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	0012331	A. BUILDING: _____ B. WING _____	C 06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES CBRF	**3380 BRIDLEWOOD DR PLOVER, WI 54467**

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N 000	Initial Comments On 06/09/2026, Surveyor conducted an abbreviated survey and complaint investigation. Additional information was gathered through 06/16/2026. As a result of the survey, 3 deficiencies were identified and the complaint was substantiated. Census: 39	N 000		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure Resident 3's Individual Service Plan (ISP) was reviewed and revised based on assessment upon a change in Resident 3's needs and abilities specifically regarding falls, wandering behaviors, call-light use and the implementation of a retractable gate in his/her room. Findings include:	N 389		

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

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N 389	Continued From page 1 On 06/09/2026 at 9:30 AM, Surveyor observed a black mesh retractable gate attached to Resident 3's private room doorframe. Surveyor observed Caregiver D (C-D) open the gate and walk into Resident 3's room to administer his/her medications. Surveyor observed C-D leave Resident 3's room following medication administration and leave the black gate open. On 06/09/2026 at 9:32 AM, Surveyor interviewed C-D. S/he stated the gate is utilized to inhibit other confused residents from accessing Resident 3's room, that the family is aware of its use, and that Resident 3 can open and close the gate on his/her own. On 06/09/2026, Surveyor reviewed Resident 3's records including observation notes and incident reports. Surveyor noted the following entries: Observation Notes: -- 04/06/2026 at 5:00 AM: " ...resident was found wandering around north commons ..." -- 04/17/2026: " ...found resident walking around south commons without a walker ..." -- 04/26/2026: " ...staff found resident sitting by the kitchen with her legs through the arm sleeves of a pullover sweatshirt. Resident was very confused and dazed and talking about seeing spiders ...resident did not have [his/her] walker ..." -- 04/29/2026: " ...Large circular area of bruising noted to right upper arm, from fall last night ...large abrasion also noted on left lower back ..." -- 05/05/2026 at 1:15 AM: " ...resident opened the gate on [his/her] door and walked into north commons ..." -- 05/15/2026: " ...Resident has been awake all night ...wandering around [his/her] room and	N 389		

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talking to people that are not there ..."
-- 05/21/2026: " ...hospice RN ...came to assess resident after [his/her] unwitnessed fall. [hospice RN] asked ...staff to prove that resident was being toileted regularly ...[hospice RN] said [s/he] doesn't [sic] understand why resident is falling then ...explained resident is restless, confused, hallucinates ...wanders all over without [his/her] walker ...management discussed with family the risks of moving a high fall risk to a bigger room ..."

Incident Reports:

-- 04/29/2026 at 7:00 PM: " ...Fall-Unwitnessed ...Staff entered resident's room and observed resident in left lateral position on the floor in between recliner and closet ..."
-- 04/30/2026 at 9:48 PM: " ...Fall-Unwitnessed ...staf [sic] found resident in doorway of bathroom ..."
-- 05/10/2026 at 12:25 PM: " ...Fall-Unwitnessed ...observed resident sitting on the floor next to recliner ..."
-- 05/15/2026 at 10:19 PM: " ...Fall-Unwitnessed ...staff found resident on floor between bathroom and bedroom ..."
-- 05/21/2026 at 10:02 PM: " ...Fall-Unwitnessed ...staff found resident sitting on the floor by bed ..."

On 06/10/2026 at 11:06 AM, Surveyor interviewed Resident 3's activated Power of Attorney G (POA-G). S/he described Resident 3 as severely altered and confused and unable to utilize his/her call light appropriately. S/he stated his/her preference for the gate and described an incident where another Resident wandered into Resident 3's room during the night which led to the retractable mesh gate installation approximately 5

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to 6 months prior. S/he attested to Resident 3's ability to open and close the gate when it was initially installed, but was uncertain whether Resident 3 could still operate the gate appropriately. S/he acknowledged that Resident 3 has had an increase in falls recently. S/he believed Resident 3 was on a two-hour toileting schedule, but that Resident 3 will oftentimes toilet him/herself. S/he stated staff typically check on Resident 3 every 2 hours when s/he visits. S/he shared Resident 3's preference to stay in his/her room versus spending time in the common areas.

Following Surveyors request, on 06/10/2026 Administrator B emailed Resident 3's most recent individualized service plan (ISP) dated September of 2025. The ISP read in part, " ...Toileting ...One assist with all toileting needs, not incontinent. Staff to monitor bowel movements daily ...Monitor, document and report and changes in toileting status. Monitor skin integrity and assist with incontinence care and cleansing as needed ...Wandering Exit Seeking ...Does not wander around facility and has not exhibited any exit seeking behaviors ...Daily supervision to ensure resident is safe and secure ...Communication Skills ...Resident does use call light when needed. Staff to check on him/her frequently ...Fall Protocol ...Low Fall Risk at this time ...Daily supervision ...Keep call light in reach..."

The ISP did not include:

-- Resident 3's needs regarding toileting and monitoring checks, specifically the need and intervals for checks.
-- Resident 3's current wandering behaviors specifically his/her recent tendencies to wander outside his/her room at night.
-- Resident 3' assessed ability to appropriately

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N 389	Continued From page 4 utilize his/her call-light. -- An update to Resident 3's fall risk status to identify him/her as a fall risk due to his/her recent history of falls including intervention and assessed needs in place to decrease fall risk for Resident 3. -- The need and implementation of a gate on Resident 3's private room doorframe, including any interventions attempted prior to implementing the gate and continued assessment regarding the gates appropriateness to assure it is safe for Resident 3 to use and necessary. On 06/16/2026 at 2:00 PM, Surveyor interviewed Director of Operations A (DO-A), Administrator B (A-B) and Director of Health Services C (DHS-C). A-B acknowledged Resident 3's recent increase in falls and that s/he is a fall risk. When asked if Resident 3 has wandering tendencies, A-B stated "no." DHS-C stated that Resident 3 does not utilize a call-light appropriately and that hourly rounding is completed to monitor him/her. DO-A volunteered that hourly checks are completed on Resident 3 and that staff try to get Resident 3 out of his/her room when possible to negate falls. DO-A acknowledged the use of the retractable gate on Resident 3's doorway, that s/he is able to open and close it, and it's purpose to deter other Residents from wandering into Resident 3's room. They acknowledged that Resident's ISP did not include the aforementioned items. DO-A stated that they will review Resident 3's ISP and make the appropriate changes.	N 389		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of	N 415		

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medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.

This Rule is not met as evidenced by:
Based on observation, interview and record review, the provider did not ensure accurate documentation of medication administration.

On 06/09/2026, Resident 1 did not receive his/her nystatin cream. Caregiver D documented nystatin cream was administered to Resident 1 as prescribed.

Findings include:

On 06/09/2026 at 8:55 AM, Surveyor observed Caregiver D (C-D) during a medication pass. C-D document on the electronic charting system that Resident 1's nystatin cream was administered at 8:55 AM. Surveyor inquired about the cream and C-D stated that "floor staff" administers the cream but was unsure who administered the cream to Resident 1 earlier that morning. S/he stated that staff do not "observe" medication administration "we hear" whether it has been administered by another staff member. C-D offered to ask if Resident 1 had received the cream that morning.

On 06/09/2026 at 9:03 AM, Surveyor observed C-D approach Resident 1 and inquire about

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his/her nystatin cream. Resident 1 denied being administered his/her nystatin cream by facility staff that morning. Resident 1 denied administering his/her own nystatin cream. Resident 1 stated s/he had not been administered nystatin "for weeks" and was utilizing an alternative ointment.

On 9:05 AM, Surveyor interviewed C-D. S/he acknowledged that Resident 1 had not been administered his/her scheduled nystatin cream and s/he had inaccurately documented the cream as being administered by him/herself.

On 06/09/2026 at 10:40 AM, Surveyor interviewed Director of Health Services C (DHS-C). Surveyor requested to see Resident 1's morning medication pass. DHS-C provided Surveyor with document titled "Medication Listing for Tuesday 06/09/2026" which indicated that C-D had administered Resident 1 his/her nystatin cream at 8:55AM. DHS-C viewed Resident 1's morning medication pass on his/her computer and verified that the nystatin cream was documented as given by C-D at 8:55 AM.

On 06/09/2026, Surveyor reviewed Resident 1's current Individualized Service Plan (ISP) dated February of 2026 which indicated his/her need for medications to be administered by facility staff.

On 06/09/2026, Surveyor reviewed Resident 1's active medication list which read in part, " ...Nystatin Cream Daily ...Apply ...2 times daily and as needed to treat and prevent rash ..."

On 06/09/2026 at approximately 1:15 PM Surveyor interviewed Director of Operations A (DO-A). S/he acknowledged that caregivers should not document administering a medication

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N 415	Continued From page 7 unless they themselves administered it. "Documentation of current medications in the medical record facilitates the process of medication review and reconciliation by the provider, which is necessary for reducing ADEs [Adverse Drug Events] and promoting medication safety. The need for provider to provider coordination regarding medication records, and the existing gap in implementation, is highlighted in the American Medical Association's Physician's Role in Medication Reconciliation, which states that "critical patient information, including medical and medication histories, current medications the patient is receiving and taking, and sources of medications, is essential to the delivery of safe medical care. However, interruptions in the continuity of care and information gaps in patient health records are common and significantly affect patient outcomes" (2007, p.7). This is because clinical decisions based on information that is incomplete and/or inaccurate are likely to lead to medication error and ADEs. Weeks, Corbette, & Stream (2010) noted similar barriers ..." source: https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2023_Measure_130_MIPSCQM.pdf, retrieval date 04/29/2024	N 415		
N 502	83.46(1)(a) Comfortable and safe temperatures A CBRF shall maintain comfortable and safe temperatures. The CBRF shall provide tempered air at all times to eliminate cold air drafts. The heating system shall be capable of maintaining temperatures of 74º F. in areas occupied by residents.	N 502		

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This Rule is not met as evidenced by:
Based on interviews and record review, the provider did not ensure that comfortable and safe temperatures were maintained.

Findings include:

On 06/01/2026, the Department received a complaint regarding temperature control in the facility.

On 06/09/2026 at 12:00 PM, Surveyor interviewed Resident 2. S/he stated that it is "always hot in here" but that a fan helps "a little bit." Resident 2 requested his/her fan be turned on. Resident 2 was observed wearing a sweater and attempted to cover him/herself up with a blanket at one point during the interview. Surveyor observed the thermostat in Resident 2's room reading 72 degrees Fahrenheit.

On 06/09/2026 at 3:10 PM, Surveyor interviewed Caregiver E (C-E). S/he recalled an incident recently where an individual approached him/her with concerns that Resident 2's room was too hot. C-E said s/he checked the thermostat in the hallway that controls the area that Resident 2's room was located in, and that it was switched to the off position and not on cool. S/he said the thermostat was set to maintain 68 degrees, the cooling switch was in the off position, and the thermostat was displaying a temperature of 80 degrees. C-E stated s/he turned the thermostat switch to cool.

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N 502	Continued From page 9 On 06/09/2026 at 12:50 PM, Surveyor interviewed Administrator B (A-B). S/he said s/he was notified of a concern regarding the temperature of Resident 2's room. S/he said once s/he was notified of the concern, s/he had staff check all thermostats in the facility, turn them down, and within 2 hours it was fixed. S/he then provided Surveyor with a folder containing additional documents regarding the incident. On 06/09/2026 at 1:15 PM, Surveyor interviewed Director of Operations A (DOA-A). S/he recalled a recent incident where s/he was notified that one of the facility thermostats was identified as being in the off position, was turned to the cool setting, and the issue was resolved within 2 hours of notification. On 06/09/2026 at 1:24 PM, Surveyor interviewed Maintenance F. S/he said that the facility has multiple thermostats and each once controls a different "zone" in the facility. S/he said the thermostats are set at 74 degrees, but that it can sometimes be "tricky" to maintain temperatures in the building due to the fluctuating temperatures during the fall and spring months. S/he said there was a "cold snap", then the temperatures increased outside and one thermostat in the facility was "missed" and not switched back to "cool." Of 06/09/2026 at 2:00 PM, Surveyor reviewed documentation provided by A-B regarding the incident. It contained a statement signed by DOA-A, a statement signed by A-B, and a Memo sent out to staff. The documents contained the following: -- Statement signed by DOA-A dated 05/25/2026: " ...The AC [sic] was on in the building but staff	N 502		

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had unfortunately missed the thermostat for the corner of the building where ...it was 79 in [his/her] room. When brought to [A-B's] attention it was directed to be turned on immediately and within 2 hours the temperature was cool again and comfortable. [S/he] complained that the thermostats are locked up. This is true due to memory care and just having people adjusting things all the time. So there is a key locked up in med [sic] room that the supervisor can access and turn on ...or adjust the thermostats as needed ..."

-- Statement signed by A-B dated 05/25/2026: " ...AC [sic] was turned on in the facility on 5/24/26. In the evening was on the phone with a staff member when a family member walked in ...very upset ...complained about how warm it was in [Resident 2's] room. I was not in the building at this time, but on the phone with staff ...[S/he] proceeded to tell me that the AC [sic] was not on and [s/he] was told that we do not turn on the AC [sic] until June 1st and that staff do not have access to this ...I did try to inform him that the information [s/he] received was not true and we would never have asset [sic] date to turn on AC [sic] or Heat [sic] ...told [him/her] I would look into this immediately ...The staff member and I stayed on the phone as [s/he] walked through the building to check on all of the thermostats. I had her turn the AC [sic] down more on all the thermostats. I advised staff to watch this closely to make sure it helped. I was in contact with staff throughout the night and within 2 hours the temperature was cooler. I advised staff to turn the AC [sic] up if it was too cool and that we needed to make sure all rooms were comfortable and that the residents were comfortable. [DOA-A] was aware of the situation and continued to contact staff to make sure it was comfortable ...Staff have

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keys to adjust the temperature if there is a concern at any time and we do not have a set date to turn on the AC [sic] or the heat ..."

-- Memo sent to staff dated 05/26/2026: " ...TO: All Staff FROM: [DOA-A] ...We are obligated to be able to maintain at [sic] 74-degree ...recently we had AC [sic] on and then shut it off in some of the buildings as it was too cold outside ...we are going to be hot again and we NEED to make sure that we maintain these temperatures. If it is ever a weekend or after hours these temps [sic] can still be adjusted but only by the med tech ...The director on call just needs to be in the loop if you ever adjust things so we know what's happening in case we are having issues with any of the units ...please know that we have that capability to adjust. It is hard in spring and fall to coordinate as it is cold at night and hot in day so it is hard to adjust but can be. We must always know the temp that is comfortable for our residents ...If you are unable to get things adjusted accordingly then you can call me ...24/7 ..."

On 06/16/2026, Surveyor interviewed DOA-A, A-B, and Director of Health Services C (DHS-C). DOA-A acknowledged that there was an incident where the thermostat regulating the temperatures in Resident 2's room had been missed and not switched to the cool setting when the other six thermostats in the facility had been switched to the cool setting. S/he acknowledges that the thermostat was switched to cool and within 2 hours of staff being notified of a concern, the facility's temperature was back to a comfortable level for the residents.