STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525379	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - Regional Vent Center	2815 County Highway I Chippewa Falls, WI 54729

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 did not notify the Ombudsman of residents who were transferred from the facility to a hospital for 5 of 5 residents (R) (R4, R7, R20, R31, R33).The facility was unable to locate a policy pertaining to ombudsman notification for transfers. Example 1 (R7) On 02/27/2026, R7 had a change in condition and was transferred to the hospital. On 04/15/2026 at 10:03 AM, Surveyor interviewed Nursing Home Administrator (NHA) A who stated he was unable to find documentation that the Ombudsman was notified of resident transfers and/or discharges. NHA A stated the staff member responsible for Ombudsman notification left in September of 2025 and NHA A was unable to locate the notifications to the Ombudsman requested. Example 2 R31 was admitted to the facility on [DATE], with diagnoses including respiratory failure, dependency on ventilator, and renal insufficiency/failure. Surveyor reviewed R31's medical record noting on 8/12/25, 12/24/25, 1/30/26, 3/18/26, and 4/3/26, R31 was transferred to the hospital. R31's medical record does not indicate documentation of ombudsman notification for any of R31s discharges. Example 3 R20 was admitted to the facility on [DATE], with a diagnosis including acute respiratory failure, neuromuscular dysfunction, unspecified cranial injury, and dependence on a ventilator. Surveyor reviewed R20's medical record noting on 9/24/25, 3/4/26, 3/7/26, and 3/31/26, R20 was transferred to the hospital. R20's medical record does not indicate documentation of ombudsman notification for any of R20's discharges. Facility was unable to provide evidence of ombudsman notification for R31's or R20's transfers to the hospital. Example 4 R33 was admitted to the facility on [DATE] with diagnosis of Guillain-Barre Syndrome requiring (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525379	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - Regional Vent Center	2815 County Highway I Chippewa Falls, WI 54729

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ventilator assist via tracheostomy. R33 was discharged to home on [DATE] following successful weaning off ventilator and tracheostomy removal. Review of R33's medical record does not indicate documentation of ombudsman notification of R33's discharge. Example 5 R4 was admitted to facility on 01/30/26, with diagnoses including, in part, acute chronic respiratory failure with hypercapnia, acute and chronic respiratory failure with hypoxia, unspecified protein-calorie malnutrition, type 2 diabetes mellitus with diabetic nephropathy, fusion of spine, post-polio syndrome, insomnia, hyperkalemia, scoliosis, anxiety disorder, gastrostomy status, tracheostomy, and dependence on respirator ventilator status. Surveyor reviewed R4's medical record and found R4 was hospitalized on [DATE]. Surveyor did not find that the ombudsman was contacted regarding R4's transfer to hospital on [DATE]. On 04/15/26 at 9:21 AM, Surveyor requested ombudsman notification from NHA A. NHA A stated, I will go look for the notification. No notification was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525379	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - Regional Vent Center	2815 County Highway I Chippewa Falls, WI 54729

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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interviews, the facility did not ensure the safety of food handling in accordance with professional standards for food service safety. This had the potential to affect all 13 of the 29 residents that eat orally.-Cook did not check the temperature of the fried eggs prior to serving.-Personal food was stored in the resident's refrigerator-Food was dished up in bowls with no label or date on dish or tray.-Cereal was not covered prior to leaving kitchen and going to resident's room.-Rectangular baking pans were on bottom shelf not enclosed, not covered, or inverted. -An open bag of macaroni was on kitchen shelf without an open on or use by date.Findings include:The facility's policy titled, Record of Food Temperatures reviewed on March 2024, states, Food temperatures will be checked on all items prepared in the dietary department. The facility's policy titled, Date Marking for Food Safety reviewed on 9/26/24, states, . 2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. 3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared.On 4/13/26 at approximately 8:30 AM, during kitchen tour, Surveyor observed [NAME] H fry several eggs over easy for 3 residents' breakfast. [NAME] H did not check the temperature to ensure eggs reached a safe temperature before serving to the residents. Surveyor observed a brown neoprene lunch bag, not labeled in the resident refrigerator. Surveyor asked [NAME] H about content of the bag and [NAME] H replied it was her lunch. [NAME] H immediately removed it from the fridge and stated personal/staff food was not supposed to be in the resident's refrigerator and she should have put her lunch in the breakroom fridge downstairs.Surveyor noted cottage cheese was dished up in bowls on a tray in the refrigerator without a label or date on the tray or on the bowls. [NAME] H reported she had just dished them up for breakfast and did not put a date on them.Surveyor observed [NAME] H serve a bowl of cereal not covered to a resident eating in their room. Surveyor asked [NAME] H if cereal should be covered and [NAME] H stated she forgot to put a lid on it.Surveyor noted rectangular baking pans were on bottom shelf not enclosed, not covered, or inverted. [NAME] H was not sure why some pans were not inverted or covered.Surveyor found an open bag of macaroni on kitchen shelf without an open on or use by date. [NAME] H then dated open bag.On 4/13/26 at 2:30 PM, Surveyor met with Dietary Director (DD) I, who stated employees have a refrigerator downstairs they are supposed to put their lunches in. Staff are not to put their personal lunch bags in the resident refrigerator. DD I agreed that all prepared cooked food should have a temperature taken to ensure food is cooked to a safe temperature before serving to residents, clean dishes should be introverted or covered when stored, all food should be covered when leaving the kitchen, and all opened packaged foods should be dated with open by or use by dates.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525379	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - Regional Vent Center	2815 County Highway I Chippewa Falls, WI 54729

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not immediately consult with the resident's physician when there is need to alter treatment for 2 of 5 residents (R4 and R13) reviewed for MD notification. -R4 began to have difficulty with nebulizer treatments with increased dyspnea and shortness of breath which were then held by nursing staff and not administered as physician orders specify. Staff did not notify the provider with condition change and holding of the nebulizer treatments for 2 days.-R13 had a change of condition with low oxygen saturations, and the MD was not notified of the change in respiratory status and low oxygen saturations. The next day R13 was transferred to the emergency room and was diagnosed with pneumonia. Findings include: Surveyor reviewed facility policy titled, Resident Change in Condition, last reviewed 08/25, which states, .RN notification: 1. LPN's RTs, medication aides, and other unlicensed personnel must report to the RN in charge of the resident's care, all residents experiencing a change in condition that warrants assessment and notification of the medical provider. Recognition: 3. When a change of condition does occur, the team will recognize that change from baseline and report appropriately. Surveyor reviewed facility procedure titled, The Society for Post-Acute and Long-Term Care Medicine (AMDA) Guidelines resource sheet, dated 2014-2024, which states, Immediate notification: any symptom or apparent discomfort that is: -acute or sudden in onset, and -a marked change in relation to unusual symptoms and signs, or-unrelieved by measures already prescribed. Example 1 R4 was admitted to facility on [DATE], with diagnoses including, in part, Acute chronic respiratory failure with hypercapnia, acute and chronic respiratory failure with hypoxia, unspecified protein-calorie malnutrition, type 2 diabetes mellitus with diabetic nephropathy, fusion of spine, post-polio syndrome, insomnia, hyperkalemia, scoliosis, anxiety disorder, gastrostomy status, tracheostomy, and dependence on respirator ventilator status. R4's Minimum Data Set (MDS) assessment, dated [DATE], identified on admission that R4 had a Brief Interview for Mental Status (BIMS) score of 13. This indicated R4 had intact cognition. The MDS assessment also identified R4 has impairment of upper and lower extremity bilaterally requiring total dependent assistance with bathing/showering self, transfer, and toileting. Surveyor reviewed R4's care plans: The resident [R4] is ventilator dependent related to respiratory care plan, initiated on [DATE]: -Assess for signs and symptoms of hypoxia, altered level of consciousness, irritability, listlessness, and cyanosis. -Monitor for changes in respiratory rate or death. Observe/document for use of accessory muscles. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525379	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - Regional Vent Center	2815 County Highway I Chippewa Falls, WI 54729

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify MD if significant changes. The resident [R4] has oxygen therapy related to respiratory care plan, initiated on [DATE]. -Monitor for signs and symptoms of respiratory distress and report to MD as needed: Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color changes to blue/gray. -Oxygen settings: O2 as ordered. -Monitor/document changes in condition, increased restlessness, anxiety, and air hunger. Surveyor reviewed R4's progress notes, which state, -On [DATE] at 7:25 AM, Vitals: 73% O2 on Vent. -On [DATE] at 7:25 AM, eAdmin Record, Nebulizer treatment respiratory evaluation: Document lung sounds four times a day. Resident [R4] appeared in distress. Registered Nurse (RN) suctioned scant, clear. Respiratory Therapist (RT) put on 10L O2. HR (heart rate) came down over 20 min. 0725 AM HR 86, sat 96 on 5L (liters) decreased now to 3L. Resident resting comfortably. -On [DATE] at 9:56 AM, Skilled Nursing Note: Respiratory rate regular. Lungs are clear to auscultation bilaterally. Resident with no cough. Resident with dyspnea. The resident utilizes oxygen continuously. Liter flow: 3L. Mental Status: Confusion/Disorientation: Lethargic/Comatose, Comments: resident had period of dyspnea during nebulizer treatment. RT notified. Required increased 02 for a short period of time. Pt. (patient) no longer having Shortness of Breath (SOB). -On [DATE] at 10:53 AM, eAdmin record: Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML, 3 ml via trach four times a day for wheezing or shortness of breath. On [DATE] at 10:53 AM, eAdmin Record: Note Text: Held nebulizer due to morning reaction during neb. Also, tried to change her to wean, but continued to low minute Vent alarm and appeared very breathless. Will try again later. -On [DATE] at 11:37 AM, Communication: Provider: Note Text: NP updated on blood sugar trends. See scanned sheet with written orders. -On [DATE] at 12:05 PM, Respiratory Therapy: Lung Assessments: RUL (right upper lobe) Clear. Comments: after her [R4]'s morning neb resident [R4] got SOB (short of breath) and lung sounds were a rubbing noise. She [R4] had to go on 10L O2 (oxygen) for about 20 min (minutes) until sats (oxygen saturation) remained above 90. -On [DATE] at 3:29 PM, Vitals taken, respirations 34 breaths/min. -On [DATE] at 3:31 PM, Respiratory Therapy (RT): Progress Note: RT tried weaning resident [R4], and heart rate increased, and respirations were where resident [R4] looked uncomfortable. Stopped weaning. When resident [R4] got back to baseline, RT tried giving nebs and after 4 minutes resident [R4] work of breathing and heart rate increased again, stopped neb early. Resident [R4] recovered after about 10 minutes. RT Director informed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525379	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - Regional Vent Center	2815 County Highway I Chippewa Falls, WI 54729

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On [DATE] at 6:43 PM, Condition Note: Oxygen therapy: delivery route, amount, and oxygen saturation: 02 Room Air 02 SATS 94% Pulse 113 Respirations 32. Resident [R4] states she has shortness of breath on and off all day. -On [DATE] at 7:33 PM, eAdmin record: Note Text: declined to have breathing treatment (neb). -On [DATE] at 7:35 PM, eAdmin record: Note Text: Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML, 3 ml via trach four times a day for wheezing or shortness of breath. Resident [R4] chooses not to have, was having difficulty on the am shift nebs, chooses not to have tonight. -On [DATE] at 7:36 PM, eAdmin Record: Note Text: Sodium Chloride Inhalation Nebulization Solution 3 %, 4 ml via trach four times a day for Mucous Plugging. Resident [R4] chose not to have this shift, due to difficulty during the day with treatment. -On [DATE] at 11:06 AM, eAdmin Record: Note Text: Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML, 3 ml via trach four times a day for wheezing or shortness of breath. Held d/t (due to) resident [R4] desaturations and labored breathing when nebs are running. -On [DATE] at 11:07 AM, eAdmin Record: Note Text: Sodium Chloride Inhalation Nebulization Solution 3 %, 4 ml via trach four times a day for Mucous Plugging. Held due to desaturations while nebs are running. -On [DATE] at 12:00 PM, Respiratory Therapy: Lung Assessments: Action/Plan: 7:00 AM, breathing treatment administered. Resident [R4] began to feel SOB (short of breath) and breathing harder, O2 sat dropped from 98% to 90% after 5 minutes. Breathing treatment stopped and O2 sat went up to 96% and SOB resolved. Hold future breathing treatments today.Comments: Expiratory wheezes noted which improved with suction. Rhonchi bilaterally. -On [DATE] at 12:32 PM, Respiratory Therapy Progress note: Note Text: Resident [R4] wanted to try wean mode on her vent. After less than a minute, resident [R4] O2 sat down and resident [R4] said 'hard to breathe' and was switched back to her usual vent settings. -On [DATE] at 2:26 PM, Communication: Provider (telephone order): Cough assist QID (four times a day) and Q2 prn (every 2 hours as needed) for secretions clearance. -On [DATE] at 3:08 PM, eAdmin Record: Note Text: Sodium Chloride Inhalation Nebulization Solution 3 %, 4 ml via trach four times a day for Mucous Plugging. Held due to not tolerating. -On [DATE] at 3:08 PM, eAdmin Record: Note Text: Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML, 3 ml via trach four times a day for wheezing or shortness of breath. Held due to not tolerating. -On [DATE] at 7:26 PM, eAdmin Record: Note Text: Nebulizer post treatment: Nebulizers on hold, resident is having difficulty tolerating. -On [DATE] at 7:28 PM, eAdmin Record: Note Text: Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML, 3 ml via trach four times a day for wheezing or shortness of breath. Not tolerating nebs. -On [DATE] at 9:17 AM, eAdmin Record: Note Text: Sodium Chloride Inhalation Nebulization Solution 3 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525379	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - Regional Vent Center	2815 County Highway I Chippewa Falls, WI 54729

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	%, 4 ml via trach four times a day for Mucous Plugging. Held due to resident not tolerating. -On [DATE] at 11:26 AM, eAdmin Record: Note Text: Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML, 3 ml via trach four times a day for wheezing or shortness of breath. Resident not tolerating. -On [DATE] at 11:58 AM, Communication Provider (Telephone Order): Information: CXR (chest x-ray) for increased SOB. On [DATE] at 11:10 AM, Surveyor interviewed registered nurse (RN) E and asked about facility policy regarding a change of condition. RN E reported staff follow the AMDA (American Medical Director Association) guidelines which are in binder at the nurse's station. RN E walked over to binder and provided Surveyor with copy of change in condition guidelines to notify physicians. RN E reported to Surveyor that staff would notify nurse manager on unit to report change in conditions to provider. Surveyor asked RN E if there a resident presents with low O2 saturations, increasing liters of oxygen delivered, and holding a nebulizer treatment warrant a provider notification. RN E reported that Nurse Manager C, Assistant Director of Nursing (ADON) J, or Director of Nursing (DON) B, would be contacted, and they report to the provider on call. Surveyor asked how provider is notified on nights and weekends. RN E reported that all above are still notified of the COC (change of condition) and contact the provider on call. On [DATE] at 11:18 AM, Surveyor interviewed RN K and Nurse Manager M and asked RN K and Nurse Manager M about R4, and what would constitute a COC. RN K reported staff follow the AMDA Guidelines which are in binder at the nurse's station. Nurse Manager M stated, Yes, the acute change of condition guidelines are located at nurses' station. RN K reported that any kind of change in condition that is not R4's baseline gets reported right away. Surveyor asked RN K does the provider need to be contacted when staff hold a nebulizer medication. RN K stated that all medications being held need to be reported to provider right away so that if there are any further orders or change in medication, that R4 may need for continuity of care. On [DATE] at 11:27 AM, Surveyor interviewed ADON J and asked ADON J who is responsible for notifying the provider of change in condition of a resident's status. ADON J reported that all staff are to report changes in conditions to either Nurse Manager C, ADON J, or DON B. ADON J reported that then one of the 3 of us will review chart, and all pertinent information than call the provider once all information is together. Surveyor asked ADON J if Respiratory Therapist (RT) G notified provider of respiratory condition changes. ADON J reported that all RTs are to report change in condition to floor nurses as well as Nurse Manager C, ADON J, or DON B so that one of us three can inform the provider once all information is gathered. On [DATE] at 8:01 AM, Surveyor entered NHA A's office. Present in room, were NHA A, DON B, and RT Director. Surveyor interviewed DON B and RT G. Surveyor asked DON B and RT G what expectations or parameters are taken to ensure a provider on call is notified of a change in condition such as R4 having difficulty breathing and nebulizers being held. RT G reported to Surveyor that this is a unique facility handling ventilator respiratory needs. RT G reported that residents' lung sounds such as R4's changes every minute of every day and then are treated with many interventions such as a quick nebulizer might fix the SOB or lung sound concern, as well as repositioning, or cough assistance on a short-term basis without notifying provider on call. RT G reported that after a longer amount of time residents struggling with respiratory needs that can't be corrected would warrant a provider on call to be notified. DON B reported to Surveyor that that they need to formulate specific (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525379	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - Regional Vent Center	2815 County Highway I Chippewa Falls, WI 54729

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	parameters with Medical Director L regarding when to notify provider if ventilation concerns/issues such as After bagging for a period of time with no resolution, increased SOB after so much time without correction. Surveyor asked RT G and DON B what the expectation is for holding a nebulizer medication for R4 and when should the provider on call been notified of the change in medication administration. DON B reported that all staff are to notify provider if there is a hold on a medication or need a change in a medication as soon as possible so that the provider on call can change the orders as needed. RT G reported to Surveyor that RT G should have notified provider on call in the change in nebulizer use for R4 sooner than provider was notified. On [DATE] at 10:32 AM, Surveyor interviewed Medical Director L and asked expectation for nursing staff to notify provider on call of a nebulizer medication being held when someone becomes SOB and having difficulty tolerating nebulizers. Medical Director L stated staff should notify the provider on call regarding a change in condition and needing medications held or changed. Medical Director L stated to Surveyor, Provider should be notified of condition of change, but this facility utilizes RTs, and they have the expertise and judgement to navigate respiratory concerns for short term management such as change in lung sounds, SOB, dyspnea, and increased heart rate when on ventilator. Once interventions are implemented such as repositioning, ventilator changes, cough assist, suctioning, and nebulizers and it cannot be corrected within a timely manner then provider needs to be notified as soon as possible. R4 had nebulizer treatments held due to inability to tolerate the treatments the MD was not promptly notified of this change in resident status. Example 2 R13 was admitted to the facility on [DATE] and has diagnosis that include dependance on ventilator due to chronic respiratory failure with hypoxia (low oxygen levels) and hypercapnia (high carbon dioxide levels), chronic obstructive pulmonary disease (COPD) and tracheostomy. R13 has a brief interview for mental status (BIMS) score of 15 which means cognitively intact. R13 makes own health care decisions. R13's medical record indicated R13 is full cardiopulmonary resuscitation (CPR). R13 care plan, last revised on [DATE], has Focus statements.The resident is night ventilator dependent related to respiratory failure. Goals include R13 will have no signs/symptoms of infection. Interventions include tracheostomy suctioning as necessary, ventilator at night and tracheostomy care. On [DATE] at 11:09 AM, Surveyor interviewed R13 if having thoughts/concerns using ventilator during the nighttime as ordered by R13's physician. R13 stated, I want to get out of here.I don't know why I have to have this trach (tracheostomy) in place. I don't need it. Record review of R13's medical chart: - On [DATE] at 7:20 AM, nursing documentation by registered nurse (RN) E indicated episode of R13 gasping. RN E placed R13 on ventilator with increased air flow and started to bag R13. RN E states in note resistance felt [during bagging] and unable to bag. R13's oxygen level per pulse oximetry was at 40%. RN E proceeded to perform lavage and suction R13. R13 had return of color and oxygenation (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525379	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - Regional Vent Center	2815 County Highway I Chippewa Falls, WI 54729

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	levels of 94% while on ventilator. RT D presented upon scene and took over care of R13's respiratory monitoring. - No documentation in R13's record of provider notification of respiratory event on [DATE]. - On [DATE] at 7:45 AM, R13's went to an eye appointment and subsequently was transferred to the ED for a change in condition and returned to the facility same day with a diagnosis of pneumonia. On [DATE] at 12:11 PM, Surveyor interviewed Registered Nurse (RN) F, who was involved with R13's respiratory episode on [DATE]. RN F stated R13 had been refusing suctioning and using ventilator at night off and on. RN F stated R13 will refuse the ventilator until he ends up in the hospital. RN F could not confirm if a provider was updated on R13's status on [DATE] or [DATE]. Surveyor interviewed Respiratory Therapist (RT) D on R13's refusal of ventilator at night. RT D stated, He does this all the time.has been noncompliant for a long time. RT D stated R13 refuses the ventilator and suctioning or treatments, then ends up in the hospital. RT D stated nursing management is updated to a resident change in status and the provider is notified. RT D documents all assessments in medical records. Provider routine rounding progress notes dated [DATE], [DATE], [DATE], [DATE] and [DATE] had no indication that provider(s) was aware R13 refused ventilator at night and/or treatments. On [DATE] at 2:25 PM, Surveyor interviewed Director of Nursing (DON) B regarding staff expectations for reporting any changes in condition to a provider. DON B stated nursing manager (NM) C rounds in the mornings and speaks with staff. When staff identify a change in resident's condition or need to notify a physician, NM C gathers information from them and places a call to update the provider. It is expected that NM C documents provider notifications in the medical record. Surveyor asked DON B if the event on [DATE] for R13 required physician notification. DON B stated because it was felt R13 had a mucous plug requiring suctioning only, the physician would not need to be updated. Surveyor asked DON B since it was determined the next day after another respiratory event at outside facility that R13 had pneumonia, should that have required a physician notification earlier to possibly have prevented a transfer to the hospital. DON B confirmed it would fall under requirements for physician notification. DON B confirmed with Surveyor that R13 was full code status. DON B could not provide any documentation that a provider was notified of R13's change in respiratory status for [DATE] or [DATE].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525379	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - Regional Vent Center	2815 County Highway I Chippewa Falls, WI 54729

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interview the facility did not provide the accurate Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) thus did not provide the accurate potential financial liability to residents whose Medicare coverage ended for 1 of 1 resident reviewed (R7).R7 was receiving Medicare A benefits. R7's Medicare coverage ended on 12/12/25. R7 was not provided with a SNFABN form thus not provided with accurate financial liability. Evidenced by: Surveyor reviewed R7's beneficiary notices for Medicare Part A services ending. Surveyor could not find that a SNFABN Form was given to R7 to inform R7 of the financial liability. On 04/14/26 at 1:13 pm, Surveyor interviewed Nursing Home Administrator (NHA) A and asked for beneficiary notices for R7 when R7's Medicare benefits were ending. NHA A stated to Surveyor that NHA A admits to not giving R7 a SNFABN form when R7's benefits were about to end. NHA A reported that the person in charge of making sure beneficiaries are completed has not worked since September of 2025, so this SNFABN form was missed for R7.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525379	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - Regional Vent Center	2815 County Highway I Chippewa Falls, WI 54729

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not develop a comprehensive person-centered care plan for the diagnosis of fluid overload and new anticoagulation medication administration post hospitalization for 1 of 16 residents (R) R4 reviewed for care plans.This is evidenced by: R4 was admitted to facility on 01/30/26, with diagnoses including, in part, acute chronic respiratory failure with hypercapnia, acute and chronic respiratory failure with hypoxia, unspecified protein-calorie malnutrition, type 2 diabetes mellitus with diabetic nephropathy, fusion of spine, post-polio syndrome, insomnia, hyperkalemia, scoliosis, anxiety disorder, gastrostomy status, tracheostomy, and dependence on respirator ventilator status. Surveyor reviewed R4's physician orders, which state, .-Apixaban 2.5 mg give 1 tablet via G-Tube two times a day for Deep Vein Thrombosis (DVT) based on age greater than 80 and weight less than 60kg.-Side effect: Anticoagulant-Monitor for side effects: Blood in urine/stool, black stool, severe bruising, prolonged nosebleeds, bleeding gums, vomiting/coughing up blood, every shift Complete documentation in progress note if side effects noted. Surveyor reviewed R4's hospital note from 02/25/26, which states, .[R4] has a history of restrictive lung disease secondary to post-polio syndrome, chronic hypoxic and hypercapnic respiratory failure, ventilator dependence via tracheostomy, type 2 diabetes with nephropathy, malnutrition with PEG, and recurrent ventilator associated pneumonia, who was admitted on [DATE] for acute on chronic respiratory failure with hypercapnia and hypoxia. On arrival [R4] is lethargic and significant pressure is necessary to sufficiently bag the patient for chest rise. Heart rate 121, and respirations 8. Physical examination: Lethargic, critically ill appearing, malnourished, moderate respiratory distress, toxic. For the acute pulmonary embolism, [R4] was initially treated with heparin infusion and subsequently transitioned to apixaban. Therapeutic thoracentesis was performed on 2/22, with removal of 1.1 L of serous fluid from the right pleural space, resulting in improved respiratory comfort. Record review identified R4 had fluid overload concerns with pitting edema when transferred to hospital on [DATE]. R4 was re-admitted to the facility on [DATE] after being diuresis in the hospital and placed on anticoagulation medication to take twice daily. Review of R4's care plan identified no problems or interventions related to R4's recent hospitalization with fluid overload and assessing for edema. Review of R4's care plan identified no problems or interventions related to R4's recent need of an anticoagulation. On 04/15/26 at 10:41 AM, Surveyor interviewed Director of Nursing (DON) B and asked if R4 should have a fluid overload and anticoagulation comprehensive care plan in place post hospitalization for stated above concerns to decrease complications or readmissions into hospitals. DON B reported that R4 should have both comprehensive care plans in place for fluid overload and anticoagulation therapy, so that staff have interventions to help assist R4 in R4's overall health. DON B reported that DON B would create R4's care plan for fluid overload and anticoagulation therapy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525379	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - Regional Vent Center	2815 County Highway I Chippewa Falls, WI 54729

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not review/revise the resident's person-centered comprehensive care plan for 1 resident (R13) of 16 residents reviewed for care plans in a sample of 16 residents. The facility's interdisciplinary team (IDT) did not update/revise R13's care plan after each quarterly or comprehensive review assessments to reflect R13's refusals of using the ventilator at night and noncompliance to fluid restrictions, resulting in a possible decline in R13's physical health and hospitalization.Findings include:The facility policy, titled Care Plan Revisions Upon Status Change, last revised 05/05/2025, states, The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change.R13 was admitted to the facility on [DATE] and has diagnoses that include dependance on ventilator due to chronic respiratory failure with hypoxia (low oxygen levels) and hypercapnia (high carbon dioxide levels), chronic obstructive pulmonary disease (COPD), tracheostomy, chronic heart failure. R13 has a brief interview for mental status (BIMS) score of 15/15 which means cognitively intact. R13 makes own health care decisions. R13 care plan, last revised on 02/19/2026, has Focus statements, I have a nutritional problem related to.ventilator dependence at night. The resident is night ventilator dependent related to respiratory failure. Goals include R13 will maintain weight as evidenced by no significant weight gain and R13 will have no signs/symptoms of infection. Interventions include fluid restriction, tracheostomy suctioning as necessary and tracheostomy care. On 04/13/2026 at 8:50 AM, R13 was observed sitting at dining table eating breakfast independently. R13 did not have ventilator in place and was using portable oxygen. On 04/13/2026 at 11:09 AM, Surveyor interviewed R13 and asked if having thoughts/concerns using ventilator during the nighttime as ordered by R13's physician. R13 stated, I want to get out of here.I don't know why I have to have this trach (tracheostomy) in place. I don't need it. Record review of R13's medical chart:- R13 was admitted to facility with physician orders for ventilator use during nighttime hours to reduce episodes of hypoxia. R13 has a tracheostomy is place with oxygen use during daytime hours. - R13 has physician orders dated 02/12/2026 for fluid restriction - not to exceed 2200cc (milliliters) to 2800cc. Dietary amount: 1500cc; AM nursing amount 500cc, PM nursing amount 500cc; night (NOC) nursing amount 300cc. - R13 has physician orders dated 02/12/2026 to suction and/or lavage with normal saline.to clear catheter. - R13 has physician order dated 02/12/2026 for ventilator at night. Trach collar during the day. - Nursing documentation dated 02/12/2026 to current date, indicate R13 is noncompliant with fluid restrictions, taking in excess amounts of fluids. Dietary notations of R13's weight gain of 7.61% in past 90 days. R13 has had education of risks of excessive fluid intake by a dietician and nursing. - Nursing documentations indicate R13 repeatedly refuses cares that include suctioning of tracheostomy, nebulizer treatments and ventilator use at nighttime since 01/26/2026. - R13 was hospitalized for respiratory complications 01/30/26 to 02/12/2026. R13 was evaluated in the emergency department on 03/25/2026 for respiratory complications. - R13's care plan does not have revised risk/benefit or education provided to R13 regarding R13's choice to not follow physician ordered fluid restrictions. - R13's care plan does not have revised risk/benefit or education to R13 or alternative treatment interventions in place for R13's refusal of tracheostomy suctioning, nebulizer treatments or ventilator use during the night. On 04/14/2026 at 12:11 PM, Surveyor interviewed Registered Nurse (RN) F on R13's use of ventilator at night. RN F stated R13 has been refusing suctioning and using ventilator at night off and on because R13 believes he can have tracheostomy removed and go home. RN F stated R13 is also noncompliant with fluid restriction and drinks over the amount allowed, which results in R13's weight gain. On 04/14/2026 at 12:45 PM, Surveyor interviewed Respiratory Therapist (RT) D on R13's refusal of ventilator at night. RT stated, He does this all the time.has been noncompliant for a long time. On 04/14/2026 at 2:25 PM, Surveyor (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525379	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - Regional Vent Center	2815 County Highway I Chippewa Falls, WI 54729

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interviewed Director of Nursing (DON) B what staff expectations are for revising and updating a resident's care plan. DON B stated care plans are reviewed quarterly by the IDT (Interdisciplinary Team) and changes are made if needed. If there are any changes in a resident's plan of care outside of the quarterly review, including refusals of care or noncompliance of cares, it is to be communicated to a nursing manager, who then will update care plan.