STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525425	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - Fennimore	1850 11th St Fennimore, WI 53809

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. .Based on document review, interview and policy review, the facility failed to protect the resident's rights for one of two residents (R1) reviewed for abuse to be free from verbal abuse. Facility failed to protect R1 from verbal abuse.Findings include:Review of the facility's policy titled, Resident Abuse, Neglect, Misappropriation of Property, and Exploitation Prevention Program dated October 2023 revealed, Purpose.to protect its residents from abuse.Policy: Each resident has the right to be from abuse.Abuse includes verbal abuse. Review of the facility's investigative file revealed on 09/11/25 at approximately 6:00PM (evening meal), revealed that two Certified Nurse Aides (CNA) 2 and CNA3 witnessed an incident involving R1 and CNA1. During the evening meal, R1 was asking for reassurance about what he should eat or drink. R1 uses repetitive phrases and words as part of his normal communication style. CNA 2 and CNA3 stated that they witnessed CNA1 respond to R1's repetitive vocalizing by leaning close to him and saying R1, R1, R1, do you hear me? Well, I can hear you. You don't like that either, do you. CNA2 and CNA3 stated that CNA1 appeared visibly annoyed. CNA2 noted that R1 lowered his head and said okay. CNA2 stated that R1 appeared sad.During an interview on 10/14/25 at 3:30 PM, the Abuse coordinator (Administrator) confirmed that CNA1 had verbally abused R1 during the evening meal on 09/11/25.Facility failed to protect R1 from verbal abuse.

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. .Based on document review, interview and policy review, the facility failed to thoroughly investigate an allegation of verbal abuse for one of two residents (R1) reviewed for abuse. The failure to thoroughly investigate an allegation of abuse had the potential to negatively impact residents in the facility.Findings include:Review of the facility's policy titled, Resident Abuse, Neglect, Misappropriation of Property, and Exploitation Prevention Program dated October 2023 revealed, .Investigation would include interviews with staff working on the shift when the abuse occurred as well as include interviews with staff that worked the previous shift.Review of the facility's investigative file revealed on 09/11/25 at approximately 6:00PM (evening meal), two Certified Nurse Aides (CNA) 2 and CNA3 witnessed an incident involving R1 and CNA1. During dinner, R1 was asking for reassurance about what he should eat or drink. R1 uses repetitive phrases and words as part of his normal communication style. CNA2 and CNA3 stated that they witnessed CNA1 respond to R1's repetitive vocalizing by leaning close to him and saying R1, R1, R1, do you hear me? Well, I can hear you. You don't like that either, do you. CNA2 and CNA3 stated that CNA1 appeared visibly annoyed. CNA2 noted that R1 lowered his head and said okay. CNA2 stated that R1 appeared sad.Review of the facility's investigative file for R1 revealed that the abuse coordinator (Administrator) confirmed that CNA1 had verbally abused R1 during the evening meal on 09/11/25.During an interview on 09/14/25 at 3:30 PM, the Administrator reviewed the nursing schedule for 09/11/25 and stated that Registered Nurse (RN)1, Licensed Practical Nurse (LPN)2, CNA1, CNA2 and CNA3 worked the evening shift on 09/11/25, which included the evening meal.Review of the facility's investigative file revealed that there were no statements from RN1 or LPN2. In addition, the investigative file did not include staff interviews from the previous shift. During the interview on 09/14/25 at 3:30 PM, the Administrator confirmed that the investigative file did not include the staff interviews as indicated in the facility's Abuse policy.