

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525551	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2026
NAME OF PROVIDER OR SUPPLIER Whispering Pines Nursing and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a safe and sanitary manner. This practice had the potential to affect all 34 residents residing in the facility. Staff did not consistently monitor food holding temperatures. Toasters in the main kitchen contained dried food debris. Staff did not follow sanitation practices when using a thermometer to check cooking temperatures. Findings include: On 4/12/26 at 9:24 AM, Surveyor completed an initial tour of the kitchen with Dietary Manager (DM)-C who stated the facility follows the Federal Food Code. Food Cooking/Holding Temperatures: The facility's Food Temperature Record policy, dated 6/28/22, indicates: It is the policy of the facility to ensure foods and beverages are held and served at temperatures which comply with state and federal regulations. Preparation of food is to be completed as close to serving time as possible and transferred to holding equipment no more than 30 minutes prior to meal service. 4. Hot foods must be held at a minimum temperature of 135 degrees Fahrenheit (F). The 2022 Food and Drug Administration (FDA) Food Code documents at 2-103.11 Person in Charge: The person in charge shall ensure that: (I) Employees are properly maintaining the temperatures of time/temperature control for safety foods during hot and cold holding through daily oversight of the employees' routine monitoring of food temperatures. The 2022 FDA Food Code documents at 3-501.16 Time/Temperature Control for Safety Food, for Hot and Cold Holding: Bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature danger zone of 41 degrees F to 135 degrees F too long. Up to a point, the rate of growth increases with an increase in temperature within this zone. Beyond the upper limit of the optimal temperature range for a particular organism, the rate of growth decreases. Operations requiring heating or cooling of food should be performed as rapidly as possible to avoid the possibility of bacterial growth (A) Except during preparation, cooking, or cooling, or when time is used as the public health control. (1) At 135 degrees F or above or (2) At 41 degrees F or less. During an initial tour of the kitchen on 4/12/26 at 9:24 AM, DM-C stated the facility monitors cooking and holding temperatures. DM-C stated cooking temperatures are obtained when food comes out of the oven, and holding temperature are obtained prior to meal service. On 4/12/26 from 12:16 PM to 12:41 PM, Surveyor observed lunch service. Surveyor noted holding temperatures were not obtained prior to, during, or after serving was completed. On 4/12/26, Surveyor reviewed the facility's Food Temperature Logs for the past 30 days. Surveyor noted the following inconsistencies with the completion of cooking and holding temperatures: ~ For the week of 3/15/26 to 3/21/26, cooking temperatures were incomplete for 4 of 21 meals; holding temperatures were incomplete for 2 of 21 meals. ~ For the week of 3/22/26 to 3/28/26, cooking temperatures were incomplete for 1 of 21 meals; holding temperatures were incomplete for 6 of 21 meals. ~ For the week of 3/29/26 to 4/4/26, cooking temperatures were incomplete for 5 of 21 meals; holding temperatures were incomplete for 3 of 21 meals. On 4/12/26 at (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 - Many	2:55 PM, Surveyor interviewed DM-C who stated cooking and holding temperatures should be completed for all meals. DM-C stated DM-C did not check holding temperatures for lunch on 4/12/26 because the food was removed from the oven close to serving time. DM-C acknowledged cooking and holding temperatures should be obtained for all meals. DM-C acknowledged there were inconsistencies in the log entries for cooking and holding temperatures. Kitchen Equipment: The 2022 FDA Food Code documents at 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils: (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. The 2022 FDA Food Code documents at 4-602.12 Cooking and Baking Equipment: (A) The food-contact surfaces of cooking and baking equipment shall be cleaned at least every 24 hours. During an initial tour of the kitchen with DM-C on 4/12/26 at 9:24 AM, Surveyor observed two toasters that contained a significant amount of dried food debris and crumbs on the interior and exterior. On 4/12/26 at 2:58 PM, Surveyor interviewed DM-C who stated the toasters should be cleaned after each use or at least every day. DM-C acknowledged the dried food debris and verified the toasters should have been cleaned. Food Temperature Measuring Device: The facility's Calibration of Thermometer policy, dated 6/1/23, indicates: The purpose of the policy is to ensure thermometers are calibrated on a regular basis, documented food temperatures are accurate, and proper procedures are used to clean and sanitize probe thermometers. 4. Procedure - Cleaning and Sanitizing: 4.1. Prior to each use, probe thermometer must be cleaned (if visibly soiled) and/or sanitized with an alcohol wipe or Quat sanitizer. Stem must air dry completely for at least 10-15 seconds before inserting into food. Thermometer must also be sanitized with an alcohol wipe or Quat sanitizer between each use, allowing thermometer to air-dry completely as listed above each time it is sanitized. The 2022 FDA Food Code documents at 4-602.11 Equipment Food-Contact Surfaces and Utensils: (A) Equipment food-contact surfaces and utensils shall be cleaned: (4) Before using or storing a food temperature measuring device; and (5) At any time during the operation when contamination may have occurred. On 4/12/26 at 11:35 AM, Surveyor observed DM-C obtain cooking temperatures. DM-C used a probe thermometer to check the internal cooking temperature of bone-in chicken. DM-C did not sanitize the probe prior to inserting it into the chicken. After removing the thermometer, DM-C placed the thermometer on the prep counter. Surveyor noted the prep counter contained dried food debris. DM-C temped the chicken again with the same thermometer. DM-C did not sanitize the thermometer after setting it on the prep counter or before inserting the thermometer into the chicken. Surveyor observed DM-C repeat the process an additional 3 times. During the observation, Surveyor did not observe DM-C sanitize the thermometer. On 4/12/26 at 11:41 AM, Surveyor observed DM-C obtain cooking temperatures. DM-C used a probe thermometer to check the internal cooking temperature of mashed potatoes. DM-C did not sanitize the probe prior to inserting it into the potatoes or after removing the thermometer. DM-C placed the thermometer on the prep counter where it rested against a cloth that contained food debris. DM-C temped the mashed potatoes again with the same thermometer. DM-C did not sanitize the thermometer before inserting it into the mashed potatoes. On 4/12/26 at 2:58 PM, Surveyor interviewed DM-C who confirmed DM-C did not sanitize the thermometer prior to use, after setting it on the prep counter, or after it came in contact with a used cloth. DM-C verified thermometers should be sanitized between uses.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not ensure a call light was within reach for 1 resident (R) (R34) of 12 sampled residents. On 4/12/26, R34 was observed in R34's room without a call light within reach. The facility's Call Light Use and Response policy, dated 1/14/19, indicates: .4. When providing care to the residents, position the call light conveniently for the resident and within easy access for use .9. Be sure call lights are placed within reach at all times. On 4/12/26, Surveyor reviewed R34's medical record. R34 was admitted to the facility on [DATE] and had diagnoses including osteoporosis with current pathological fractures and right humerus fracture related to fall. R34's Minimum Data Set (MDS) assessment, dated 3/29/23, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R34 had intact cognition. The MDS also indicated R34 was dependent on staff for transfers, toileting, and locomotion of wheelchair. R34's medical record indicated R34 fell while self-transferring from a wheelchair to a recliner in R34's room on 3/23/26 which resulted in a right humerus fracture. On 4/12/26 at 9:42 AM, Surveyor heard R34 call out for help. Surveyor entered R34's room and asked if R34 needed help. R34 was in a wheelchair with a sling on R34's right arm. R34 indicated R34 was in pain, could not call staff, and needed a pain pill. Surveyor noted R34's call light was on the floor approximately 10 feet from the wheelchair. R34 stated staff brought R34 back to the room and left. R34 did not remember who brought R34 back to the room. Surveyor informed Registered Nurse (RN)-F that R34 requested a pain pill. On 4/12/26 at 9:49 AM, Surveyor interviewed RN-F who verified R34's call light was on the floor and R34 could not reach it. RN-F attached R34's call light to the wheelchair and indicated the call light should always be within reach. On 4/13/26 at 9:30 AM, Surveyor interviewed Director of Nursing (DON)-B who verified the facility's policy indicates a resident's call light should be within reach and accessible at all times.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure Pre-admission Screening and Resident Review (PASRR) requirements were met for 1 resident (R) (R20) of 5 sampled residents. R20 had a mental illness diagnosis as indicated on R20's PASRR Level I Screen. A PASRR Level II Screen was not completed. Findings include: According to the State of Wisconsin Department of Health Services (DHS), Pre-admission Screening and Resident Review (PASRR) is a federal requirement that all applicants to Medicaid-certified nursing facilities be assessed to determine whether they might have an intellectual disability (ID)/developmental disability (DD) and/or mental illness (MI). This is called a Level I Screen. The purpose of a Level I Screen is to identify individuals whose total needs require they receive additional services for their ID/DD and/or MI. Individuals who test positive at Level I are then evaluated in depth to confirm the determination of an ID/DD and/or MI for PASRR purposes. This is a Level II Screen. This assessment produces a set of recommendations for necessary services that are meant to inform the individual's plan of care. Nursing facilities may seek county exemption for applicants with ID/DD and/or MI whose stay in the facility is expected to be recuperative care or short-term, as evidenced by receipt of County Review of Nursing Home, IMD or ICF/IID Referrals. From 4/12/26 to 4/14/26, Surveyor reviewed R20's medical record. R20 was admitted to the facility on [DATE] and had diagnoses including multiple sclerosis, depression, and anxiety. R20's Minimum Data Set (MDS) assessment, dated 3/19/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R20 was not cognitively impaired. R20 was responsible for R20's healthcare decisions. R20's medical record contained a PASRR Level I Screen, dated 7/10/25, that indicated R20 had a current MI diagnosis. Surveyor noted R20's medical diagnoses included depression and anxiety. R20's MDS assessment, dated 7/10/25, indicated R20 had depression and anxiety. R20's medical record did not contain a PASRR Level II Screen. On 4/14/26 at 11:50 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated Business Office Manager (BOM)-E was responsible for completing PASRRs. On 4/14/26 at 11:53 AM, Surveyor interviewed BOM-E who verified R20 did not have a PASRR Level II Screen. BOM-E stated BOM-E should have completed one and must have missed the Level II Screen.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not provide the necessary edema care and treatment for 1 resident (R) (R16) of 1 sampled resident. R16 had an order for Tubigrips for diagnoses of lymphedema and congestive heart failure (CHF). The Tubigrips were not consistently applied. In addition, R16's care plan did not contain interventions to address lymphedema. Findings include: From 4/12/26 to 4/14/26, Surveyor reviewed R16's medical record. R16 was admitted to the facility on [DATE] and had diagnoses including chronic wound with lower extremity lymphedema, congestive heart failure (CHF), and chronic pain. R16's Minimum Data Set (MDS) assessment, dated 4/1/26, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R16 had intact cognition. R16 made R16's own healthcare decisions. A Hospital Discharge summary, dated [DATE], indicated R16 had chronic wounds with bilateral lower extremity (BLE) lymphedema. The summary stated to continue compression wraps. A Health Status Note, dated 3/26/26, indicated R16 had BLE 2+ edema. A Daily Skilled Charting Note, dated 4/11/26, indicated R16 had BLE 2+ pitting edema. Pedal pulses were present. A care plan, dated 4/12/26, indicated R16 had chronic pain related to cervicalgia, urinary disorder, and lymphedema. The care plan contained an intervention, dated 3/26/26, to administer treatments as ordered. (Of note: The care plan did not contain interventions that addressed lymphedema such as elevating legs or Tubigrips.) R16's April 2026 Medication Administration Record (MAR) contained the following orders: ~ Oxycodone HCL 5 milligrams (mg) 1 tablet every 6 hours as needed (PRN) for severe pain. (R16 did not receive oxycodone on 4/12/26. On 4/13/26 at 9:10 PM, R16 received oxycodone which was effective.) ~ Gabapentin 300 mg three times daily (TID) for neuropathic pain. (The medication was administered as ordered on 4/12/26, 4/13/26, and 4/14/26.) On 4/12/26 at 12:40 PM, Surveyor observed R16 in a wheelchair with R16's legs in a dependent position and feet on the floor. R16's feet were swollen. R16 was wearing Tubigrips. R16 indicated the Tubigrips were for compression to decrease swelling. On 4/14/26 at 8:30 AM, Surveyor interviewed R16 who was frustrated and upset that R16's Tubigrips had not been applied since they were removed on the evening of 4/12/26. R16 stated R16 had pain and increased swelling in both legs. R16 was in a wheelchair with R16's legs in a dependent position. R16 was not wearing Tubigrips. R16's feet were swollen and painful to touch. On 4/14/26 at 8:41 AM, Surveyor interviewed Director of Nursing (DON)-B who stated R16 did not indicate to DON-B during AM medication pass that R16's Tubigrips were not applied or that R16 was in pain. DON-B was made aware by a Certified Nursing Assistant (CNA) that R16's Tubigrips were not applied and could not be found. DON-B stated castor oil was applied to R16's legs so the Tubigrips may have been soiled and sent to laundry. DON-B asked therapy staff to get new Tubigrips for R16. On 4/14/26 at 10:25 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding R16's Tubigrips. A short time later, Surveyor observed NHA-A enter R16's room with Tubigrips. On 4/14/26 at 11:45 AM, Surveyor again interviewed DON-B who verified R16's Hospital Discharge Summary indicated R16 should have compression wraps (Tubigrips). DON-B was not aware who completed R16's admission and verified R16's care plan did not contain interventions to address lymphedema until 4/14/26.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure it was free of a medication error rate of 5% or greater. During medication administration observations, 2 errors occurred during 30 opportunities which resulted in a 6.67% medication error rate that affected 1 resident (R) (R27) of 3 residents observed during medication administration. During the AM medication pass on 4/13/26, R27's insulin aspart (for diabetes) was administered late. In addition, the wrong dose of Slow Magnesium (a supplement containing magnesium chloride with calcium) was administered. Findings include: The facility's Administering Medications policy, revised 1/22/24, indicates: Purpose: To ensure safe and effective administration of medication in accordance with physician orders and state/federal regulations . 4. Medications shall be administered per provider's written/verbal orders upon verification of the right medication, dose, route, time, and positive verification of the resident's identity when no contraindications are identified .the medication is labeled according to accepted standards .On 4/14/26, Surveyor reviewed R27's medical record. R27 was admitted to the facility on [DATE] and had diagnoses including diabetes and nutritional anemia. R27's Minimum Data Set (MDS) assessment, dated 1/22/26, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R27 had moderate cognitive impairment. On 4/13/26 at 9:23 AM, Surveyor observed Registered Nurse (RN)-D prepare and administer R27's AM medications. RN-D was aware RN-D was administering R27's insulin aspart late, but indicated RN-D did not like to administer insulin in the dining room. During preparation of R27's medications, Surveyor noted the bottle of Slow Magnesium used for R27 contained magnesium 128 milligrams (mg), chloride 373 mg, and calcium 212 mg. On 4/13/26 at 10:00 AM, Surveyor reviewed R27's Medication Administration Record (MAR) and noted the following orders:~ Slow Mag tablet delayed release 71.5-119 mg (magnesium chloride-calcium carbonate), give 1 tablet by mouth once daily for supplement.~ Insulin aspart 100 unit/milliter, inject per sliding scale .Inject subcutaneously in the morning at 7:30 AM. On 4/13/26 at 10:56 AM, Surveyor interviewed RN-D who compared the facility's Geri Care Slow Magnesium Chloride with Calcium bottle to R27's MAR and acknowledged the doses were different. RN-D verified Slow Magnesium at the higher dose of magnesium 128 mg, calcium 212 mg, and chloride 373 mg was administered and was incorrect. On 4/13/26 at 11:05 AM and 11:48 AM, Surveyor interviewed Director of Nursing (DON)-B and informed DON-B of Surveyor's medication administration observations. DON- B indicated the administration of Slow Magnesium was a medication error due to the different doses. DON-B reviewed R27's MAR and confirmed insulin aspart was ordered for 7:30 AM. DON-B verified insulin aspart was administered late if given after 9:00 AM.		