that employee will make an immediate verbal report to the Abuse Preventionist or designee. If the discovery occurs outside of normal business hours, the Abuse Preventionist and/or designee will be called. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 dated 7/10/19. If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation. After receipt of the allegation the Abuse Preventionist and administrator in conjunction with Risk Management will immediately evaluate the resident's situation using the criteria as stated in this policy. Determination will be made for required reporting to HHSC per reporting guidelines found in Provider letter 19-17. A report to the appropriate agency will include the following: The name and address of the suspected victim. The name and address of the suspected victim's care giver, if known. Resident to Resident The above policy will apply to potential resident-to-resident abuse. Provider letter 19-17 will be reviewed to determine if resident-to-resident abuse occurred.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on interviews and record reviews the facility failed to have evidence all allegations of abuse, neglect or mistreatment were thoroughly investigated for 2 of 10 residents (Resident #1, and #2) reviewed for abuse. The ADM (Abuse Preventionist) and the DON failed to follow the facility's abuse policy by not conducting a thorough investigation and documenting regarding the Resident-to-Resident inappropriate sexual activity between residents (Resident #1 kissed Resident #2) that occurred on an unknown date. These failures could place residents as risk for abuse and neglect by not investigating allegations of abuse, neglect, exploitation, or mistreatment. Findings included: Record review of Resident #1's face sheet, dated 03/19/25, revealed an [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include dementia (memory loss), major depressive disorder, and anxiety. Record review of Resident #1's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 08, which indicated the resident's cognition was moderately impaired. Section B Hearing, Speech and Vision revealed that Resident #1 had clear speech, had the ability to make himself understood and had the ability to understand others. Record review of Resident #5's care plan, dated 10/01/24, revealed the following: Focus Sexually inappropriate AEB: was witnessed kissing a female resident on the lips in the dining room initiated 1/21/25. Goal Resident will have no episodes of sexually inappropriate behavior in the next 90 days initiated 1/21/25. Interventions Evaluate the resident ability to understand behavior and the consequences of that behavior initiated 1/21/25. Explain to the resident the acceptable expressions of sexuality based on the cognitive evaluation initiated 1/21/25. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Listen/talk to the resident-see if they will tell you why they do the behavior initiated 1/21/25. Psychiatric Services consult as needed initiated 1/21/25. Reinforce with staff that clear, firm limits are healthy and required when resident makes inappropriate gestures or statements initiated 1/21/25. Report incidents of inappropriate sexual behavior to charge nurse and if other resident are involved, immediately intervene to protect the safety of all residents involved initiated 01/21/25 Record review of Resident #1's progress notes dated 01/18/25-01/19/25 revealed: There was no progress note related to Resident #1 kissing Resident #2. An interview was not conducted with Resident #1 because he was not actively in the facility on 03/19/25. Record review of Resident #2's face sheet, dated 03/19/25, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include dementia (memory loss), and chronic hepatitis C. Record review of Resident #2's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 03, which indicated the resident's cognition was severely impaired. Section B Hearing, Speech and Vision revealed that Resident #2 had clear speech, usually made herself understood and usually had the ability to understand others. Record review of Resident #5's care plan, dated 02/10/25, revealed the following: Focus Cognitive Function: Resident #2 has impaired cognitive function/dementia or impaired thought processes Dementia, impaired decision making initiated 2/13/23. Goal The resident will maintain current level of cognitive function initiated 02/13/23. Interventions/Task Discuss concerns about confusion, disease process, nursing home placement with the resident/family and care givers initiated 02/13/23. Record review of Resident #2's care plan, 2/10/25, did not address a desire to be in a relationship or incidents of inappropriate sexual behavior. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's progress notes dated 01/18/25-01/19/25 revealed there was no progress note related to Resident #2 being kissed by Resident #1. During an interview on 03/19/25 at 2:09 PM, Resident #2 stated she had a boyfriend. She said she did not know his name but that he was at the facility on 03/19/25. She said she did not remember if she kissed anyone. After asking why she was being questioned, she said she could kiss if she wanted to and felt safe in the facility. During an interview on 03/19/25 at 11:59 AM, the DON said that the Activity Director reported to her a few days after the incident (Resident #1 and Resident #2 kissed) occurred. She was unable to report the date the incident occurred. She stated it was reported to her that it was a peck on the lips. She said she was told that the residents were separated. She said Resident #2 had a BIMS of 3. The DON said she was unsure if anything else was done regarding the incident. She said the only person she spoke with was the Activity Director about the incident, and she would have more information. During an interview on 03/19/25 at 12:02 PM, the Activity Director stated that approximately 2 months ago, Resident #1 and Resident #2 kissed. The Activity Director stated that Resident #1 resided in the male-locked unit, and he would come out and assist her with activities. She stated that Resident #1 would shake hands and hug other residents, and Resident #1 was friendly. She said that because he was out of the male-locked unit, he was with her and helped her gather supplies, gather residents, and deliver items. The Activity Director stated they were near the nurse's station when he kissed Resident #2. Before she knew it, she observed Resident #1 and Resident #2 pecking each other on the lips. The Activity Director stated she separated both residents and explained to Resident #1 that he could not do that because of illnesses he could be exposed to. She stated Resident #1 joked and said, They were both grown. The Activity Director stated she spoke with Resident #2, but she did not understand at that moment and did not recall the incident. The Activity Director stated she believed Resident #2 had dementia. The Activity Director stated she did not think any other staff observed the incident. The Activity Director stated she reported the incident to the ADM and DON the same day the incident occurred. She said it was discussed the next morning in the morning meeting but did not remember the details of the meeting. She said that neither of the residents had a history of inappropriate sexual behaviors. The Activity Director stated she did not document the incident in either of the resident's progress notes. She stated she did not have a reason for not documenting the incident. She stated moving forward, she had just reminded Resident #1 of the best way to greet people. She stated the incident did not happen again. She stated she did not pass the information about the incident to the male-locked unit staff. During an interview on 03/19/25 at 1:15 PM, Family Member E stated she was not notified by facility staff about Resident #1 kissing another resident, but that Resident #1 told her about it. She said he told her he was told not to do it anymore. She could not remember if the kiss was on the lips or cheeks. She referred to the incident by saying, It was just a kiss! The interview ended abruptly because she said she was out with her grandchildren and would call back. During an interview on 03/19/25 at 1:30 PM, the Assistant Activity Director stated she had no first-hand information about Resident #1 kissing Resident #2. She stated that she heard about it but was not given specific instructions related to Resident #1 regarding the matter. She said that Resident #1 had never displayed behavior like that before. She said neither resident had the cognitive ability to make decisions independently. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An attempt to interview Family Member F was unsuccessful on 03/19/25 at 1:18 PM. During an interview on 03/19/25 at 2:34 PM, the ADM stated that HR had told her that Resident #1 had kissed Resident #2. The ADM stated Resident #1 greets everyone and the ladies at the facility and swoons over him. ADM stated that she once was told by Family Member E that while in the community, he (Resident #1) oversaw completing shopping for the ladies in his apartment complex. She said that after HR told her she went and spoke with the Activity Director, she (the Activity Director) told her (The ADM) both residents (Resident #1 and #2) greeted each other and pecked each other on the lips. She said The Activity Director pulled both Residents apart. The ADM stated it was unusual but not an issue. She said she (The ADM) did not see it as inappropriate. She said they discussed the incident in the morning meeting and lightly mentioned that they should plan it because it could be inappropriate. She said she assumed that was why the DON care planned it as inappropriate behavior. The ADM stated Resident #2 was not cognitively able to make her own decisions, and neither was Resident #1. She said she had spoken with Resident #2, and she did not remember. She said she did not talk with Resident #1. She said Resident #1 greets people in this manner. She showed the investigator that he would give a side hug, press his face to other residents, and made a kissing sound. She said he was not asking permission of the residents to greet them in that manner. The ADM stated she did not think there was anything to it. She said she did have a surveillance system, but where the incident occurred, it would not have been an unobstructed view for the cameras. She said she did not even think to look at the camera because she did not think Resident #1 meant to do it. She stated when she spoke with Resident #2, she (Resident #2) was not upset. She said it was reported to her that Resident #2 was pecking him back. She said Resident #2 could let her feelings be known. During an interview on 03/19/25 at 3:04 PM, the DON stated she was familiar with the facility's abuse policy, specifically conducting a thorough investigation. She said the purpose of conducting a thorough investigation and documenting it was to determine if they needed to substantiate, figure out what happened, and what could have been done to prevent it. She stated they usually get witness statements from all the people who were involved. She stated they typically would try to interview the staff and residents as soon as it happens so that the information was fresh on their minds. She said the longer they wait, the more the residents could forget. She said the PNO of not conducting a thorough investigation and documenting it was then they could not prevent it from happening again and the lack of documenting would make it difficult for others to know about the incident. She said the incident should have been documented in the resident progress notes. She said she did not know it was not documented in the progress notes. She said she was unaware that the incident between Resident #1 and #2 should have been investigated, but in hindsight, she could see where they should have been investigated. She said the system to monitor investigations was if they had a self-report, they would follow the self-report protocol based on what occurred. She said that this was generated in their computer system. She said she would review all documentation. She said she had been trained to conduct a thorough investigation regarding allegations of abuse. She said she had been trained to conduct a thorough investigation and document regarding ANE. She said she expected all allegations of ANE reported to be documented and thoroughly investigated. She said she and the ADM were responsible for investigating and the documentation of the investigation. She said that the reason the incident was not thoroughly investigated or documented was because they did not perceive the incident as ANE. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675527	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER: Whisperwood Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 5502 W 4th St Lubbock, TX 79416	

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/19/25 at 3:36 PM, the ADM stated she was familiar with the facility's abuse policy, specifically conducting a thorough investigation. She said conducting a thorough investigation and documenting was to ensure they did not miss anything and get the whole story. She said an investigation would involve interviewing other residents to see if it was a pattern. She said she would also interview the residents involved. She said they would interview any witnesses. She only interviewed Resident #2, HR, and the Activity Director. She said she did not document the interviews because she did not think about it. She said she did not perceive the incident between Resident #1 and Resident #2 as an incident. She said she was aware an investigation was not completed because they did not feel it was a reportable incident, and she failed to report it. She said she did not consider it a reportable incident when it was reported to her. She said she heard it from HR, and she told her they (Resident #1 and Resident #2) were kissing. She said the system they used to monitor investigations was that she and the DON drive the process and get interviews. She said she was unsure if she would have expected the incident to be documented in the resident progress notes. She said she had been trained to conduct a thorough investigation and document that investigation. She said she expected all reportable incidents to be thoroughly investigated and documented. She said she, as the ADM, was responsible for conducting a thorough investigation and documenting the investigation. She said the incident (Resident #1 and Resident #2 kissing) was not investigated and documented because they genuinely did not feel it was reportable. She said she mentioned in the morning meeting on an unknown date that the incident needed to be care planned with the DON being new care planned the incident as inappropriate sexual behavior, but she did not feel that the behavior was sexually inappropriate. Record review of the facility policy, Abuse/Neglect, date revised 03/29/18, revealed: The resident has the right to be free from abuse . Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents . The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, and situations that may constitute abuse or neglect to any resident in the facility. Investigation Comprehensive investigations will be the responsibility of the administrator and/or Abuse Preventionist. All allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injuries of unknown source will be investigated. The administrator in consultation with the Risk Management Department will be responsible for investigating and reporting cases to the HHSC. Resident to Resident The above policy will apply to potential resident-to-resident abuse. Provider letter 19-17 will be reviewed to determine if resident-to-resident abuse occurred.