STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366014	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whispering Hills Rehabilitation and Nursing Center	416 Wooster Road Mount Vernon, OH 43050

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure Resident #13 and #44 received a written bed hold authorization letters and the Ombudsman was notified of all hospitalization and discharges. This affected two residents (Resident #13 and #44) of three residents reviewed for discharge planning. The facility census was 38.Findings Include: 1. Review of Resident #44 ' s medical record revealed admission date 01/05/26 and a discharge to the hospital on [DATE] with diagnoses including but not limited to chronic obstructive pulmonary disease, unspecified sequelae of cerebral infarction, dysphagia, hypertension, anxiety disorder and depression. Review of Resident #44 ' s admission Minimum Data Set (MDS) dated [DATE] revealed Resident #13 was cognitively intact with a Brief Interview Mental Status (BIMS) score of 14 out a possible 15 and required staff assistance with Activities of Daily Living (ADL) tasks. Further review revealed Resident #44 was his own representative and had a family member as an emergency contact. a. Review of Resident #44 ' s Interact Transfer assessment dated [DATE] revealed Resident #44 was transferred to the hospital for shortness of breath, diaphoretic (excessive, often cold or clammy, sweating that is not caused by heat or exercise) and panicking. Review of Resident #44 ' s progress notes dated 01/24/26 at 7:00 P.M. revealed Resident #44 came to the nurse ' s station in a panic stating he was having difficulty breathing, resident appeared diaphoretic. The physician and family were notified of the transfer. Review of the facility Bed Hold Authorization letter dated 01/24/26 revealed Resident #44 had 30 Medicaid bed hold days remaining. Resident #44 did not sign or date the bed hold authorization acknowledging the receipt of the bed hold notice. The Business Office Manager (BOM) #435 had signed and dated the form and had noted Resident #44's sister was notified of the bed old letter. Further review of the bed hold authorization letter revealed the facility must distribute copies of the completed bed hold notice at the time of transfer with the original document issued to the resident or resident representative. Interview on 02/19/26 at 12:44 P.M. with Business Office Manager (BOM) #435 confirmed Resident #44's sister had only been contacted for the bed hold authorization via telephone on 01/24/26 and a written bed hold notification was not issued to Resident #44 upon transfer to the hospital. b. Review of the Notification to Ombudsman of Resident discharge date d 02/19/26 revealed the Ombudsman had not been notified of Resident #44 ' s hospitalization on 01/24/26. Interview on 02/19/26 at 12:44 P.M. with BOM #435 verified she does not notify the Ombudsman of Resident #44's discharge to the hospital. (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #13 ' s medical record revealed admission date 12/24/25 and a discharge to the hospital on [DATE] with diagnoses including but not limited to osteomyelitis, depression, unhealed pressure ulcers, and paraplegia. Review of Resident #13 ' s Medicare/5-Day Minimum Data Set (MDS) dated [DATE] revealed Resident #13 was cognitively intact with a Brief Interview Mental Status (BIMS) score of 15 out a possible 15 and required staff assistance with Activities of Daily Living (ADL) tasks. Further review revealed Resident #13 was his own representative and had a family member as an emergency contact. Review of Resident #13 ' s Interact Transfer assessment dated [DATE] revealed Resident #13 was transferred to the hospital for specific laboratory testing of blood cultures related to unhealed pressure ulcers with osteomyelitis. Review of Resident #13 ' s progress notes dated 02/03/26 12:40 P.M. revealed Resident #13 was transferred to the hospital for further laboratory testing related to unhealed pressure ulcers with osteomyelitis. The physician, resident and resident family member were notified of the hospital transfer. Review of the facility Bed Hold Authorization letter dated 02/03/26 revealed Resident #13 has 30 Medicaid bed hold days remaining. Resident #13 did not sign or date the bed hold authorization acknowledging the receipt of the bed hold notice. The Business Office Manager (BOM) #435 had signed and dated the form and had noted Resident #13 had been contacted by telephone concerning the bed hold letter. Further review of the bed hold authorization letter revealed the facility must distribute copies of the completed bed hold notice at the time of transfer with the original document issued to the resident or resident sponsor. Resident #13 remained hospitalized at the time of the onsite survey. Interview on 02/19/26 at 12:44 P.M. with BOM #435 confirmed Resident #13 had only been contacted for the bed hold authorization via telephone on 02/03/26 and a written bed hold notification was not issued to Resident #13 upon transfer to the hospital. Review of the facility ' s policy titled Bed-Holds and Returns undated revealed prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review the facility failed to assist a dependent resident with fingernail care. This deficient practice affected one resident (Resident #3) out of two residents reviewed for Activities of Daily Living. The facility census was 38.Findings Include: Review of Resident #3's medical record revealed admission date 08/04/25 with diagnoses including but not limited to respiratory failure, type two Diabetes, depression, history of stroke and vascular dementia.Review of Resident #3's self-care deficit care plan dated 08/05/25 revealed Resident #3 required encouragement and assistance from staff to complete self-care tasks.Review of Resident #3's Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #3 had impaired cognition with a Brief Interview Mental Status (BIMS) score of 11 out of possible 15, used a wheelchair for mobility, and was dependent on staff for the completion of personal hygiene tasks.Review of Resident #3's shower documentation dated from 01/12/26 to 02/16/26 revealed on 01/22/26 Resident #3's fingernails had been trimmed and there were no further documentation of nails being trimmed. An observation on 02/17/26 at 10:25 A.M. revealed Resident #3 resting in bed with bilateral hands visible. Resident #3's fingernails were observed to have chipped light blue fingernail polish. All fingernails were long and had dark colored substances observed under the nails.An interview on 02/18/26 at 10:41 A.M. with Certified Nursing Assistance (CNA) #107 confirmed Resident #3 had long dirty fingernails and the staff should be assisting Resident #3 in cleaning and trimming her fingernails on a regular basis.Review of the facility's policy titled Care of Fingernails/Toenails dated 10/2010 revealed nail care includes daily cleaning and regular trimming.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, interview, and record review the facility failed to ensure Resident #18 had audiology follow up completed. This affected one (#18) of one residents reviewed for hearing or vision concerns. The census was 38. Findings include:Record review for Resident #18 revealed an admission date of 05/16/25. Diagnoses include type II diabetes without complications, essential (primary) hypertension, peripheral vascular disease, acquired absence of right leg above knee, plasma cell leukemia having not achieved remission, solitary plasmacytoma not having achieved remission, need for assistance with personal care, adjustment disorder with mixed anxiety and depressed mood, and bilateral hypertensive retinopathy.Review of Resident #18's 360 care Audiology appointment dated 09/29/25 9:30 A.M. exam revealed Resident #18 was referred by the facility due to decreased hearing. A otoscopy was completed and it revealed impacted cerumen of both ears. Debrox (ear wax softener used to help remove wax from the ears) was recommended for cerumen management. Follow up noted as cerumen management in 1-3 months.Review of Resident #18's quarterly Minimum Data Set (MDS) 3.0 dated 01/25/26 revealed a Brief Interview for Mental Status (BIMS) score of 15. Review of Resident #18's hearing, speech, and vision, revealed Resident #18 had minimal difficulty with hearing and no hearing aids.Review of Resident #18's care plan confirmed Resident #18 has a communication deficit problem related to hearing deficit. Goal to maintain current level of communication through the review date. Interventions include being conscious of resident position when in groups, activities, dining room to promote proper communication with others, prefers communicating with the television off, monitor/document/report PRN changes in ability to communicate, refer to audiology for hearing consult as ordered.Observation on 02/17/6 at 10:16 A.M. revealed Resident #18 was pointing to their ears while attempting to communicate.Interview on 02/18/26 at 4:25 P.M. with the Social Worker confirmed Resident #18 was not scheduled for a follow-up Audiology appointment.Review of the facility's policy titled, Referral Agreements dated 10/2008 confirmed to facilitate referrals, the facility has entered into referral agreements with agencies that will provide services to residents. The scope of agencies and the agreements are consistent with the needs of the facility's resident population. Inquiries concerning the availability and use of referral agencies should be directed to social services or to administrator.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and policy review the facility failed to ensure appropriate trach care was provided. This affected one resident (Resident #34) of one residents observed for trach care.Findings Include: Review of the medical record for Resident #34 revealed an admission date 02/10/26 with diagnosis including but not limited to malignant neoplasm of tongue, protein-calorie malnutrition, dysphagia, and anxiety. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #34 had intact cognition and required tracheostomy (trach) care daily. Review of the physician orders dated 02/10/26 revealed trach care per protocol and speaking/[NAME] Muir valve to trach, as tolerated cuff must be deflated on trach prior to placement of speaking valve.Observation on 02/19/26 at 1:35 P.M. of Resident #34's trach care with Registered Nurse (RN) #315 revealed during trach care RN #315 removed the speaking valve off the trach and placed it on the bed side table. RN #315 suctioned Resident #34 and placed the suction tubing on the bedside table and the end of the suction tubing fell into the clean hydrogen peroxide/normal saline solution to clean the trach area. RN #315 continued with trach care and removed the trach collar to clean under the collar, (with the hydrogen peroxide solution that the suction tubing fell into). RN #315 let go of the trach cannula and Resident #34 coughed the outer trach tube cuff out, onto Resident #34's chest. RN #315 quickly picked up the trach cannula and inserted it back into trach stoma. RN #315 then picked up the speaking valve (that had fallen on the floor) and secured it back on the trach cuff. Interview on 02/19/26 at 2:05 P.M. with RN #315 verified the above observation of the suction tubing falling into the clean solution (the suction tubing is not considered clean). RN #315 verified the outer trach cuff fell out of the trach stoma and she put it back in and did not get a new trach tube cuff. RN #315 verified she should not have put the dirty speaking valve that had fallen on the floor back on the trach cuff, she should have replaced it with a new speaking valve. Review of the facility policy Tracheostomy Care, dated August 2013 revealed aseptic technique (using sterile gloves, tools, and solutions to clean the stoma and inner cannula) must be used.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Resident #20 received antipsychotic medication as scheduled and per the resident's routine dose resulting in a significant medication error. This affected one (Resident #20) out of six residents reviewed for medications. The facility census was 38. Findings include: Review of the medical record revealed Resident #20 was admitted on [DATE] with diagnoses that included schizoaffective disorder bipolar type, borderline intellectual functioning, and Asperger's syndrome. A care plan dated 02/05/24 revealed Resident #20 required psychotropic/mood stabilizer medications for behavior management. Interventions included to administer psychotropic/mood stabilizer medications as ordered. A care plan dated 02/09/24 revealed Resident #20 had behavior problems with interventions that included to administer medications as ordered. A psychiatric note dated 10/01/25 revealed Resident #20 received Invega Sustenna (atypical antipsychotic) 156 milligram/milliliter (mg/ml) intramuscular (IM) injection every 28 days for schizoaffective disorder. An electronic medical administration record progress note dated 11/20/25 at 9:27 P.M. revealed Resident #20's Invega was on order. A general progress note dated 11/21/25 at 12:13 P.M. revealed Resident #20's Invega was delivered. The physician was notified and was agreeable to administering Invega 156 mg/ml one time only. (Please note, the psychiatrist who gave the initial medication order, was not contact).There was no record of administration for the resident's Invega (ordered monthly) administered in December 2025. A general progress note dated 01/11/26 at 8:10 A.M. revealed Resident #20 approached the nurse and asked about their (routine) Invega injection. The nurse called the psychiatric provider to ask about a clarification. A progress note dated 01/11/26 at 8:42 A.M. revealed the facility was awaiting a call back from psychiatric provider. The on-call medical provider was notified (not the psychiatrist), and a new order was received to administer Invega 117 mg IM one time only. The facility to contact psychiatric services for continued taper increase dose on next business day. A progress note dated 01/13/26 at 9:27 A.M. revealed Resident #20 was administered Invega 117 mg IM on 01/12/26. A general progress note dated 01/14/26 at 1:49 P.M. revealed a clarification order was received from psychiatric certified nurse practitioner. Resident #20 was to receive Invega 156 mg/ml on 01/27/26 and then every 28 days. A psychiatric progress note dated 01/14/26 revealed a facility nurse called and was uncertain why Resident #20 Invega injections was not on the MAR for December (not administered). The resident had asked about the injection, and it was discovered the dose was past due. The on-call medical doctor was notified and gave an order to administer Invega 117 mg IM. It had been more than six weeks since the last injection so Resident #20 would require an additional dose in one week. Resident #20 was scheduled to receive 156 mg/ml on 01/27/26 and then every 28 days. The annual Minimum Data Set (MDS) dated [DATE] revealed Resident #20 was cognitively intact. The resident had delusions and received antipsychotic medications. A physician order dated 01/27/26 revealed Resident #20 was ordered Invega intramuscular injection every 28 days for schizoaffective disorder. A psychiatric note dated 01/28/26 revealed Resident #20 took medication as prescribed and missed a dose of Invega. The medical team ordered a low loading dose of Invega, and an additional dose was administered one week later. Invega was discontinued by the medical provider on 11/20/25. Interview during the onsite survey was attempted with Resident #20 however the resident was unable to be interviewed due to cognition. An interview on 02/18/26 at 10:38 A.M. Director of Nursing (DON) verified Resident #20 missed a scheduled dose of Invega in December. DON stated Invega was not available on the scheduled date in November. The nurse obtained a new order so Invega could be administered when it arrived. The new order was one time only and not for every 28 days which resulted in the Invega order not being resumed monthly in December 2025, causing the omitted dose.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff interviews, the facility failed to provide required specialized rehabilitative services (speech therapy) for one of one residents reviewed (Resident #17) who was identified as needing further swallowing assessment. Findings include: Review of the medical record revealed Resident #17 was admitted on [DATE] with diagnoses including dysphagia, traumatic brain injury, schizophrenia, major depressive disorder, type II diabetes mellitus, and other chronic medical conditions.Review of the comprehensive Minimum Data Set (MDS) dated [DATE] reflected cognitive impairment.Review of the Registered Dietitian (RD #316) Weight Review dated 02/19/2026 revealed Resident #17 experienced significant weight loss. The RD documented the resident recently had teeth extracted and requested a Speech-Language Pathology (SLP) evaluation to assess swallowing function and determine if the current diet order remained appropriate. Review of physician orders and therapy documentation revealed no evidence that an SLP evaluation was completed following the RD's documented recommendation.On 02/19/2026 at 11:06 A.M., interview with Therapy Manager (TM #115) revealed therapy typically received referrals verbally from nursing staff. TM #115 confirmed the speech therapist had not seen Resident #17 since July 2025 and stated documentation would be present if an evaluation had been completed.On 02/19/2026 at 11:15 A.M., interview with Director of Nursing (DON #111) and Regional DON (#418) revealed staff enter therapy orders and verbally notify therapy when referrals are made. The DON acknowledged being unaware the SLP evaluation had not been completed for Resident #17.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review the facility failed to ensure Resident #34 and Resident #37 had complete and accurate medical records. This affected 2 of 16 medical records reviewed. The census was 38. Finding include: Record review of Resident #34's medical record revealed an admission date of 02/10/26. Diagnoses include malignant neoplasm of tongue and mouth, dysphagia, and tracheostomy status. Review of Resident #34's comprehensive The Minimum Data Set (MDS) 3.0 dated 02/17/26 revealed a Brief Interview for Mental Status (BIMS) score of 15. Record review of Resident #34's medical record revealed an active physician order for Nothing by Mouth (NPO) diet Nothing by Mouth texture, nothing by mouth consistency dated 02/10/26. Review of Resident #34's medical record revealed a care plan stating Resident #34 has an alteration in neurological status related to dysphagia. Goals include being able to function at the fullest potential possible as outlined by the interdisciplinary team, will maintain optimal status and quality of life within limitations imposed by neurological deficits, and will free from signs and symptoms of complications of dysphagia (aspiration pneumonia and dehydration). Interventions include adjust diet to accommodate chewing, swallowing, or eating issues to maximize independence and nutritional intake, give medications as ordered, monitor intake to assure an adequate fluid intake to prevent dehydration, physical therapy, occupational therapy, and speech therapy evaluate and treat as ordered. Observation on 02/17/26 at 12:30 P.M revealed Resident #34 with clear liquids on bedside table. Observation on 02/17/26 at 4:18 PM revealed Resident #34 with clear liquids on bedside table. Interview on 02/17/26 at 4:20 P.M. with LPN#104 confirmed Resident #34 has been getting clear liquids stating Resident #34 had an appointment the day prior and had an order for clear liquids. LPN #104 confirmed there was no order in Resident #34's medical record for clear liquid diet and was observed entering the clear liquid diet order into electronic medical record (EMR). Review of Resident #34's order/change of diet communication sheet for dietary staff revealed Resident #34 was upgraded to clear liquid diet on 02/16/26 with communication signed by LPN #104. Interview on 02/18/26 at 11:25 AM with Rehab Director confirmed Resident #34 did have swallow study and they advised she could tolerate clear liquid diet. The nurses are responsible for entering new diet orders when a resident comes from an appointment. Interview on 02/19/26 at 3:25 P.M. with Rehab Director and Regional Nurse revealed Resident #34's clear liquid diet order was not immediately entered because the facility's speech therapist was trying to clarify if Resident #34 should be on full liquid diet or clear liquid diet. Rehab Director and Regional Nurse confirmed the clear liquid diet order was communicated to the kitchen before clarification was received and Resident #34 was receiving clear liquid diet. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record revealed Resident #37 was admitted on [DATE] with diagnoses that included fracture of sacrum, major depressive disorder, and adjustment disorder with anxiety. Fall risk assessments dated 12/05/25, 12/27/25, 01/08/26, and 01/22/26 revealed Resident #37 was at high risk for falls. A care plan dated 12/08/25 revealed Resident #37 was at high risk for falls. Interventions included to encourage resident to use adaptive devices, ensure non-skid footwear, call light within reach, and bed in the lowest position. The 5-day Medicare Minimum Data Set (MDS) dated [DATE] revealed Resident #37 had cognitive impairment. A general progress note dated 12/27/25 at 1:14 A.M. revealed a Certified Nursing Assistant (CNA) went to answer Resident #37's call light and found the resident on his knees facing the bed. Resident #37 stated he slid off the bed. Resident #37 denied any pain or discomfort. A Fall Scene Investigation Report dated 12/27/25 revealed Resident #37 slipped, call light was functioning and bed height was not appropriate. The section for previous fall interventions in place was marked no. A general progress note dated 12/31/25 at 11:20 A.M. revealed the intradisciplinary team discussed Resident #37's fall. A new intervention was put in place for a mat to the floor on the right side of the bed. Resident stated he slid out of bed was found on knees on floor next to bed. No injuries noted. New intervention: Mat to floor exiting side of bed. MD DON and POA notified. A general progress note dated 01/08/26 at 4:01 A.M. revealed staff heard Resident #37 yelling for help. Resident #37 was found on the floor on the left side of the bed. Resident #37 stated he was trying to get out of bed. A Fall Scene Investigation Report dated 01/08/26 revealed Resident #37's call light was in reach and functional. No injuries were apparent. An interview on 02/19/26 at 2:26 P.M. Director of Nursing (DON) verified that the fall investigations for 12/27/25 and 01/08/26 were completed on paper forms and kept in the DON's office and not with the medical record. The DON stated information was also completed on risk management forms that were also not part of the medical record. DON verified that both fall investigations did not reveal if Resident #37 was wearing non-skid footwear and if the bed was in a low position. The Falls-Clinical protocol policy revised September 2012 revealed the staff will evaluate and document falls that occur while the individual is in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure infection control procedures were followed during a dressing change for Resident #4. This affected one (Resident #4) out of two residents with percutaneous endoscopic gastrostomy (PEG) tubes. The facility census was 38. Findings include: Review of the medical record revealed Resident #4 was admitted on [DATE] with diagnoses that included Parkinson's disease, dementia associated with Parkinson's disease, muscle weakness, contractures, dysphagia, and recurrent urinary tract infections. A physician order dated 04/01/22 revealed Resident #4's peg tube site was to be cleansed with wound wash, patted dry, and a split gauze placed every shift. A plan of care dated 11/04/25 revealed Resident #4 required tube feeding due to dysphagia, swallowing problems, and malnutrition. Interventions included enhanced barrier precautions, and the head of the bed to be elevated greater than 30 degrees during and after tube feeding. The annual Minimum Data Set (MDS) dated [DATE] revealed Resident #4 had a Brief Interview Mental Status (BIMS) of 12 which indicated cognitive impairment. An observation on 02/18/26 at 11:48 A.M. revealed Licensed Practical Nurse (LPN) #311 washed her hands, applied gloves, and removed the split gauze pad around Resident #4's peg tube site. A small amount of reddish/brown drainage was noted on the gauze pad. LPN #311 did not remove her gloves or complete any type of hand hygiene. LPN #311 used a bottle of wound cleanser to clean the skin at the wound cite. LPN #311 then placed the bottle of wound cleanser on the bed next to Resident #4. LPN #311 placed a clean split gauze pad around the peg tube insertion cite. LPN #311 put the bottle of wound cleanser on Resident #4's over-the-bed table and then removed her gloves. LPN #311 then took the bottle of wound cleanser and placed it back in the treatment cart. An interview on 02/18/26 at 11:52 A.M. LPN #311 verified she did not remove her gloves after removing the soiled dressing. LPN #311 also verified that she placed the wound cleanser in Resident #4's bed and put the wound cleanser bottle back in the treatment cart before cleaning the bottle. Review of the Dressings, Dry/Clean policy revised September 2013 revealed hands should be washed and dried thoroughly, the soiled dressing removed, and to pull glove over dressing and discard into plastic or biohazard bag. Wash and dry hand thoroughly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366014	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whispering Hills Rehabilitation and Nursing Center	416 Wooster Road Mount Vernon, OH 43050

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to follow the antibiotic stewardship guidelines. Resident #37 was ordered antibiotics prior to the culture and sensitivity results being obtained. This affected one (Resident #37) out of six residents reviewed for unnecessary medications. The facility census was 38. Findings include: Review of the medical record revealed Resident #37 was admitted on [DATE] with diagnoses that included fracture of sacrum, major depressive disorder, adjustment disorder with anxiety, obstructive and reflux uropathy, and benign prostatic hyperplasia without urinary tract symptoms. Review of the December infection control log revealed Resident #37 had a urinary tract infection with an onset date of 12/31/25. Resident #37 was ordered Macrobid (antibiotic) and infection was resolved on 01/02/26. The January infection control log revealed Resident #37 had a urinary tract infection with an onset date of 12/31/25. Resident #37 was ordered Levofloxacin (antibiotic), and the infection was resolved on 01/09/26. A general progress note dated 12/31/25 revealed Resident #37's urinalysis was reviewed, and the resident was ordered Macrobid 100 milligrams (mg) twice a day until results of the culture were received. The medication administration record (MAR) revealed Resident #37 received Macrobid 100 mg the evening of 12/31/25 through the morning of 01/02/26.A general progress note dated 01/02/26 at 4:09 P.M. revealed a call was placed to the hospital requesting final culture and sensitivity results for Resident #37. The results were obtained, the nurse practitioner was notified, and new orders were received. Resident #37's Macrobid was to be stopped, and an order was received to start Levofloxacin 750 mg once a day for five days. Culture and sensitivity results dated 01/02/26 revealed the infection was resistant to Macrobid. A new order was received for Levofloxacin 750 mg daily for five days. The MAR revealed Resident #37 received Levofloxacin from 01/03/26 through 01/07/26. A plan of care dated 01/21/26 revealed Resident #37 was at risk for urinary retention. Interventions included to monitor for signs/symptoms of urinary tract infection. The 5-day Medicare Minimum Data Set (MDS) dated [DATE] revealed Resident #37 had a brief interview for mental status (BIMS) score of nine which indicated cognitive impairment. The MDS also revealed the resident had an indwelling catheter. An interview on 02/19/26 at 11:58 A.M. Director of Nursing (DON) verified Resident #37 was started on Macrobid before the culture and sensitivity came back. DON verified the infection was resistive to Macrobid and Resident #37 had to be started on another antibiotic. Antibiotic Stewardship-Orders for Antibiotics revised December 2016 revealed appropriate indications for use of antibiotics include pathogen susceptibility, based on culture and sensitivity.