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	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whisperwood Nursing & Rehabilitation Center	5502 4th Street 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services. The facility failed to ensure the dishwasher was working properly with the hot water temperature and the facility failed to allow the food processor for puree to air-dry completely before using. These failures could place residents at risk for food contamination and foodborne illness. The findings include: Observations during the puree process on 01/21/26 at 11:36 AM revealed [NAME] A pureed hamburger patties in the food processor. After the hamburger patties were pureed, [NAME] A transferred the food to a smaller container and then [NAME] A washed the food processor in a 3-compartment sink and then placed the food processor on a tray to go through a wash cycle in the low temperature/chemical dishwasher. The food processor was removed from the tray when the wash cycle was completed, and the food processor was then picked up and placed back on the machine with liquid dripping from the food processor. [NAME] beans were added to the food processor to puree. The green beans were pureed and transferred to a smaller container and then [NAME] A washed the food processor in a 3-compartment sink and then placed the food processor on a tray to go through a wash cycle in the low temperature/chemical dishwasher. It was noted at this time that the dishwasher temperature in the wash cycle did not go above 88 degrees F. The data plate on the dishwasher stated the wash cycle minimum temperature should be 120 degrees F. During an interview on 01/21/26 at 11:45 AM, [NAME] A stated she had checked the dishwasher temperature earlier that morning and it was reaching 120 degrees F. [NAME] A stated she did not know what changed but she would get the DM to help. During an interview on 01/21/26 at 11:50 AM, the DM stated she did not know what was wrong with the dishwasher, but the facility would not use it until it could be serviced, and the facility would use a 3-compartment sink for this time. During an interview on 01/21/26 at 12:14 PM, the DM stated a switch had been turned off to the water booster and that was why the dishwasher was not reaching up to temperature. The DM stated she was not sure who switched off the water booster. During an interview on 01/23/26 at 9:17 AM, [NAME] A stated she had been trained to let the food processor air-dry completely before using again. [NAME] A stated she was trying to get the puree food done on time for the meal and that was why she did not let it air-dry before using it. [NAME] A stated it had been a while since she had been trained and could not remember exactly. [NAME] A stated a potential negative outcome to the residents was it could cause the food to taste different. [NAME] A stated she did not know what happened to the dishwasher not getting up to 120 degrees F. [NAME] A stated she had been trained to check the dishwasher temperatures when using but had forgotten to check during the puree process. [NAME] A stated a potential negative outcome to the residents was it could make them sick if the dishes were not cleaned properly. During an interview on 01/21/26 at 9:25 AM, the DM stated the dietary staff were trained on allowing the food processor to air-dry and checking the temperature of the dishwasher. The DM stated she had only worked at the facility for about a month, so she was not sure the last time the dietary staff were trained in these areas. The DM stated she expected the dietary staff to check the dishwasher temperature every time it gets used. The DM stated a potential negative outcome to 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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents with not allowing the food processor to air dry was it could have some sanitizer or chemicals still in there. The DM stated a potential negative outcome to the residents with the dishwasher not reaching a minimum temperature of 120 degrees F was it could not be hot enough for the chemicals to work on the dishes. During an interview on 01/23/26 at 9:45 AM, the ADM stated she would need to look at the facility policy regarding the puree process and air-drying the food processor before using. The ADM stated she did not know when the cooks were last trained on the puree process and stated they were trained on hire and orientation for new cooks. The ADM stated not allowing the food processor to air-dry could contaminate the food. The ADM stated the kitchen staff were trained on checking the dishwasher temperatures. The ADM stated she expected the dishwasher temperature to be checked before washing dishes with it. The ADM stated she expected a 3-compartment sink to be used if the dishwasher could not be used. The ADM stated a potential negative outcome to the residents was that the dishes could be contaminated and spread infection. Record review of the facility policy titled, Dishwashing Preparation and Dishwashing, undated, reflected the following: The facility will complete the dishwashing process in a sanitary manner to provide clean and sanitary dishes and utensils.Procedure:.2. Automatic dishwasher: Low temperature machinec. The wash period shall be at least 40 seconds with a temperature of 120 degrees F in dish machine. The sanitizing rinse period shall be at least 20 seconds with minimum temperature of 120 degrees F. Record review of the facility's policy titled, Equipment Sanitation, undated, reflected the following: We will provide clean and sanitized equipment for food preparation. The facility will clean all food service equipment in a sanitary manner.Procedure:.8. Blenders and food processors bowls should be inverted after cleaning to drain dry on shelves or trays with vented slots or bar netting. Record review of the chemical label for the dishwasher titled, Sani 3000 Liquid Dish Machine Sanitizer, undated, reflected the following: Keep out of reach of Children. Danger.First Aid: Ingestion: DO NOT induce vomiting. DO NOT give carbonate of any kind. Give large amounts of water. Consult physician immediately.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to maintain and ensure safe and sanitary storage of residents' food items for 1 of 1 Resident's personal refrigerators reviewed for food safety (Resident #66) in that: The facility did not have a system in place to assist residents in cleaning and maintaining their personal refrigerators to ensure safe food handling and prevent consumption of spoiled and/or expired foods. The personal refrigerator in Resident #66's room did not contain a thermometer. The refrigerator contained an unknown substance that was unlabeled and undated. Resident #66 was unable to identify an unlabeled and undated unknown substance in the personal refrigerator. These failures could place residents at risk for food borne illnesses.Findings include: Record review of Resident #66's electronic face sheet dated 01/23/2026 revealed a [AGE] year-old female admitted to the facility on [DATE]. The face sheet included the following diagnoses: Schizoaffective disorder, bipolar type (a chronic mental illness combining symptoms of schizophrenia (hallucinations, delusions, disorganized thinking) with symptoms of bipolar disorder (manic episodes with high energy, irritability, impulsivity, and sometimes depressive episodes); bipolar disorder; and Alzheimer's Disease, unspecified, (progressive, irreversible neurodegenerative brain disorder and the most common cause of dementia (loss of cognitive functioning, thinking, memory, mood, and behavior)). Record review of Resident #66's Annual MDS dated [DATE], under Section C Cognitive Patterns, revealed a BIMS of 10, indicating the resident was moderately cognitively impaired. During an observation and interview on 01/22/2026 at 9:15 AM, Resident #66's room contained a personal refrigerator. There was not a thermometer present indicating the refrigerator's temperature. The refrigerator contained perishable items such as cans of soda and an unknown brown substance in an undated, unlabeled zip lock bag. Resident #66 stated she did not know who cleaned her refrigerator. Resident #66 stated she was not aware of a zip lock bag of food in her refrigerator and could not state what was in the bag. Resident #66 stated she did not know how often her refrigerator was supposed to be clean. Resident #66 did not respond when asked if anyone had ever cleaned it out for her. During an interview on 01/23/2026 at 11:00 AM, the ADM stated residents, and their families were responsible for maintaining their personal refrigerators. The ADM stated this included cleaning the refrigerator, storing food properly, and discarding spoiled food items. The ADM stated facility staff could assist, if needed, but there was no specific staff assigned to this duty. The ADM stated the facility relied on family and residents to ensure the refrigerators were maintained. The ADM stated she believed all personal refrigerators contained a thermometer, purchased by the family. The ADM stated there was no task assigned to facility staff to check personal refrigerators to ensure they were maintaining a safe temperature. The ADM stated if a resident were not cognitively capable of maintaining their refrigerator themselves, the family would be responsible for maintaining it. The ADM stated if a resident's family did not visit frequently and the resident was not cognitively or physically capable of maintaining their personal refrigerator, a facility staff could assist the resident, but there was no current system in place to ensure this was done. The ADM stated the facility administration staff make rounds to resident rooms and could assist residents with checking their personal refrigerators, but there was no current system in place to ensure this was done. The ADM stated a cognitively impaired resident that had no frequent visitors was permitted to have a personal refrigerator in their room. The ADM stated there was no system in place to ensure resident's personal refrigerators were consistently maintained. The ADM stated if a resident or resident's family were unable to maintain the personal refrigerator in the resident's room, it was possible expired or spoiled food could be left in the refrigerator and there was a risk of residents consuming the food. Record review of the facility's policy titled Personal Refrigerators Policy, Environmental Services Policy and Procedure 2026, revealed: Residents of the facility may place a personal or dormitory size refrigerator in their room if space permits and under Life Safety Code regulations, that the resident room has an (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	adequate electrical system, such as proper outlets, to allow the connection of a refrigerator without overloading the electrical system. The care and maintenance of any refrigerator is the responsibility of the resident and/or responsible party. It is also the responsibility of the resident and/or resident representative to properly store non-facility supplied foods that require refrigeration in their personal refrigerator. If food is expired or appears spoiled or moldy, the facility reserves the right to discard it. Housekeeping can assist the residents and/or family member by inspecting the refrigerators at least weekly and assist with removal of outdated food items and cleanliness.Care and MaintenanceThe resident and/or resident representative should clean and maintain the refrigerators according to the manufacturer's user manual. If needed you can ask facility housekeeping or maintenance staff for assistance. Temperature ControlThe refrigerator compartment should be maintained at temperature of 35-41 degreesThe freezer compartment should be maintained at zero degrees or less, or food frozen to a solid state Temperatures can be monitored by the use of a thermometer designed for a refrigerator/freezer that can be purchased from a department store.Cold Food StorageFood should be stored in the refrigerator/freezer as determined by the food item. Commonly Used DatesSell by date - indicates that a product should not be sold after that date if the buyer is to have it at its best qualityBest by or Use by date -the maker's estimate of how long a product will keep at its best quality. They are quality dates only, not safety dates. If stored properly, a food product should be safe. wholesome and of good quality after its Use by or Best by date. Expired date - the food items should not be consumed and should be discarded if not eaten by the expiration dateFruits and Vegetables - should not be consumed and should be discarded if there are signs of spoilage. Signs of spoilage on fruits and vegetables are mold, a soft and mushy consistency, and a bad smell.Regardless of dates, if any food that shows signs of spoilage should not be consumed and should be discarded.DietsIt is recommended that food stored in the refrigerator that is to be consumed by the resident should be according to the resident's diet ordered by the physician. Risks associated with non-compliance with diet (this is not an all-inclusive list); hyperglycemia (high blood sugar), aspiration, pneumonia, choking, and up to and including death. If you have any questions related to the resident's diet, please refer to the nurse.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1 of 3 Residents (Resident #6) reviewed for hospice care: The facility failed to ensure Resident #6 had a physician's order for hospice care. This failure could result in residents not receiving care without a physician's order.The findings included: Record review of the admission record for Resident #6, dated 01/21/26 revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: dementia (a decline in mental ability), dysphagia (difficulty swallowing), and age-related cognitive decline. The admission record revealed Resident #6 used Hospice Company A. Record review of the annual MDS for Resident #6, dated 10/07/25, Section O revealed Resident #6 was receiving hospice services. Record review of the care plan for Resident #6, last reviewed on 12/10/25, revealed a focus area for: [Resident #6] has a terminal prognosis and/or is receiving hospice services, initiated on 09/25/25. Record review of the physician orders for Resident #6, dated 01/23/26, revealed no physician order for hospice care services. Record review of a facility document titled, MDS Resident Matrix, dated 01/21/26 revealed Residents #6 was checked off for Hospice. During an interview on 01/22/26 at 3:17 PM with LVN and the ADON, LVN A stated she did not see a physician order for hospice for Resident #6. LVN A stated she knew Resident #6 was on hospice services because it stated what hospice was used in the banner in his chart. The ADON stated it was nursing in general who were responsible for ensuring a resident had physician orders for hospice services. The ADON stated she did not think he needed a physician order for hospice services because the hospice physician writes orders for Resident #6. LVN A stated she did not know why Resident #6 did not have a physician order for hospice. The ADON stated a potential negative outcome for the residents was not contacting the correct provider or they [the facility] could do something not on hospice orders. During an interview on 01/22/26 at 3:30 PM with the DON and the Corporate Nurse, the DON stated it was unknown why Resident #6 did not have a physician order for hospice. The DON stated she knew Resident #6 was on hospice because it stated on the banner in his chart. The DON stated the nurse or the MDS nurse usually put in hospice orders on admission. The Corporate Nurse stated a potential negative outcome to the residents was there would be an unknown diagnosis for why hospice was treating the residents. During an interview on 01/23/26 at 9:45 AM, the ADM stated she expected there to be a physician order for hospice services and the diagnosis. The ADM stated the nurse who was responsible for receiving the order for hospice from the physician was the nurse responsible for ensuring the order was put in. The ADM stated all the nurses had been trained. The ADM stated a potential negative outcome to the residents was she was unsure if the physician was aware there was not an order for hospice. Record review of the facility policy and procedure titled, Hospice Services, undated, reflected the following: As an end of life measure, the resident or responsible family member may choose to use hospice services within the facility.Procedures:11. The DON or designee will be responsible for ensuring that documentation is a part of the current clinical record. At a minimum, the documentation will include: Physician Certification of Terminal Illness.