

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Dove Healthcare - Superior		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 New York Ave Superior, WI 54880	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>47657</p> <p>Based on interview and record review, the facility did not report an incident of a resident-to-resident altercation, when a resident (R) R5 grabbed wrist of R4, resulting in R4 being transferred to emergency room for x-rays and acquiring bruising to wrist, to the State Survey Agency or police department, immediately upon learning of the incident and did not submit the 5-day completed investigation within 5 days as required. The facility practice had the potential to affect 1 of 4 residents (R) reviewed for abuse (R4).</p> <p>This is evidenced by:</p> <p>The facility policy titled, Resident Abuse, Neglect, Misappropriation of Property, and Exploitation Prevention Program last reviewed October 2024, states in part under section 7. Reporting/Response, To whom to report - To the Administrator, State survey agency, local law enforcement. An Adult Protective Services; and when to report, Immediately but not later than two hours after forming the suspicion and if no seriously bodily injury report not later than 24 hours . Report results of all investigations of alleged violations within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>On 12/17/24, Surveyor reviewed the facility's self-report that occurred on 10/05/24 between R4 and R5 where it was noted that R5 had grabbed a tight hold around R4's wrist while in dining room resulting in developing bruising to wrist following a trip to emergency room to rule out any fractures. This facility did not report incident until 10/09/24 and did not submit completed investigation until 10/15/24.</p> <p>R4 was admitted to facility on 06/19/18 with diagnosis of Alzheimer's and vascular dementia.</p> <p>R4's most recent Minimum Data Set (MDS) was an annual assessment with a target date of 11/11/24, which indicated R4 has short term and long-term memory problems and is severely impaired for decision making.</p> <p>R4's care plan indicates alteration in mood and behavior and can be aggressive towards others.</p> <p>R5 was admitted to facility on 06/08/22 with diagnosis of traumatic subdural hemorrhage, Alzheimer's, and delusional disorder.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R5's most recent MDS was a quarterly assessment with a target date of 10/03/24 which indicated R5 has both short-term and long-term memory problems and is rarely/never understood.</p> <p>R5's care plan indicates an alteration in behavior with behavioral disturbances and anger outbursts.</p> <p>On 12/17/24 at 1:07 PM, Surveyor attempted to interview R5 but R5 would not respond.</p> <p>On 12/17/24 at 1:11 PM, Surveyor interviewed R4 who had no recollection of the incident.</p> <p>On 12/18/24 at 11:15 AM, Surveyor interviewed Assistant Nursing Home Administrator (NHA) B who stated the facility was made aware of the incident that occurred on 10/05/24 immediately but had not reported incident to the State Survey Agency until 10/09/24 and police were not notified of incident per policy.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>47657</p> <p>Based on interview and record review, the facility did not conduct an investigation of a resident-to-resident altercation that occurred on 10/05/24, wherein resident (R) R5 grabbed wrist of R4, resulting in R4 being transferred to emergency room for x-rays. Immediately upon learning of the incident, the facility did not conduct an investigation, staff and residents were not interviewed, interventions and monitoring were not put into place to prevent reoccurrence until 10/09/24. The facility practice had the potential to affect 1 of 4 residents (R) reviewed for abuse (R4).</p> <p>This is evidenced by:</p> <p>The facility policy titled, Resident Abuse, Neglect, Misappropriation of Property, and Exploitation Prevention Program last reviewed October 2024, states in part under section 7. Reporting/Response, Dove healthcare must report alleged violations related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source and misappropriation of resident property and report the results of all investigations to the state survey agency, and other proper officials such as law enforcement and adult Protective Services within the prescribed time frame this required reporting is the responsibility of the administrator or designee.</p> <p>On 12/17/24, Surveyor reviewed the facility's self-report that occurred on 10/05/24 between R4 and R5 where it was noted that R5 had grabbed a tight hold around R4's wrist while in dining room resulting in developing bruising to wrist following a trip to emergency room to rule out any fractures.</p> <p>R4 was admitted to facility on 06/19/18 with diagnosis of Alzheimer's and vascular dementia.</p> <p>R4's most recent Minimum Data Set (MDS) was an annual assessment with a target date of 11/11/24, which indicated R4 has short term and long-term memory problems and is severely impaired for decision making.</p> <p>R4's care plan indicates alteration in mood and behavior and can be aggressive towards others.</p> <p>R5 was admitted to facility on 06/08/22 with diagnosis of traumatic subdural hemorrhage, Alzheimer's, and delusional disorder.</p> <p>R5's most recent MDS was a quarterly assessment with a target date of 10/03/24 which indicated R5 has both short-term and long-term memory problems and is rarely/never understood.</p> <p>R5's care plan indicates an alteration in behavior with behavioral disturbances and anger outbursts.</p> <p>On 12/17/24 at 1:07 PM, Surveyor attempted to interview R5 but R5 would not respond.</p> <p>On 12/17/24 at 1:11 PM, Surveyor interviewed R4 who had no recollection of the incident.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/18/24 at 11:15 AM, Surveyor interviewed Assistant Nursing Home Administrator (NHA) B who stated the facility was made aware of the incident that occurred on 10/05/24 immediately but had not reported incident to the State Survey Agency until 10/09/24 and police were not notified of incident per policy. Assistant NHA B confirmed that an investigation was not initiated, and interventions were not put into place to prevent reoccurrence until 10/09/24.</p> <p>NHA A stated that residents and staff interviews were not conducted, and staff were not educated following this incident.</p>		