

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 08/15/2025
NAME OF PROVIDER OR SUPPLIER Whisperwood Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 08/15/2025
NAME OF PROVIDER OR SUPPLIER Whisperwood Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately notify with the responsible party of an incident involving the resident which had the potential for requiring physician intervention for 2 (Resident #1 & Resident #2) of 7 residents reviewed for notification of change. The facility failed to immediately notify Resident #1's responsible party when Resident #2 verbally abused Resident #1 on 7/11/25 between 7:00 PM and 7:30 PM. This failure could place residents responsible party at the risk of not being aware/informed of residents' conditions. Findings included: Resident #1 Record review of Resident #1's face sheet, 8/14/25, revealed an [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include dementia (memory loss), schizoaffective disorder (mental disorder), anxiety (increased worry), insomnia (difficulty sleeping), major depressive disorder (increase sadness) and UTI (infection in the urinary system). Record review of Resident #1's Comprehensive Minimum Data Set, dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 00, which indicated the resident's cognition was severely impaired. Record review of Resident #1's care plan, dated 7/14/25, revealed the following: Resident #1 had a focus for elopement and wandering specifically that she wandered aimlessly (date initiated 8/14/25). The goal was for Resident #1 to remain safe within the facility unless accompanied by a staff or authorized person. Interventions included distracting resident from wandering by offering pleasant diversions and supervising closely and make regular compliance rounds. Resident #1 had a focus for coping, specifically Resident #1 had a tough time coping with a roommate as roommate might have been verbally aggressive towards Resident #1 (date initiated 7/14/25). The goal was for Resident #1 to feel comfortable in a safe living environment. Interventions included staff would listen to Resident #1's concerns. Staff would monitor if Resident #1 were unable to cope with roommate and the social worker would find a new roommate if applicable. Record review of Resident #1's progress notes, dated 5/13/25-8/14/25, revealed: No incidents documented involving Resident #1 and any other residents on 7/11/25. 07/13/25 at 9:11 PM LVN B documented: family report a CNA reported to them Resident #1's roommate was cursing at her and telling her to clean up after herself in the bathroom. Initial treatment included skin assessment; roommate placed on 1:1 monitoring supervision. Medical doctor and nurse practitioner notified. Responsible party was notified. 07/13/25 at 10:37 PM LVN B documented skin assessment conducted with no negative findings. 07/14/25 at 2:58 AM LVN B documented trauma assessment conducted. There were no negative findings or experiences documented or found. Resident #1 did not express fear or anger. 7/14/25 at 9:36 PM the DON documented a late entry indicating Resident #1's family reported to administration that the CNA (unidentified in the progress note) told them Resident #1's roommate was cursing at Resident #1 and telling her to clean up after herself in the bathroom. Resident #1's roommate was placed on one-to-one monitoring. Skin Assessment performed on Resident #1. A room swap was made. Family was aware and notified. FNP was notified. 7/15/25 at 8:36 AM LVN EE documented that Resident #1 appeared to be in no pain and monitoring was conducted. 7/15/25 at 8:37 AM LVN EE documented that Resident #1 had no signs or symptoms of distress noted, resident in good spirits. 7/15/25 at 10:13 PM LVN BB documented that Resident #1 had no signs or symptoms of distress and did not complain of any pain. During an interview on 8/14/25 at 12:31 PM, Resident #1 could not recall the incident that occurred between she and Resident #2. She could not identify her last roommate by name. She stated she could not remember if she was afraid on 7/11/25. She could not remember how long she had been in the room that she was and why she had moved. She reported that she felt safe at the facility. Resident #2 Record review of Resident #2's face sheet, dated 8/14/25, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include intermittent explosive disorder (mental disorder characterized by outburst of anger or violence), anxiety (increased worry) and dementia (memory loss). Record review of Resident #2's Comprehensive Minimum Data Set, 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 E did not reveal any coded behaviors. Record review of Resident #2's Quarterly Minimum Data Set, dated [DATE], revealed: Section E Behavior Resident #2 had other behavioral symptoms not directed towards others. Resident #2's care plan, dated 7/14/25 revealed the following: Resident #2 had a focus for behavioral symptoms specifically that Resident #2 had potential to demonstrate physical behaviors. (initiated 7/4/25) The goal was for Resident #2 to demonstrate effective coping skills. Interventions included staff analyzing key times, places, circumstances, triggers, and what de-escalates behavior and document</p>		

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 08/15/2025
NAME OF PROVIDER OR SUPPLIER Whisperwood Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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 08/15/2025
NAME OF PROVIDER OR SUPPLIER Whisperwood Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the residents had the right to be free from verbal abuse and neglect for 2 (Resident #1 and #2) of 7 residents reviewed for abuse. The facility staff failed to protect Resident #1 from verbal abuse from Resident #2 on 7/11/25 between 7:00 PM and 7:30 PM. The noncompliance was identified as PNC. The IJ began on 07/11/25 and ended on 7/25/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of abuse, neglect, trauma, injury and psychosocial harm. Findings included: Resident #1 Record review of Resident #1's face sheet, 8/14/25, revealed an [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include dementia (memory loss), schizoaffective disorder (mental disorder), anxiety (increased worry), insomnia (difficulty sleeping), major depressive disorder (increase sadness) and UTI (infection in the urinary system). Record review of Resident #1's Comprehensive Minimum Data Set, dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 00, which indicated the resident's cognition was severely impaired. Record review of Resident #1's care plan, dated 7/14/25, revealed the following: Resident #1 had a focus for elopement and wandering specifically that she wandered aimlessly (date initiated 8/14/25). The goal was for Resident #1 to remain safe within the facility unless accompanied by a staff or authorized person. Interventions included distracting resident from wandering by offering pleasant diversions and supervising closely and make regular compliance rounds. Resident #1 had a focus for coping, specifically Resident #1 had a tough time coping with a roommate as roommate might have been verbally aggressive towards Resident #1 (date initiated 7/14/25). The goal was for Resident #1 to feel comfortable in a safe living environment. Interventions included staff would listen to Resident #1's concerns. Staff would monitor if Resident #1 were unable to cope with roommate and the social worker would find a new roommate if applicable. Record review of Resident #1's progress notes, dated 5/13/25-8/14/25, revealed: No incidents documented involving Resident #1 and any other residents on 7/11/25. 07/13/25 at 9:11 PM LVN B documented: family report a CNA reported to them Resident #1's roommate was cursing at her and telling her to clean up after herself in the bathroom. Initial treatment included skin assessment; roommate placed on 1:1 monitoring supervision. Medical doctor and nurse practitioner notified. Responsible party was notified. 07/13/25 at 10:37 PM LVN B documented skin assessment conducted with no negative findings. 07/14/25 at 2:58 AM LVN B documented trauma assessment conducted. There were no negative findings or experiences documented or found. Resident #1 did not express fear or anger. 7/14/25 at 9:36 PM the DON documented a late entry indicating Resident #1's family reported to administration that the CNA (unidentified in the progress note) told them Resident #1's roommate was cursing at Resident #1 and telling her to clean up after herself in the bathroom. Resident #1's roommate was placed on one-to-one monitoring. Skin Assessment performed on Resident #1. A room swap was made. Family was aware and notified. FNP was notified. 7/15/25 at 8:36 AM LVN EE documented that Resident #1 appeared to be in no pain and monitoring was conducted. 7/15/25 at 8:37 AM LVN EE documented that Resident #1 had no signs or symptoms of distress noted, resident in good spirits. 7/15/25 at 10:13 PM LVN BB documented that Resident #1 had no signs or symptoms of distress and did not complain of any pain. During an interview on 8/14/25 at 12:31 PM, Resident #1 could not recall the incident that occurred between she and Resident #2. She could not identify her last roommate by name. She stated she could not remember if she was afraid on 7/11/25. She could not remember how long she had been in the room that she was and why she had moved. She reported that she felt safe at the facility. Resident #2 Record review of Resident #2's face sheet, dated 8/14/25, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include intermittent explosive disorder (mental disorder characterized by outburst of anger or violence), anxiety (increased worry) and dementia (memory loss). Record review of Resident #2's Comprehensive Minimum Data Set, 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 E did not reveal any coded behaviors. Record review of Resident #2's Quarterly Minimum Data Set, dated [DATE], revealed: Section E Behavior Resident #2 had other behavioral symptoms not directed towards others. Resident #2's care plan, dated 7/14/25 revealed the following: Resident #2 had a focus for behavioral symptoms specifically that Resident #2 had potential to demonstrate physical behaviors. (initiated 7/4/25) The goal was for Resident #2 to demonstrate effective coping skills. Interventions included staff analyzing key times, places</p>		

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 08/15/2025
NAME OF PROVIDER OR SUPPLIER Whisperwood Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>(continued on next page)</p>

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 08/15/2025
NAME OF PROVIDER OR SUPPLIER Whisperwood Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 7 residents (Resident #1, and #2) reviewed for abuse. CNA A failed to follow the facility's abuse policy by not reporting the incident (verbal abuse) to the facility's Abuse Coordinator involving Resident #1 and Resident #2 that occurred on 7/11/25 between 7:00 PM and 7:30 PM. LVN B failed to follow the facility's abuse policy by not reporting the incident (verbal abuse) to the facility's Abuse Coordinator involving Resident #1 and Resident #2 that occurred on 7/11/25 between 7:00 PM and 7:30 PM. The ADM failed to follow the facility's abuse policy by not reporting the incident (verbal abuse) to HHSC involving Resident #1 and Resident #2 that occurred on 7/11/25 between 7:00 PM and 7:30 PM. The facility failed to notify Resident #1's family of the verbal abuse incident that occurred on 7/11/25 between 7:00 PM and 7:30 PM. The facility failed to put protective measures to protect Resident #1 from Resident #2 after a verbal abuse incident occurred on 7/11/25. The noncompliance was identified as PNC. The IJ began on 07/11/25 and ended on 7/14/25. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk for abuse and injury. Findings included: Record review of the facility's abuse policy, dated 3/29/18, revealed the following: 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. Prevention The facility will provide the residents, families, and staff an environment free from abuse and neglect. The facility will be responsible to identify, correct, and intervene in situations of possible abuse/neglect. The facility has in place a method to identify events such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse. 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. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation. If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation. Protection (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. Resident #1 Record review of Resident #1's face sheet, 8/14/25, revealed an [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include dementia (memory loss), schizoaffective disorder (mental disorder), anxiety (increased worry), insomnia (difficulty sleeping), major depressive disorder (increase sadness) and UTI (infection in the urinary system). Record review of Resident #1's Comprehensive Minimum Data Set, dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 00, which indicated the resident's cognition was severely impaired. Record review of Resident #1's care plan, dated 7/14/25, revealed the following: Resident #1 had a focus for elopement and wandering specifically that she wandered aimlessly (date initiated 8/14/25). The goal was for Resident #1 to remain safe within the facility unless accompanied by a staff or authorized person. Interventions included distracting resident from wandering by offering pleasant diversions and supervising closely and make regular compliance rounds. Resident #1 had a focus for coping, specifically Resident #1 had a tough time coping with a roommate as roommate might have been verbally aggressive towards Resident #1 (date initiated 7/14/25). The goal was for Resident #1 to feel comfortable in a safe living environment. Interventions included staff would listen to Resident #1's concerns. Staff would monitor if Resident #1 were unable to cope with roommate and the social worker would find a new roommate if applicable. Record review of Resident #1's progress notes, dated 5/13/25-8/14/25, revealed: No incidents documented involving Resident #1 and any other residents on 7/11/25. 07/13/25 at 9:11 PM LVN B documented: family report a CNA reported to them Resident #1's roommate was cursing at her and telling her to clean up after herself in the bathroom. Initial treatment</p>		

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 08/15/2025
NAME OF PROVIDER OR SUPPLIER Whisperwood Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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 08/15/2025
NAME OF PROVIDER OR SUPPLIER Whisperwood Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 Abuse Coordinator for 2 of 7 residents (Resident #1, and #2) reviewed for abuse. CNA A failed to report the allegation of abuse involving Resident #1 and Resident #2, to the abuse Coordinator (ADM) on 7/11/25 when she heard Resident #2 verbally assault Resident #1 between 7:00 PM and 7:30 PM. LVN B failed to report the allegation of abuse involving Resident #1 and Resident #2, to the abuse Coordinator (ADM) on 7/11/25 when she heard Resident #2 verbally assault Resident #1 between 7:00 PM and 7:30 PM. The Abuse Coordinator (ADM) failed to follow the facility's abuse policy by not reporting to HHSC verbal abuse involving Resident #1 and Resident #2 that occurred on 7/11/25 between 7:00 PM and 7:30 PM. The noncompliance was identified as PNC. The IJ began on 07/11/25 and ended on 7/14/25. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk for abuse and neglect. Findings included: Resident #1 Record review of Resident #1's face sheet, 8/14/25, revealed an [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include dementia (memory loss), schizoaffective disorder (mental disorder), anxiety (increased worry), insomnia (difficulty sleeping), major depressive disorder (increase sadness) and UTI (infection in the urinary system). Record review of Resident #1's Comprehensive Minimum Data Set, dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 00, which indicated the resident's cognition was severely impaired. Record review of Resident #1's care plan, dated 7/14/25, revealed the following: Resident #1 had a focus for elopement and wandering specifically that she wandered aimlessly (date initiated 8/14/25). The goal was for Resident #1 to remain safe within the facility unless accompanied by a staff or authorized person. Interventions included distracting resident from wandering by offering pleasant diversions and supervising closely and make regular compliance rounds. Resident #1 had a focus for coping, specifically Resident #1 had a tough time coping with a roommate as roommate might have been verbally aggressive towards Resident #1 (date initiated 7/14/25). The goal was for Resident #1 to feel comfortable in a safe living environment. Interventions included staff would listen to Resident #1's concerns. Staff would monitor if Resident #1 were unable to cope with roommate and the social worker would find a new roommate if applicable. Record review of Resident #1's progress notes, dated 5/13/25-8/14/25, revealed: No incidents documented involving Resident #1 and any other residents on 7/11/25. 07/13/25 at 9:11 PM LVN B documented: family report a CNA reported to them Resident #1's roommate was cursing at her and telling her to clean up after herself in the bathroom. Initial treatment included skin assessment; roommate placed on 1:1 monitoring supervision. Medical doctor and nurse practitioner notified. Responsible party was notified. 07/13/25 at 10:37 PM LVN B documented skin assessment conducted with no negative findings. 07/14/25 at 2:58 AM LVN B documented trauma assessment conducted. There were no negative findings or experiences documented or found. Resident #1 did not express fear or anger. 7/14/25 at 9:36 PM the DON documented a late entry indicating Resident #1's family reported to administration that the CNA (unidentified in the progress note) told them Resident #1's roommate was cursing at Resident #1 and telling her to clean up after herself in the bathroom. Resident #1's roommate was placed on one-to-one monitoring. Skin Assessment performed on Resident #1. A room swap was made. Family was aware and notified. FNP was notified. 7/15/25 at 8:36 AM LVN EE documented that Resident #1 appeared to be in no pain and monitoring was conducted. 7/15/25 at 8:37 AM LVN EE documented that Resident #1 had no signs or symptoms of distress noted, resident in good spirits. 7/15/25 at 10:13 PM LVN BB documented that Resident #1 had no signs or symptoms of distress and did not complain of any pain. During an interview on 8/14/25 at 12:31 PM, Resident #1 could not recall the incident that occurred between she and Resident #2. She could not identify her last roommate by name. She stated she could not remember if she was afraid on 7/11/25. She could not remember how long she had been in the room that she was and why she had moved. She reported that she felt safe at the facility. Resident #2 Record review of Resident #2's face sheet, dated 8/14/25, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include intermittent explosive disorder (mental disorder characterized by outburst of anger or violence), anxiety (increased worry) and dementia (memory loss). Record review of</p>		

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 08/15/2025
NAME OF PROVIDER OR SUPPLIER Whisperwood Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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 08/15/2025
NAME OF PROVIDER OR SUPPLIER Whisperwood Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to prevent further potential abuse, neglect, exploitation, or mistreatment for 2 of 7 residents (Resident #1, #2) reviewed for abuse. The facility failed to immediately implement protective measures to protect Resident #1 from Resident #2 after a verbal abuse incident occurred on 7/11/25 between 7:00 PM and 7:30 PM. The noncompliance was identified as PNC. The IJ began on 07/11/25 and ended on 7/14/25. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk for further abuse to include emotional and physical. Findings Included: Resident #1 Record review of Resident #1's face sheet, 8/14/25, revealed an [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include dementia (memory loss), schizoaffective disorder (mental disorder), anxiety (increased worry), insomnia (difficulty sleeping), major depressive disorder (increase sadness) and UTI (infection in the urinary system). Record review of Resident #1's Comprehensive Minimum Data Set, dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 00, which indicated the resident's cognition was severely impaired. Record review of Resident #1's care plan, dated 7/14/25, revealed the following: Resident #1 had a focus for elopement and wandering specifically that she wandered aimlessly (date initiated 8/14/25). The goal was for Resident #1 to remain safe within the facility unless accompanied by a staff or authorized person. Interventions included distracting resident from wandering by offering pleasant diversions and supervising closely and make regular compliance rounds. Resident #1 had a focus for coping, specifically Resident #1 had a tough time coping with a roommate as roommate might have been verbally aggressive towards Resident #1 (date initiated 7/14/25). The goal was for Resident #1 to feel comfortable in a safe living environment. Interventions included staff would listen to Resident #1's concerns. Staff would monitor if Resident #1 were unable to cope with roommate and the social worker would find a new roommate if applicable. Record review of Resident #1's progress notes, dated 5/13/25-8/14/25, revealed: No incidents documented involving Resident #1 and any other residents on 7/11/25. 07/13/25 at 9:11 PM LVN B documented: family report a CNA reported to them Resident #1's roommate was cursing at her and telling her to clean up after herself in the bathroom. Initial treatment included skin assessment; roommate placed on 1:1 monitoring supervision. Medical doctor and nurse practitioner notified. Responsible party was notified. 07/13/25 at 10:37 PM LVN B documented skin assessment conducted with no negative findings. 07/14/25 at 2:58 AM LVN B documented trauma assessment conducted. There were no negative findings or experiences documented or found. Resident #1 did not express fear or anger. 7/14/25 at 9:36 PM the DON documented a late entry indicating Resident #1's family reported to administration that the CNA (unidentified in the progress note) told them Resident #1's roommate was cursing at Resident #1 and telling her to clean up after herself in the bathroom. Resident #1's roommate was placed on one-to-one monitoring. Skin Assessment performed on Resident #1. A room swap was made. Family was aware and notified. FNP was notified. 7/15/25 at 8:36 AM LVN EE documented that Resident #1 appeared to be in no pain and monitoring was conducted. 7/15/25 at 8:37 AM LVN EE documented that Resident #1 had no signs or symptoms of distress noted, resident in good spirits. 7/15/25 at 10:13 PM LVN BB documented that Resident #1 had no signs or symptoms of distress and did not complain of any pain. During an interview on 8/14/25 at 12:31 PM, Resident #1 could not recall the incident that occurred between she and Resident #2. She could not identify her last roommate by name. She stated she could not remember if she was afraid on 7/11/25. She could not remember how long she had been in the room that she was and why she had moved. She reported that she felt safe at the facility. Resident #2 Record review of Resident #2's face sheet, dated 8/14/25, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include intermittent explosive disorder (mental disorder characterized by outburst of anger or violence), anxiety (increased worry) and dementia (memory loss). Record review of Resident #2's Comprehensive Minimum Data Set, 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 E did not reveal any coded behaviors. Record review of Resident #2's Quarterly Minimum Data Set, dated [DATE], revealed: Section E Behavior Resident #2 had other behavioral symptoms not directed towards others. Resident #2's care plan, dated 7/14/25 revealed the following: Resident #2 had a focus for behavioral symptoms specifically that Resident #2 had potential to demonstrate physical behaviors. (initiated 7/14/25) The goal was for Resident #2 to demonstrate effective coping skills. Interventions included</p>		