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	06/09/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not provide care and treatment to promote healing and/or prevent new pressure injuries from developing for 1 resident (R) (R3) of 3 sampled residents. R3 was at risk for the development of pressure injuries and had a care plan intervention for a left heel boot to be worn at all times. On 6/8/26, R3 was observed without a left heel boot for over four hours. Findings include: The facility's Pressure Injury Prevention and Wound Care Management policy and procedure, dated 8/26/18, indicates: The facility will ensure residents receive care and services to prevent additional pressure ulcers from forming .residents at risk for the development of pressure injuries will have their individualized care plan interventions and approaches documented in the residents' care plans .pressure reduction surfaces should be provided for prevention of pressure injuries . R3 was admitted to the facility on [DATE] and had diagnoses including metabolic encephalopathy, diabetes, multiple sclerosis, and peripheral vascular disease. R3's Minimum Data Set (MDS) assessment, dated 5/20/26, stated R3 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, indicating severely impaired cognition. The MDS assessment indicated R3 was at risk for pressure injuries, had an unhealed stage 4 pressure injury, and had pressure reducing devices for bed and chair. R3's comprehensive care plan, revised 5/14/26, indicated R3 were at risk for alteration in skin integrity related to reduced mobility, peripheral vascular disease, multiple sclerosis, and diabetes. The care plan contained interventions (added 2/11/26) for a heel boot to left foot at all times and to float heels in bed. R3's medical record indicated R3 had a healing stage 4 pressure injury on the coccyx and a recently healed (as of 6/2/26) vascular injury on the left heel. On 6/8/26 at 9:36 AM, Surveyor observed heel boots on a chair in R3's room. From 9:36 AM to 1:12 PM (3 hours and 36 minutes), R3 was in a Broda chair without heel boots. From 1:12 PM to 2:05 PM, Surveyor observed R3 in bed without a left heel boots or floated heels. On 6/9/26 at 9:56 AM, Surveyor interviewed Director of Nursing (DON)-B who verified R3's heels should be floated while in bed and R3 should have a heel boot on the left heel at all times due to R3's risk for pressure injury development.

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 0689 Level of Harm - Minimal harm or potential for 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 observation, staff and resident interview, and record review, the facility did not provide adequate supervision to prevent accidents for 1 resident (R) (R2) of 3 sampled residents. R2's care plan indicated they required supervision while eating. On 6/8/26, R2 was observed eating in their room without supervision. Findings include: R2 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, rhabdomyolysis (muscle breakdown causing their contents to enter the blood stream), type 2 diabetes, and epilepsy. R2's Minimum Data Set (MDS) assessment, dated 3/25/26, stated R2 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition. The MDS assessment indicated R2 had impairment of the upper extremities and required supervision or touching assistance with eating. R2's care plan indicated R2 had the potential for altered nutritional status related to Parkinson's disease, diabetes, left-sided weakness, and the need for an altered consistency diet. R2's Kardex (an abbreviated care plan used by nursing staff) indicated: Eating/Nutrition: Eats in dining room: rocker knife (curved blade designed to cut through food using a back-and-forth rocking motion), lipped plate, built-up utensils (adaptive eating aids with enlarged handles), provide set-up with supervision, monitor/document/report any signs/symptoms of dysphagia (difficulty or discomfort in swallowing food, liquids, and saliva): pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals. Provide adaptive utensils, rocker knife, lipped plate . A Mini Nutritional Assessment (MNA) indicated R2 was at risk for malnutrition, had weight loss on 1/6/26, and started oral nutritional supplements. On 3/17/26, R2 was upgraded to a level 7 regular consistency diet per Speech Therapy (initiated 12/10/25; revised 4/13/26). A nutrition progress note/dietitian summary, dated 5/11/26, indicated R2 had Parkinson's disease, diabetes, seizures, and left-sided weakness and ate in the main dining room with set-up assistance and supervision for meals. The note contained the following interventions: Eats in dining room .Provide set-up with supervision (initiated 1/27/26; revised 1/27/26); Monitor/document/report any signs/symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals (initiated 12/13/25). On 6/8/26 at 12:08 PM, Surveyor observed R2 in their room in a recliner. Certified Nursing Assistant (CNA)-C delivered a lunch tray and put the tray on R2's lap per R2's request. There were two cups of chocolate milk on the table. CNA-C told R2 to holler if they needed anything and exited the room. A meal ticket on the tray indicated R2 should eat in the dining room. Surveyor noted R2 had mild tremors while eating. R2 stated they were having trouble feeding themself due to tremors from Parkinson's disease and needed assistance at times. On 6/8/26 at 12:48 PM, CNA-C entered R2's room to remove the meal tray. Surveyor interviewed CNA-C after they exited the room. CNA-C verified R2 ate approximately half of the meal and indicated R2 likes to eat in the recliner with a meal tray on their lap. CNA-C indicated R2 had been shakier and more lethargic over the last few months but did not need supervision during meals. On 6/8/26 at 2:57 PM, Surveyor interviewed Director of Nursing (DON)-B who did not think R2 needed supervision during meals. On 6/9/26 at 8:28 AM, Surveyor observed R2 in a recliner in their room with a breakfast tray on a table in front of them. CNA-D was in the room working on a laptop. On 6/9/26 at 1:30 PM, Surveyor interviewed Registered Dietitian (RD)-G who stated R2 is encouraged to eat in the dining room, however, R2 is private due to Parkinson's tremors and prefers to eat in their room where supervision isn't provided. RD-G stated the facility had R2 sign a risk versus benefit statement. On 6/9/26, Surveyor reviewed a risks versus benefits statement (dated 6/9/26 at 11:45 AM) that indicated: Recommendations: Eating in dining room, supervision with meals; Discipline making recommendation: Registered Nurse (RN), Medical Doctor (MD), Dietary; Benefits associated with choosing not to follow recommendations: Resident choosing to eat in room; Risks associated with (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Few	choosing not to follow recommendations: At risk for aspiration, medical diagnosis of Parkinson's that may affect swallowing and will worsen as the disease progresses leading to choking, pneumonia, and early death; Resident/responsible party's response to risk versus benefit: Resident wishes not to eat in dining room and wants to continue eating in room. Date and time discussed with resident/responsible party: 6/9/26 at 11:45 AM; Care plan updated; Signed by: Verbal from resident, dated 6/9/26. A nutriton/dietary note, dated 6/9/26 at 11:29 AM, indicated: Met with R2 regarding oral intake, tolerance .and refusal to eat in dining room for meals. R2 has been encouraged to eat in the main dining room for meals but prefers to eat meals in their room. R2 stated they are a private person and is concerned their tremors will be noticeable to others. R2 has been advised to have supervision at meals due to safety concerns and the ability to offer more assistance as needed with the potential progression of Parkinson's disease and seizure activity. R2 is their own decision maker and agrees to sign a risks versus benefits statement to continue to eat in their room .R2 has no complaints regarding chewing, swallowing, nausea, or vomiting. Has snacks in room (crackers, sodas, etc.) and is aware of snacks available from nursing staff. Does not wish to have additional foods added to meals .likes regular consistency food .Will update nutrition plan of care as needed. On 6/9/26 at 2:38 PM, Surveyor interviewed R2 regarding their understanding of the risks versus benefits statement. R2 stated the only part R2 understood is that there is a risk for choking. R2 stated supervision was mentioned, but staff did not say for sure if it would be provided. R2 stated shaking in public makes them uncomfortable which is why they haven't been in the dining room in months. R2 stated staff do not provide supervision in their room during meals except during breakfast that morning. On 6/9/26 at 2:50 PM, Surveyor interviewed RD-G and Unit Manager Registered Nurse (RN)-H regarding R2's risks versus benefits statement. RD-G and RN-H stated the facility typically does not have staff provide supervision in a resident's room during meals. RD-G and RN-H stated staff offered R2 different or less busy spots in the dining room and stated R2 would receive more supervision in the dining room versus staff walking up and down the hall monitoring R2. On 6/9/26 at 2:55 PM, Surveyor interviewed Regional Director of Clinical Services (RDCS)-I who stated supervision is supervision, whether in the dining room or not, and the issue would be corrected.

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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, staff interview, and record review, the facility did not ensure appropriate respiratory care was provided for 2 residents (R) (R5 and R6) of 2 sampled residents. R5 received oxygen therapy with humidification. A bottle of distilled water used for oxygen therapy was left uncovered. In addition, the bottle was dated 6/2 which was 3 days beyond the expiration date per the facility's policy. R6 received oxygen therapy with humidification. A bottle of distilled water used for oxygen therapy was not dated when opened in accordance with the facility's policy. Findings include: The facility's Policy and Procedure Respiratory Infection Control Practices, revised 6/15/23, indicates: Purpose: To provide infection control guidelines to help prevent infections associated with respiratory therapy equipment, including ventilators, and to prevent transmission of infections to residents and staff. Oxygen Administration .b. Use distilled water for humidification as needed. c. [NAME] bottle of distilled water with date and initials upon opening and discard after 72 hours . 1. R5 was admitted to the facility on [DATE] for short-term rehab and had a diagnosis of heart failure. R5's admission Minimum Data Set (MDS) assessment, dated 6/8/26, indicated R5 received oxygen therapy. R5's medical record included an order for oxygen at 4 liters per minute (lpm) via nasal cannula with a start date of 6/4/26. On 6/9/26 at 10:33 AM, Surveyor and Director of Nursing (DON)-B observed R5's oxygen concentrator and a gallon of distilled water (highly purified water) on R5's bedside table that was used to fill a humidification bottle. The bottle of distilled water was uncovered and contained a hand-written date of 6/2. The cover was on the table next to the bottle. DON-B put the cover on the bottle and verified the bottle was dated 6/2 (which was past the 72 hour expiration date noted in the facility's policy). 2. R6 was admitted to the facility on [DATE] and had a diagnosis of pneumonia. R6's Minimum Data Set (MDS) assessment, dated 6/3/26, included a pulmonary diagnosis of asthma, chronic obstructive pulmonary disease (COPD), or chronic lung disease. The MDS assessment indicated R6 used oxygen therapy. R6's care plan contained an intervention to provide oxygen per Medical Doctor (MD) orders (dated 5/4/26). On 6/9/26 at approximately 10:40 AM, Surveyor and DON-B observed R6's oxygen concentrator and an open, undated gallon of distilled water on R6's bedside table that was used to fill a humidification bottle. DON-B verified the bottle did not contain an open date.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not provide pharmacy services to ensure the accurate administration of medication for 1 resident (R) (R2) of 4 sampled residents.R2 had an order for a carbidopa-levodopa (orally disintegrating) 25-250 milligrams (mg) tablet every 8 hours (used to treat motor symptoms of Parkinson's disease, including stiffness, tremors, and slowness). The order was entered for 8:00 AM, 12:00 PM, and 4:00 PM. Findings include: The facility's Policy and Procedure Physician Orders, revised 11/13/24, indicates: Purpose: To provide guidance to ensure physician orders are transcribed and implemented in accordance with professional standards .3. Physician orders must be documented clearly in the medical record including the required components of a complete order .e. dose and frequency of administration .6. Clear and complete orders will be transcribed to the appropriate administration record (Medication Administration Record (MAR)/Treatment Administration Record (TAR)) . R2 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, rhabdomyolysis (muscle breakdown causing muscle contents to enter the blood stream), type 2 diabetes, epilepsy, mood disorder, and insomnia. R2's Minimum Data Set (MDS) assessment, dated 3/25/26, stated R2 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition. On 6/8/26 and 6/9/26, Surveyor reviewed R2's medical record. R2's MAR included an order for carbidopa-levodopa (oral tablet disintegrating) 25-250 mg, give 1 tablet by mouth three times daily related to Parkinson's disease without dyskinesia (involuntary, erratic, and uncontrollable muscle movements) without mention of fluctuations. The order was dated 12/28/25 at 9:30 AM and scheduled for 0800 (8:00 AM), 1200 (12:00 PM), and 1600 (4:00 PM). A provider visit note, dated 5/15/26, contained an order for carbidopa-levodopa, orally disintegrating, 25-250 mg oral tablet, take 1 tablet by mouth every 8 hours. (Of note: R2's MAR was not updated with the new order to administer the medication every 8 hours.) A Discharge summary, dated [DATE], included an order for carbidopa-levodopa oral tablet disintegrating 25-250 mg (every 8 hours). R2's MAR was not updated with the newly ordered medication administration time of every 8 hours. On 6/8/26 at 2:57 PM, Surveyor interviewed Director of Nursing (DON)-B who reviewed R2's MAR and noted carbidopa-levodopa was scheduled for 8:00 AM, 12:00 PM, and 4:00 PM. DON-B verified the carbidopa-levodopa order for every 8 hours on R2's 5/18/26 discharge summary. DON-B stated R2 at times requests medication times be changed due to anxiety. DON-B stated they would talk to R2 and check with the pharmacy. On 6/9/26 at 12:15 PM, Surveyor interviewed Medical Doctor (MD)-J who stated R2's carbidopa-levodopa administration time would not have increased seizures, however, there may have been an increase in Parkinson's symptoms. MD-J stated they try to time the administration of the medication with nursing administration times and the resident's sleep schedule.

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not provide adaptive eating equipment for 1 resident (R) (R2) of 3 sampled residents. R2 was not provided with a lipped plate (a plate with raised edges to assist in guiding food onto utensils and prevent spills), a rocker knife (a curved blade designed to cut through food using a back-and-forth rocking motion) or built-up utensils (adaptive eating aids with enlarged handles) as indicated in their plan of care. Findings include: R2 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, rhabdomyolysis (muscle breakdown causing their contents to enter blood stream), type 2 diabetes, epilepsy, mood disorder, and insomnia. R2's Minimum Data Set (MDS) assessment, dated 3/25/26, stated R2 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition. The MDS assessment indicated R2 had impairment of the upper extremities and required supervision or touching assistance with eating.A care plan indicated R2 had the potential for altered nutritional status related to Parkinson's disease, diabetes, left-side weakness, and the need for an altered consistency diet. A Mini Nutritional Assessment (MNA) indicated R2 was at risk for malnutrition, had weight loss on 1/6/26, and started oral nutritional supplements. On 3/17/26, R2 was upgraded to a level 7 regular consistency diet per the Speech Therapy (initiated 12/10/25; revised 4/13/26).R2's Kardex (an abbreviated care plan used by nursing staff) indicated: Eating/Nutrition: Eats in dining room: rocker knife, lipped plate, built-up utensils, provide set-up with supervision, monitor/document/report any signs/symptoms of dysphagia (difficulty or discomfort in swallowing food, liquids, or saliva) .Provide adaptive utensils: rocker knife, lipped plate .A nutrition progress note/dietitian summary, dated 5/11/26, indicated R2 had Parkinson's disease, diabetes, seizures, and left-side weakness and ate in the main dining room with set-up assistance and supervision for meals. The summary contained the following interventions: .rocker knife, lipped plate, built-up utensils (initiated 12/10/25; revised 12/12/25) .On 6/8/26 at 12:08 PM, Surveyor observed R2 in a recliner in their room with their legs elevated. Certified Nursing Assistant (CNA)-C delivered R2's lunch tray and placed the tray on R2's lap per their request. There were two cups of chocolate milk on the bedside table. CNA-C asked if R2 needed help cutting food. R2 declined. CNA-C told R2 to holler if they needed anything. After CNA-C exited the room, Surveyor asked if staff offer to help R2 during meals. R2 stated staff do not offer very often. R2 opened a napkin which contained a regular fork, knife, and spoon. R2's lipped plate contained half of a baked sweet potato, green beans, and a slice of meat with gravy. R2 was also given a piece of cake with whipped topping in a bowl. R2 attempted unsuccessfully to cut the meat and poked the fork into the meat to take bites. R2 had tremors while eating. A meal ticket on R2's tray included the following instructions: .adaptive equipment: lipped plate. R2 stated they were having trouble eating due to tremors from Parkinson's disease and showed Surveyor their hands which were shaking. R2 stated they needed assistance with eating at times. On 6/8/26 at 12:46 PM, Surveyor interviewed R2 and observed their lunch plate. R2 ate all of the meat and sweet potato. When Surveyor asked about utensils, R2 stated staff used to provide funny looking utensils that R2 used for a while but had stopped providing them.On 6/8/26 at 12:48 PM, CNA-C entered R2's room to remove the meal tray. Surveyor interviewed CNA-C after exiting R2's room. CNA-C verified R2 consumed approximately half of the meal and stated R2 liked to eat in their recliner with a meal tray on their lap. CNA-C stated R2 had became shakier and lethargic over the last few months. CNA-C stated they ask R2 if needs assistance cutting food and R2 says yes at times. On 6/8/26 at 2:57 PM, Surveyor interviewed Director of Nursing (DON)-B who stated R2 still required built-up silverware. On 6/9/26 at 8:28 AM, Surveyor observed R2 in a recliner in their room with their feet down and a breakfast tray on a table in front of them. CNA-D was in the room working on a laptop. R2 stated it was hard to eat as R2 attempted to cut bacon, eggs, and toast but had difficulty. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2 did not have a lipped plate or built-up utensils. CNA-D did not get up to assist R2. When asked if staff offered to set up their meal, R2 stated no. When asked if CNA-D offered to cut R2's meal, CNA-D stated no and that R2 did not usually ask to have their food cut. CNA-D stated CNA-D just set R2's meal on the table. When CNA-D asked if they could cut up R2's breakfast, R2 asked if CNA-D could make them a breakfast sandwich. Surveyor reviewed R2's meal ticket which indicated R2 should have a lipped plate. CNA-D stated it did not look like R2 had a lipped plate. CNA-D made R2 a breakfast sandwich and cut it in half. R2 was able to pick up the sandwich and eat it. On 6/9/26 at 8:50 AM, Surveyor observed CNA-D with R2's breakfast tray. R2 consumed 100% of the breakfast sandwich and 75% of the chocolate milk. Surveyor and CNA-D went to the kitchen to review adaptive equipment. CNA-D informed Assistant Dietary Manager (ADM)-E that R2 did not receive a lipped plate at breakfast. ADM-E stated they get interrupted and likely missed providing a lipped plate. Dietary Manager (DM)-F joined the interview and stated when therapy sends an order for adaptive equipment, DM-F enters the order on the meal ticket and verbally informs staff. DM-F stated dietary staff see the adaptive equipment on the meal ticket and serve the meal appropriately. DM-F stated orders should be added to a resident's meal ticket when they are written and provided to the resident at meals. A nutritional/dietary note, dated 6/9/26 at 11:29 AM, indicated: .R2 should have built-up utensils and a lipped plate at meals to ease the ability to self feed. R2 typically eats 50-75% of meals. On 6/9/26 at 1:28 PM, Surveyor interviewed DM-F who stated RD-G informed them of a discrepancy between R2's care plan and meal ticket. DM-F added adaptive equipment of built-up utensils and a rocker knife and provided Surveyor with R2's updated meal ticket which included a lipped plate, rocker knife, and built-up utensils.