STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675527	A. Building B. Wing	04/22/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 1 of 5 residents (Resident #1) reviewed for care plans. The facility failed to develop an accurate, consistent, and completed care plan for Resident #1, specific to Resident #1's dietary needs ordered by the physician. This failure could place residents at risk of not receiving the care required to meet their individualized needs.Findings include: Record review of Resident #1's face sheet, dated 04/21/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Dementia in other diseases classified elsewhere, moderate without agitation (a decline in cognitive abilities that affects a person's daily functioning), age related cognitive decline, dysphagia (difficulty swallowing), Parkinson's disease with dyskinesia and fluctuations (progressive neurological disorder that affects movement), malignant neoplasm of the tonsillar pillar (type of throat cancer), and cognitive communication deficit. Record review of Resident #1's admission MDS assessment, dated10/7/2025, revealed in Section C - Cognitive Patterns, Resident #1 had a BIMS score of 01, which indicated severe cognition impairment. Record review of the current care plan for Resident #1, undated, revealed the following Focus areas: The resident has a swallowing problem r/t throat cancer. Date Initiated: 09/25/2025, with a Goal that stated, (Resident) will not have injury related to aspiration. The Interventions/Tasks included the following, All staff to be informed of resident's special dietary and safety needs. Date Initiated: 09/25/2025; Alternate small bites and sips. Use a teaspoon for eating. Do not use straws. Date Initiated: 09/25/2025.Check mouth after meal for pocketed food and debris. Report to nurse. Provide oral care to remove debris. Date Initiated: 09/25/2025.Diet to be followed as prescribed. Date Initiated: 09/25/2025.Instruct resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly. Date Initiated: 09/25/2025.Monitor for shortness of breath, choking, labored respirations, lung congestion. Date Initiated: 09/25/2025.Monitor/document/report to nurse/dietitian and MD PRN for difficulty swallowing, holding food in mouth, prolonged swallowing time, repeated swallows per bite, coughing, throat clearing, drooling, pocketing food in mouth. Date Initiated: 09/25/2025.Refer to Speech therapist for Swallowing Evaluation. Date Initiated: 09/25/2025.Resident has a diet order other than Regular and is at risk for unplanned weight loss or gain. Large Portions, Mechanical Soft texture, Regular consistency. Date Initiated: 09/25/2025. Revision on: 01/15/2026, with a Goal that stated, Resident will maintain ideal weight and receive proper nutrition daily x 90 days. Date Initiated: 09/25/2025. The Interventions/Tasks included: Determine food preferences and provide within dietary limitations. Date Initiated: 09/25/2025.Encourage meal completion and document amount consumed. Date Initiated: 09/25/2025.House shakes TID. Date Initiated: 01/15/2026.Monitor weight per facility protocol. Date Initiated: 09/25/2025.Offer sub if resident eats less than 50% or dislikes meal and offer supplement if resident continues to eat less than 50%. Date Initiated: 09/25/2025.Place a Red Glass on the (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's meal tray to identify the resident to staff as possibly needing assistance, encouragement, and substitutes. Date Initiated: 01/15/2026. Praise resident for eating well. Date Initiated: 09/25/2025.RD assess per facility protocol Date Initiated: 09/25/2025.Serve diet and snacks as ordered. Date Initiated: 09/25/2025. ST eval and Tx per Physicians orders as condition warrants. Date Initiated: 09/25/2025. Record review of Resident #1's active physician's order, dated 4/21/2026, revealed an order that stated the following: Fortified/Enhanced Diet: diet Pureed texture, Nectar consistency, shakes with all meals/large portions for Weight Gain related to dementia in other diseases classified elsewhere, moderate, with agitation. Order start date: 03/05/2026. Record review of Resident #1's Vitals/Weights Report, dated 04/21/2026, revealed the following weights for the resident: 2/20/2026 - 128.003/13/2026 - 128.004/17/2026 - 130.0 Record review of Resident #1's lunch meal ticket, dated 04/21/2026, indicated Resident #1 received a Regular/Pureed diet. During an observation and interview on 04/22/2026 at 1:00 PM revealed Resident #1 was in the dining room eating lunch. Resident #1 was assisted with his meal by staff. Resident #1 received a pureed meal, and Resident #1 finished all food on his plate. An interview was attempted with Resident #1; however, Resident #1 was unable to be interviewed due to impaired cognitive functioning. CNA A stated Resident #1 received a pureed diet at every meal. During an interview on 04/22/2026 at 9:50 AM, the ADM stated the DON was responsible for ensuring care plans were updated when a resident's physician's orders were changed. The ADM stated, according to Resident #1's active physician order, he should have received a pureed diet. The ADM stated this should have been reflected on Resident #1's care plan as well. The ADM stated when Resident #1's dietary change was ordered by the physician, the care plan should have been updated as soon as possible. The ADM stated care plan reviews were completed at least quarterly. The ADM stated she was not aware Resident #1's care plan reflected a mechanical soft diet. The ADM stated nursing staff received training on care plans upon hire and received regular in-service trainings. The ADM stated it was her expectation that care plans were updated as soon as any changes or updates were received. The ADM stated if a care plan was not accurate, it could affect a resident's daily care and could cause inconsistencies. The ADM stated she would ensure the care plan was reviewed and updated as soon as possible. During an interview on 04/22/2026 at 10:45 AM, the DON stated the Interdisciplinary Team worked together to ensure care plans were updated with any necessary changes, but it was her responsibility to ensure care plans were updated. The DON stated when a resident received an updated dietary order, it was her responsibility to ensure the care plan was updated as well. The DON stated she was not aware Resident #1's care plan indicated he received a mechanical soft diet. The DON stated the care plan should have reflected a pureed diet as indicated in the resident's physician's order. The DON stated she received training on care plans, and all nursing staff received this training upon hire. The DON stated care plans were reviewed regularly and during quarterly reviews. The DON stated it was her expectation the facility staff worked collectively, as a team, to ensure care plans were updated and accurate. The DON stated if a care plan was not updated or accurate, all staff may not be updated on a resident's current needs. The DON stated she would do a full review of the resident's care plan as soon as possible to ensure it was updated and accurate. The DON stated that a resident not receiving the correct diet could impact the resident's nutrition. Record review of the facility's, undated, policy titled, Comprehensive Care Planning reflected the following: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and time limits to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following -The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; and.Comprehensive Care PlansA comprehensive care plan will be- The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences, and needs of the resident and in response to current interventions.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident was offered a therapeutic diet when there was a nutritional problem and the health care provider ordered a therapeutic diet for 1 of 5 residents (Resident #1) reviewed for therapeutic diets.The facility failed to ensure Resident #1 was given supplemental shakes at every meal (three times a day) as ordered by the physician. This failure could place residents at risk for poor intake, weight loss, unmet nutritional needs, and a loss of dignity.Findings include: Record review of Resident #1's face sheet, dated 04/21/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included the following: Dementia in other diseases classified elsewhere, moderate without agitation (c a decline in cognitive abilities that affects a person's daily functioning), age related cognitive decline, dysphagia (difficulty swallowing), Parkinson's disease with dyskinesia and fluctuations (progressive neurological disorder that affects movement), malignant neoplasm of the tonsillar pillar (type of throat cancer), and cognitive communication deficit. Record review of Resident #1's admission MDS assessment, dated10/7/2025, revealed in Section C - Cognitive Patterns, Resident #1 had a BIMS score of 01, which indicated severe cognition impairment. Record review of the current care plan for Resident #1, undated, revealed the following Focus areas: The resident has a swallowing problem r/t throat cancer. Date Initiated: 09/25/2025, with a Goal that stated, (Resident) will not have injury related to aspiration. The Interventions/Tasks included the following, All staff to be informed of resident's special dietary and safety needs. Date Initiated: 09/25/2025; Alternate small bites and sips. Use a teaspoon for eating. Do not use straws. Date Initiated: 09/25/2025.; Check mouth after meal for pocketed food and debris. Report to nurse. Provide oral care to remove debris. Date Initiated: 09/25/2025.; Diet to be followed as prescribed. Date Initiated: 09/25/2025.; Instruct resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly. Date Initiated: 09/25/2025.; Monitor for shortness of breath, choking, labored respirations, lung congestion. Date Initiated: 09/25/2025.; Monitor/document/report to nurse/dietitian and MD PRN for difficulty swallowing, holding food in mouth, prolonged swallowing time, repeated swallows per bite, coughing, throat clearing, drooling, pocketing food in mouth. Date Initiated: 09/25/2025. ; Refer to Speech therapist for Swallowing Evaluation. Date Initiated: 09/25/2025. Resident has a diet order other than Regular and is at risk for unplanned weight loss or gain. Large Portions, Mechanical Soft texture, Regular consistency. Date Initiated: 09/25/2025. Revision on: 01/15/2026, with a Goal that stated, Resident will maintain ideal weight and receive proper nutrition daily x 90 days. Date Initiated: 09/25/2025. The Interventions/Tasks included: Determine food preferences and provide within dietary limitations. Date Initiated: 09/25/2025.; Encourage meal completion and document amount consumed. Date Initiated: 09/25/2025.; House shakes TID. Date Initiated: 01/15/2026.; Monitor weight per facility protocol. Date Initiated: 09/25/2025.; Offer sub, if resident eats less than 50% or dislikes meal and offer supplement if resident continues to eat less than 50%. Date Initiated: 09/25/2025.:, Place a Red Glass on the resident's meal tray to identify the resident to staff as possibly needing assistance, encouragement, and substitutes. Date Initiated: 01/15/2026.; Praise resident for eating well. Date Initiated: 09/25/2025.; RD assess per facility protocol Date Initiated: 09/25/2025; Serve diet and snacks as ordered. Date Initiated: 09/25/2025.; ST eval and Tx per Physicians orders as condition warrants. Date Initiated: 09/25/2025. Record Review of Resident #1's lunch meal ticket dated 04/21/2026 indicated Resident #1 received a Regular/Pureed diet. There was no supplemental shake listed on the meal ticket. Record review of Resident #1's Vitals/Weights Report, dated 04/21/2026 revealed the following weights for the resident: 2/20/2026 - 128.003/13/2026 - 128.004/17/2026 - 130.0 Record review of Resident #1's active physician's order, dated 4/21/2026, revealed an order that stated the following: Fortified/Enhanced Diet: diet Pureed texture, Nectar consistency, shakes with all meals/large (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	portions for Weight Gain related to dementia in other diseases classified elsewhere, moderate with agitation. Order start date: 03/05/2026. During an observation and interview on 04/22/2026 at 1:00 PM revealed Resident #1 in the dining room eating lunch. Resident #1 was assisted with his meal by staff. Resident #1 was had a pureed diet. There was no shake observed with Resident #1's meal. CNA A stated there was no supplemental shake served for Resident #1 during the meal. CNA A stated she did not know why the supplemental shake was not listed on Resident #1's meal ticket. CNA A stated the supplemental shake should have been listed on Resident #1's meal ticket. CNA A stated a supplemental shake was always provided by CNA A if Resident #1 did not finish his meal. CNA A stated Resident #1 usually had a good appetite and ate all of his food. Resident #1 received a pureed meal, and Resident #1 finished all food on his plate. An interview was attempted with Resident #1; however, Resident #1 was unable to be interviewed due to impaired cognitive functioning. During an interview on 04/22/2026 at 9:50 AM, the ADM stated she was not aware Resident #1 was not receiving supplemental shakes at every meal. The ADM stated Resident #1's physician order for supplemental shakes at every meal should have been reflected on the resident's meal ticket. The ADM stated dietary staff relied on the meal ticket to ensure therapeutic diets were followed for each resident. The ADM stated the DON was responsible for ensuring dietary orders were communicated to the Dietary Manager. The ADM stated the facility's current Dietary manager began working at the facility on 04/20/2026 and would not have been aware of Resident #1's current dietary order. The ADM stated she did not know why the meal ticket did not reflect the physician's order for supplemental shakes at every meal. The ADM stated a review would be completed to ensure the meal ticket was updated and Resident #1 was receiving his accurate therapeutic diet needs. The ADM stated Resident #1 did not have any significant weight loss over the last 90 days. The ADM stated Resident #1 was documented to have a good appetite and usually ate well. The ADM stated staff received regular training on following physician orders. The ADM stated if the resident's diet was a physician order, the DON was responsible for ensuring this was communicated to the dietary staff. The ADM stated it was her expectation that all physician orders were followed and diet orders were complied with. The ADM stated if a resident was not receiving their physician ordered diet, it may impact the resident's nutritional status and could contribute to weight loss or inconsistencies. During an interview on 04/22/2026 at 10:45 AM, the DON stated she was responsible for communicating therapeutic diets ordered by the physician to the Dietary Manager. The DON stated there was not a Dietary Manager for the facility when Resident #1 received the physician order for supplemental shakes at every meal. The DON stated she was not aware Resident #1 was not receiving the supplemental shakes with each meal or that the dietary order was not reflected on the resident's meal ticket. The DON stated the dietary staff relied on the meal ticket to ensure diets were followed as ordered by the resident's physician. The DON stated she did not know why Resident #1's meal ticket was not updated to include supplemental shakes at each meal as ordered by his physician. The DON stated Resident #1 did not have significant weight loss in the past 90 days. The DON stated she did audit meal tickets frequently, and she would complete a full audit on all meal tickets to ensure they were all accurate. The DON stated Resident #1's meal ticket had been updated on this date, 04/22/2026, to now include his dietary order for supplemental shakes at each meal. The DON stated if a resident's dietary orders were not communicated accurately to the dietary staff, the resident's nutrition could be impacted. Record review of the facility's policy related to following physical orders for therapeutic diets was requested. The facility did not provide a policy related to therapeutic diets or following physician orders.