STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525551	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whispering Pines Nursing and Rehab, LLC	50 Wolverton Ave Ripon, WI 54971

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act when allegations of abuse were not reported to local police department and/or State Agency (SA) for 3 residents (R) (R13, R20, and R51) of 4 sampled residents.R13 touched R20 inappropriately on 3/29/26. The allegation of abuse was not reported to the SA or local police department.R13 kissed R51 in the dining room on 1/12/26. The potential allegation of abuse was not reported to the SA.Findings include:The facility's Vulnerable Adult Abuse and Neglect Prevention policy, dated 11/2017, indicates: .9. Resident-to-Resident Abuse: The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, exploitation and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to facility staff, other residents .6. Reporting of Incidents: .b. The facility must report to the State Agency immediately.no later than 24 hours if the alleged violation involves neglect, misappropriation of resident property, or exploitation and does not involve serious bodily injury. IV. Call law enforcement officials if suspected concern is criminal in nature (murder, manslaughter, rape, assault and battery, sexual abuse, theft/robbery). V. For allegations or incidents of sexual abuse, aside from the immediate preliminary report to the state health department, the policy of the facility is to make a police report with the local police department. 1. From 4/13/26 to 4/14/26, Surveyor reviewed R13's medical record. R13 was admitted to the facility on [DATE] and had diagnoses including early onset Alzheimer's disease and dementia with behavioral disturbance. R13's Minimum Data Set (MDS) assessment, dated 4/12/26, had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R13 had severely impaired cognition. From 4/13/26 to 4/14/26, Surveyor reviewed R20's medical record. R20 was admitted to the facility on [DATE] and had a diagnosis of multiple sclerosis. R20's MDS assessment, dated 3/19/26, had a BIMS score of 15 out of 15 which indicated R15 had intact cognition. A progres note, dated 3/29/26 at 10:51 PM, indicated R20 was approached by R13 at approximately 6:30 PM outside the dining room. An agency nurse noticed R20 looked uncomfortable, approached the residents, and observed R13 quickly move R13's hand away from R20. The nurse did not see where R13 touched R20. The nurse approached another nurse who asked R20 what happened. When asked if R13 touched R20, R20 stated yes and pointed to R20's vaginal area. When asked if R13 touched R20's vaginal area, R20 nodded yes. When asked if R13 said anything while touching R20, R20 stated R13 said, I love you. R20 was reassured that R13's behavior was inappropriate. R20 nodded in agreement and stated, I was just like, why? R13 was removed from the area after the incident and placed on 1:1 supervision. R20 requested to go outside to smoke/vape.The facility provided Surveyor with an investigation for the incident. Surveyor noted the police were not contacted and the incident was not reported to the SA.(See interview under example 2.)2. From 4/13/26 to 4/14/26, Surveyor reviewed R51's medical record. R51 was admitted to the facility on [DATE] and had diagnoses including acute cystitis, psychophysical visual disturbances, and major depressive disorder. R51's MDS assessment, dated 1/21/26, had a BIMS score of 15 out of 15 which indicated R51 had intact cognition. R51 discharged (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the facility on 1/21/26.A progress note, dated 1/13/26 at 4:10 AM, indicated (R13) grabbed R51 by the shoulders and kissed R51 on the mouth during supper on 1/12/26. R51 stated it didn't feel good but R51 was not upset at the time. A progress note, dated 1/13/26 at 10:15 PM, indicated the writer spoke with R51 via phone with a Licensed Practical Nurse (LPN) in the room to follow-up about the incident. R51 stated it was a joke. R13 put R13's arm around R51's shoulder. R51 and R13 had been kidding with each other since day one. R51 stated R13 was a sweetheart and R51 had no problem with R13. R51 stated if R13 said something raunchy, R51 told R13 to calm it and R13 said okay.On 4/14/26 at 12:02 PM, Surveyor interviewed R51 via phone about the incident on 1/12/26. R51 stated R13 reached up and kissed R51 and R51 was not expecting it. R51 stated the kiss occurred in the dining room during supper and everyone around them laughed and thought it was a joke. R51 laughed also. R51 stated R51 did not want to be kissed and did not ask to be kissed. R51 stated R13 was fine at first but then started talking smutty. R51 felt like R13 was stalking R51 at times, however, staff were with R13 all the time after that. R51 stated R51 was moved to a table in the dining room on the other side of the wall. R13 sat at R51's old table so they would be separated. R51 stated R51 felt secluded from friends in the dining room and felt R51 was being punished for something R13 did. R51 decided to eat in R51's room. R51 stated R51 discharged from the facility on 1/26/26 because R51 did not go to the facility to be stuck in a corner. R51 informed R51's physician why R51 wanted to discharge.A physician note, dated 1/21/26, indicated R51 appeared depressed and made comments that R51 did not have a say in R51's life. R51 thought people did not like R51 because of issues with another resident (R13) who tried to kiss R51. R51 had to change seating positions in the cafeteria and refused to go to the dining room for meals. R51 wanted to discharge home and was not interested in an assisted living facility.On 4/13/26, the facility provided Surveyor with an investigation for the incident. Surveyor noted the potential allegation of abuse was not reported to the SA; however, the incident was reported to the police. (Of note: The investigation revealed another resident was upset over unwanted remarks in the dining room from R51. That incident was reported to the SA and the police. When the police were at the facility for that incident, they were informed of the incident between R51 and R13 on 1/12/26.)On 4/14/26 at 2:00 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Regional Director of Operations (RDO)-J who indicated the facility used the Department of Health Services (DHS) resident-to-resident altercation flowchart (dated 6/2018). Because R20 and R51 indicated in interviews that neither were affected by the incidents and were both their own decision makers, the facility did not report the incidents. RDO-J acknowledged incident reporting criteria needed to be reviewed with staff.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure the safety of 1 resident (R) (R17) of 2 sampled residents.R17 was at high risk for wandering and had a Wanderguard (WG) bracelet. R17 exited the facility on 4/1/26 between 4:00 AM and 4:30 AM through an unalarmed door. R17 was found approximately 1.1 miles away at 6:40 AM at R17's apartment. R17 sustained a broken finger during the elopement. (This is being cited at past non-compliance.)Findings include: The facility's Elopement Risk and Prevention policy, dated 8/1/2015, indicates: The facility shall ensure all residents receive adequate supervision and assistive devices to prevent accidents, including elopement, wandering, and unsafe exits.Between 4/13/26 and 4/14/26, Surveyor reviewed R17's medical record. R17 was admitted to the facility on [DATE] and had diagnoses including rhabdomyolysis, acidosis, presence of automatic cardiac defibrillator, and alcoholic liver disease. R17's Minimum Data Set (MDS) assessment, dated 4/1/26, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R17 had moderately impaired cognition. R17 had an activated Power of Attorney for Healthcare (POAHC.) On 3/17/26, staff placed a Wanderguard (WG) bracelet on R17 related to wandering throughout the facility and having difficulty finding R17's room. On 4/1/26, R17 exited the facility through an unalarmed employees only door and was found approximately 1.1 miles away at R17's apartment in bed. It was later determined R17 sustained a broken finger during the elopement. The facility's investigation indicated on 4/1/26 at approximately 6:18 AM, Therapy Director (TD)-G went to R17's room and R17 was not there. TD-G informed staff who began to search for R17. Staff notified Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and the police. TD-G began searching the neighborhood in TD-G's vehicle. NHA-A instructed TD-G to go to R17's previous address. When TD-G arrived at R17's previous address, the police were there. R17's wheelchair was underneath a stairwell and one of the foot pedals was at the top of the stairs. The police entered R17's residence and discovered R17 asleep in bed. The facility was aware of R17's location at approximately 6:40 AM. The facility notified R17's physician and POAHC about the elopement.R17 was transported to the emergency room (ER). R17's bloodwork was normal. The ER did not complete imaging because R17 did not report concerns with pain or movement. R17 returned to the facility at approximately 10:00 AM. R17's WG was checked and was in working order. R17 was placed on a 1:1 supervision for 72 hours and then 15 minute checks. R17 was still on 15 minute checks at the time of the survey. When NHA-A asked why R17 left the facility, R17 stated R17 wanted to sleep in R17's bed. When NHA-A asked the route R17 used to exit the facility, R17 took NHA-A down R17's hallway and turned left down another resident hallway. R17 stated R17 exited the facility through an employees only door that required a code to open. R17 did not recall entering a code. R17 indicated R17 went out the unalarmed exit door and through a courtyard to the front of the building. On 4/1/26, the facility tested all doors to ensure alarms and the WG system were working. The facility noted there was not a Tabs alarm (a magnetic monitoring device) on the employees only door or on other employees only exit doors. The facility added a Tabs alarm to the coded employees only door where R17 exited and contacted the vendor to add a WG alarm to the door. In addition, Tabs alarms were added to 2 other exit doors in the employees only area. The facility implemented hourly door checks.On 4/1/26, the facility interviewed night shift staff regarding R17's last known whereabouts. Certified Nursing Assistant (CNA)-H last saw R17 on rounds between 4:00 and 4:30 AM in a wheelchair in R17's room facing the window. CNA-I last saw R17 between 3:00 and 3:30 AM and stated R17 was by the nurses' station most of the night. CNA-I told R17 to go back to R17's room which R17 did. Surveyor verified the statements during phone interviews with CNA-H and CNA-I.On 4/2/26, therapy staff were working with R17 in the morning when R17 reported numbness in R17's fingers that moved into the hand. R17's physician ordered an X-ray which revealed a fracture of the left ring finger. R17 was offered a splint (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	but refused. Ice and elevation orders were obtained. Pain assessments were completed each shift with no concerns. During an interview, R17 indicated R17 slipped up the stairs when going to R17's apartment and fractured R17's finger. Other residents were interviewed regarding abuse and injury of unknown origin with no concerns. The facility reviewed other residents with WGs and completed new wander risk assessments.The facility initiated elopement education and care plan updates for R17, including 1:1 supervision. The facility also initiated education for the employees only door code which included not sharing the code with residents. The education indicated the code would be changed quarterly and instructed staff to ensure the code is covered when entered if residents are nearby.Between 4/13/26 and 4/14/26, Surveyor reviewed the facility's 1:1 and 15 minute check sheets, R17's care plan, elopement drills, and door checks. R17's medical record indicated R17's WG function was checked daily and placement was checked every shift. Surveyor interviewed staff who indicated they received education on the elopement policy, doors, and updates to R17's care plan which included increased supervision. Surveyor reviewed the police report which indicated at approximately 4:30 AM, the police department received a call regarding a man wearing flannel pajama pants and pushing a wheelchair near 2 cross streets and a local business. The police responded but did not find anyone. On 4/14/26, Surveyor drove the route to the cross streets indicated in the police report where an elderly gentleman was observed at approximately 4:30 AM. Surveyor noted it was 0.7 miles from the facility. R17's apartment was approximately 1.1 miles from the facility. There were sidewalks along the possible routes R17 could have taken. Between 4/14/26 and 4/15/26, Surveyor observed R17 multiple times. R17 interacted with Surveyor, other residents, and staff. During the survey, Surveyor observed the front door (which had a WG alarm) alarm on multiple occasions. If a resident with a WG wheeled past the door, the alarm activated. Surveyor observed staff respond immediately.On 4/14/26 at 11:00 AM, Surveyor interviewed NHA-A who confirmed the door R17 exited through was not alarmed. NHA-A thought R17 saw staff enter the code and most likely used the code. NHA-A indicated and Surveyor confirmed (via education review and staff interview) staff should not share the code with residents and should cover the panel when entering the code. NHA-A also indicated a WG alarm would be added to the employees only door.