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	09/10/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure adequate supervision and safety to prevent accidents from occurring for 1 of 3 residents (R7) reviewed for falls out of a total sample of 12.R7 had a history of falls including one that resulted in a T11 spinal fracture and another that resulted in a laceration with 2 staples and a subdural hematoma. The facility did not complete a thorough root cause analysis on the falls or ensure that care planned interventions were in place for R7.As evidenced by:Facility policy, titled Fall Prevention Program, with last revision date of 8/2024, includes, in part: Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Policy Explanation and Compliance Guidelines: . 5. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. A. Interventions will be monitored for effectiveness. B. The plan of care will be revised as needed. 6. When any resident experiences a fall, the facility will. e. Review the resident's care plan and update as indicated. 7. Review each fall/fall investigation during the next morning meeting/clinical meeting with the interdisciplinary team (IDT). Actions may include: a. Review investigation and determination of potential root cause of fall; b. Review of fall risk care plan and update; c. Additional revisions to the care plan; Education of staff as to any care plan revisions as needed.R7 was admitted to the facility on [DATE] with diagnoses that include, in part: Parkinson's Disease, Weakness, Other Chronic Pain, Unsteadiness on Feet, Pain in Right Knee, and History of Falling.R7's most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/31/25, indicates R7 has a Brief Interview of Mental Status (BIMS) of 14 out of 15, indicating R7 is cognitively intact. Section GG (Functional Abilities) of R7's MDS indicates R7 requires substantial/maximum assistance with toileting and partial/moderate assistance with transfers and ambulating. Section H of R7's MDS indicates that R7 is occasionally incontinent of both bowel and bladder, and that a toileting program had not been trialed, and a bowel program was not currently being used.R7's comprehensive care plan, includes, in part:--Focus: The resident is at risk for falls r/t (related to) deconditioning, gait/balance problems secondary to Parkinson's disease, frequent falls at home. Date Initiated: 11/22/23. Revision on: 11/22/23.--Goal: The resident will be free of major injury r/t falls through the review date. Date Initiated: 11/22/23. Revision on: 8/20/25.--Interventions include, in part: Grip strips at side of bed to provide traction when he is transferring to/from bed. (Date Initiated: 12/31/24). Gripper socks when not wearing shoes (Date Initiated: 10/21/24). Education provided to wear gripper socks when not wearing shoes. (Date Initiated: 1/13/25). Assure resident . has appropriate size gripper socks. (Date Initiated: 1/16/25). When weighing resident, use portable scales on end of 200 wing to take to room. (Date Initiated: 3/24/25). Dycem in recliner chair. (Date Initiated: 4/10/25). Make sure that resident has gripper socks with grips on both sides and remove and replace grip strips on the floor. (Date Initiated: 5/2/25). Replace grip strips on floor. (Date Initiated: 7/21/25). Risk vs. benefits of having oversized chair placing resident at risk for sliding out and doesn't provide enough core stability to manage balance problems. Resident is refusing to get or try a different chair that places him at risk (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
	525425	A. Building B. Wing	09/10/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	for injury, fracture, or even death. (Date Initiated: 7/21/25). Adjust dimension of chair stabilizer behind chair from square to triangular to fit in the corner. (Date Initiated: 8/6/25).--Focus: The resident as an ADL (Activities of Daily Living) self-care deficit r/t Parkinson's disease, DM (Diabetes Mellitus). Date Initiated: 11/22/23. Revision on: 11/22/23.--Interventions: Toilet Use: ambulate to/from bathroom with assist of 1 with gait belt and FWW (front wheeled walker). Date Initiated: 10/24/24. Revision on: 10/24/24 . Transfer: assist of 1 with gait belt and walker. Date Initiated: 11/22/23. Revision on: 8/7/24.On 10/14/24 at 1:15 AM, R7 had an unwitnessed fall in his room. The fall incident report indicates, in part: Resident was found. lying on the floor. head against the recliner in his room. Resident was not wearing gripper socks or shoes, he was barefoot . Injuries: bruise to right forearm, skin tear to right forearm, skin tear to left forearm. Resident was incontinent at time of fall. No root cause identified. Progress Note linked to this fall report indicates on 1/8/25: New result from MRI showing a T11 fracture. This does explain the pain. (R7 did not have a Power Chair/Recliner Screen completed prior to this fall or after falling from his recliner chair.)On 1/12/25 at 5:30 AM, R7 had an unwitnessed fall in his room. The fall incident report indicates, in part: Resident was found. laying on his back on the floor. in the doorway between his bathroom and bedroom. he had removed his left sock and it was sitting on his bedside table. Injuries: skin tear to left toe, skin tear to left forearm. No root cause identified.(Of note, on 1/12/25, the facility Fall Risk Evaluation was completed, with a score of 17, indicating R7 was a high risk for falls). On 3/22/25 at 12:15 PM, R7 had a witnessed fall while being weighed. The fall incident report indicates, in part: . CNA was attempting to weigh the resident with the stand up scale per usual and resident stepped off the left side of the scale causing him to lose his balance and fall. hitting his head on the night stand and hitting his left arm on the recliner. Injuries: abrasion to left arm. No root cause identified.(Of note, on 3/22/25, the facility Fall Risk Evaluation was completed, with a score of 9, indicating R7 was a low risk for falls).On 4/9/25 at 8:40 PM, R7 had a witnessed fall in his bathroom. The fall incident report indicates, in part: Resident was sitting in his recliner. the CNA (Certified Nursing Assistant) went to his closet to get his clothes out and during that time he had raised his electric recliner all the way up. he attempted to stand up out of his chair and slid. to the floor. Injuries: skin tear to right elbow, skin tear to back of left hand, skin tear to right knee.Root cause: weakness following hospitalization .(Of note, on 4/9/25, the facility Fall Risk Evaluation was completed, with a score of 15, indicating R7 was a medium risk for falls).On 5/1/25 at 9:20 AM, R7 had an unwitnessed fall in his room. The fall incident report indicates, in part: . The resident stated that he was attempting to go to the bathroom when he fell. states that he did hit his head on the way to the floor. Injuries: skin tear to left elbow. No root cause identified.(Of note: On 5/1/25 the facility Fall Risk Evaluation was completed, with a score of 15, indicating R7 was a medium risk for falls).On 7/15/25 at 10:50 PM, R7 had an unwitnessed fall in his room. The fall incident report indicates, in part: Resident found sitting in front of recliner. states he slid out of chair. No injuries. No root cause identified.(Of note: this is the 2nd time R7 has fallen out of his recliner. R7 does not have a Power Chair/Recliner Screen. Risk vs benefits were added to the care plan on 7/19/25).On 7/19/25 at 4:40 PM. R7 had an unwitnessed fall in his room. The fall incident report indicates, in part: . Resident states that he did not use the call light to self-transfer to the bathroom and that he knew he should have. Injuries: skin tear to left elbow. Root cause: ill-fitting chair.(Of note: this is the 3rd fall revolving around the bathroom, and R7's toileting pattern has not been assessed, and he does not have a toileting program. On 7/19/25 the facility Fall Risk Evaluation was completed, with a score of 15, indicating R7 was a medium risk for falls.)On 8/6/25 at 2:00 AM, R7 had an unwitnessed fall in his room. The fall incident report indicates, in part: .resident was found to be laying on his back in front of electric recliner that was positioned in the maximum upright position, dysom (sic) and chair cushion on floor near chair. resident states he was trying to reposition himself in the chair and slipped. blood found on floor near resident. resident was found to have head injury. when attempting to reposition patient to prepare to transfer resident, resident c/o (complained of) extreme pain to lower back. it was found that resident had an episode of emesis, resident does not (continued on next page)

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	09/10/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	know if this happened prior to or after fall. Injuries: laceration to back of head. Root cause: slipped.R7's ER notes on 8/6/25 states, in part: Patient. found on the floor in front of his wheelchair. There was emesis in front of the chair. Patient states that he might of slid out of his chair but does not remember falling out of his chair or hitting his head or vomiting. Laceration of scalp without foreign body. 1.5 cm (centimeter) posterior scalp laceration noted in the occipital area. 2 staples placed. subdural hematoma along the interhemispheric fissure.(Of note: this is R7's 3rd time falling out of his recliner, R7 did not have a Power Chair/Recliner Screen completed prior to this fall and this fall resulted in a head injury requiring staples.)R7's most recent fall risk assessment, dated 8/8/25, indicated a score of 16, indicating that R7 is a high fall risk.R7's Power Chair/Recliner Screen, dated 8/21/25, indicated that R7 was able to use his power recliner with no restrictions.(Of note, there were no other Recliner evaluations completed before 8/21/25, although R7 had had 2 previous falls from the recliner).On 9/8/25 at 10:52 AM, Surveyor observed R7 in his room in his recliner with the feet up. Surveyor asked R7 about his recent falls. R7 laughed and stated that he has had many falls and feels increasingly unsteady. R7 indicated that he uses his walker to ambulate and that he tries to get staff to go with him to the bathroom.On 9/10/25 at 10:29 AM, Surveyor observed R7 being wheeled to his room via wheelchair. R7 stated he just got back from being weighed in the shower room. Surveyor stepped out of the room while CNA C (Certified Nursing Assistant) assisted R7 with completing dressing. Surveyor re-entered R7's room and observed R7 sitting in his recliner. Surveyor observed the dycem anti-slip mat on the table next to the recliner. Surveyor asked R7 if he had any dycem in his recliner at that time. R7 stated no, that he was supposed to have a cushion in the chair but that the staff were unable to locate it. R7 stated that the dycem was supposed to be for the cushion, but that it was not in his chair and that it gets worn and slides off.On 9/10/25 at 10:33 AM, Surveyor interviewed CNA C who confirmed that there was no dycem or cushion under R7 in his recliner, only a soaker pad. Surveyor asked CNA C if the dycem should be in the recliner if it was one of his care planned interventions. CNA C stated yes, if dycem was on his care plan than he should have it in his chair.On 9/10/25 at 11:19 AM, Surveyor interviewed RN D (Registered Nurse) and asked what R7's current fall interventions were. RN D accessed R7's EHR (Electronic Health Record) and stated that grip strips in front of the recliner, gripper socks on when not wearing shoes, assure he has the appropriate sized gripper socks, and dycem in the recliner were some of R7's current fall interventions. RN D stated that R7 had been educated on his chair being too large for him. RN D stated that recently the recliner has been a big issue, and they had talked to him and his wife about getting fitted for a new recliner but that R7 is not willing to give it up his current recliner.On 9/10/25 at 11:27 AM, Surveyor interviewed CNA C about R7's current fall interventions. CNA C stated that R7's current fall interventions include having two staff assistance when they can, strips in front of his chair, making sure that he has gripper socks on and that his feet are firmly planted before moving forward.On 9/10/25 at 11:32 AM, Surveyor interviewed CNA E about R7's current fall interventions. CNA E stated that R7's current fall interventions include gripper socks if he doesn't have his shoes on, black strips in front of his chair, and a sign that says don't stand up and to call for assistance.On 9/10/25 at 2:12 PM, Surveyor interviewed DON B (Director of Nursing) about R7's multiple falls. DON B stated that they have tried about everything with R7 and tried to get him to go with a different chair because his current recliner doesn't fit him anymore. Surveyor asked DON B about R7's current fall interventions. DON B accessed R7's EHR and indicated R7's current fall interventions include gripper socks when not wearing shoes, PT (physical therapy) to evaluate, make sure he has the appropriate size gripper socks or his shoes for transfers, and dycem in the recliner. DON B stated that they like him to put the dysem between the recliner seat and the cushion and then also to put dycem on top of the cushion to keep him from sliding out. Surveyor asked DON B how they determine if the fall interventions for R7 are effective. DON B stated that they just monitor to make sure that something is working. Surveyor asked DON B if they had identified a root cause for each of R7's falls. DON B stated that yes, the IDT (interdisciplinary team) identified the root cause during the next morning's huddle. (continued on next page)

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	09/10/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor asked DON B if just indicating slipped was a true root cause of a fall. DON B indicated no, that was probably not the true root cause. Surveyor asked DON B if R7 had a toileting schedule or bladder and bowel program initiated. DON B stated that R7 had been on a toileting schedule, but that she couldn't find any documentation of it. Surveyor shared with DON B her observations and asked DON B if she would expect R7's care plan to be followed. DON B stated yes, that was her expectation.The facility failed to identify a true root cause for R7's repeated falls, and failed to ensure that the fall interventions on R7's care plan were adequately enforced. R7 had multiple falls, including two that resulted in major injury.

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	09/10/2025

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 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 and interview, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. This has the ability to affect all 34 residents.Food items were not dated or were expired.Food items were improperly storedA scoop was found in dry ingredients.Evidenced by:On 9/8/24 at 9:51 AM, Surveyor observed, along with DM I (Dietary manager), the following inside the main kitchen's walk-in refrigerator:*An opened pack of sliced cheese with no open date or use by date.*An opened pack of 3 tortillas with no open date or use by date.*2 baked potatoes in a Ziplock bag with 8/25 written on bag.*5 loaves of bread with no use by or expiration dates.*An apple on the floor At 10:15 AM, Surveyor observed an open bag of milk crystals with no date in the dry storage area. At 10:19 AM, DM I indicated to Surveyor that the above food items should be dated and discarded the baked potatoes and apple. Example 2On 9/08/2025, Surveyor observed the following, along with DM I, in the facility's main kitchen:*At 10:03 AM: box of pork ribs on the floor inside the walk-in freezer.*At 10:14 AM: a box of orange juices, a box of elbow macaroni, a box of canned vegetables and a box of rhubarb pie mix on the floor in the dry storage room. DM I stated to surveyor at 10:19 AM that she had been gone the previous week on Friday and was unable to ensure the items in the dry storage were put away timely and removed from the floor. Example 3On 9/8/25 at 10:09 AM, Surveyor observed, in the facility kitchen's dry storage area, a 20-liter container of corn starch with a scoop inside.At 10:19 AM, DM I stated to Surveyor that the scoop should not be inside the corn starch as this is an infection control concern.

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	09/10/2025

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and interview, the facility did not ensure that garbage and refuse was disposed of properly. This has the potential to affect all 34 residents.Garbage was observed surrounding the garbage dumpster.Evidenced by:On 9/8/2025 at 9:51 AM, Surveyor and DM I (Dietary Manager) observed the following outside the facility in the garbage dumpster area:*Used napkins*Approximately 10 used latex gloves*Various unknown food items crushed into the ground*Condiment packetsIt should be noted that these items were surrounding the dumpster area and also along the small hillside on the backside of the garbage dumpsters.On 9/8/25 at 9:53 AM, DM I indicated to Surveyor that there was too much garbage on the ground, and it was dirty and needed to be cleaned up. DM I was unable to identify the food items that were crushed on the ground.

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	09/10/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the Facility did not ensure allegations of abuse, suspected neglect, and/or injury of unknown origin were reported to the State Agency during the required timeframe for 1 of 12 residents (R26) reviewed.On 8/31/25, R26 reported to the facility staff that another resident came into his room and was yelling at R26 and poured urine on R26's shoes. The facility did not report this to the state agency.This is evidenced by:The facility's policy titled, Resident Abuse, Neglect, Misappropriation of Property, and Exploitation Prevention Program, last revised on 10/23, states: Each resident of [Facility Name] has the right to be free from abuse, neglect. Residents will not be subjected to abuse by anyone, including but not limited to,.any other individuals. Alleged violation is a situation or occurrence that is observed or reported by staff, resident.but not yet been investigated. Reporting/Response: [Facility Name] ensures all staff/covered individuals are trained.on reporting requirements which includes: What is to be reported - Any reasonable suspicion of a crime against a resident or individual receiving care from the facility, and all alleged violations of abuse. Who is required to report - The facility and any covered individual, which means owner, operator, employee, manager, agent or contractor of the facility. To whom to report - To the Administrator, State Survey Agency, local law enforcement, and adult protective services; and When to report - .All alleged violations, report immediately but not later than 2 hours if the alleged violation involves abuse. The Administrator or designee will report immediately all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property to the Division of Quality Assurance (DQA) via the online reporting system and maintain a copy of the report.R26's nurses progress note, written by LPN H (Licensed Practical Nurse), dated 8/31/25 at 9:47 AM, states: Resident (R26) voiced to therapy aide that another resident, [R15], went into residents room (R26's room) early this morning and was yelling at him. Resident (R26) states that he isn't able to put on any pairs of his shoes because they are wet with urine. Resident (R26) states that [R15] spilled his urinal out on his (R26) shoes and now he (R26) cannot wear any of his shoes. [R15] was questioned and states he never went into residents (R26) room. [R15] was not noted by staff to have been in [R26] room.On 9/9/25 at 3:00 PM, Surveyor called LPN H and was unsuccessful in contacting LPN H.On 9/9/25 at 3:20 PM, Surveyor interviewed DON B (Director of Nursing) regarding the incident between R15 and R26. DON B indicated the incident could be viewed as an allegation of abuse because it was a resident to resident altercation. DON B indicated she believed SS G (Social Services) and NHA A (Nursing Home Administrator) investigated the incident.Surveyor reviewed the facility's grievance/complaint log for August 2025 and September 2025. There was no grievance listed for R26 related to this incident.On 9/9/25 at 4:00 PM, SS G handed surveyor a redacted, hand-written grievance form. The grievance form states the following: Date occurred: 8/31/25 appox 5 am (Approximately 5:00 AM). Discovery date 8/31/25. Reported by: RN D (Registered Nurse). Concern: [R26] told a nurse that his neighbor [R15] entered his room and emptied a urinal into [R26]'s shoes . Investigation: [R15] stated: Resident stated I had nothing to due [sic] with this. [R26] stated: see attached.Of note, the attached paper included two progress notes from R26's electronic medical record. One progress note was the note from LPN H dated 8/31/25 at 9:47 AM.The second note, dated 9/2/25 at 10:45 AM, was a late entry written by NHA A, states: This writer spoke to [R26] on 9/2/25 and asked him about this incident. [R26] was unable to provide detail on this incident other than he stated that the neighboring resident, [R15], had entered his room at some point during the night or early morningand [sic] emptied a urinal into his shoes. He also stated to staff that maybe it could have been water, but he didn't think so. Writer asked [R26] if his shoes had been cleaned appropriately, and he stated yes, writer offered new shoes, and he refused. Writer also asked [R26] if he had any concerns about his safety around the other resident. [R26] laughed and said it was fine, and not to worry about it. Writer (continued on next page)

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	09/10/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	offered to file grievance on his behalf and he stated, ?it was in the past' and not to worry about it. Writer asked [R15] if he had been in [R26] room and emptied urine into his shoes. [R15] stated he didn't do this and that he didn't know what I was talking about. [R15] does not have any previous history of entered other residents' rooms anddisturbing [sic] their personal property. Informed [R26] that if [R15] entered his room again or made any statements that made him feel uncomfortable to please tell staff right away. Of note, this note was entered on 9/9/25 at 3:50 PM. This was 20 minutes after surveyors interviewed DON B regarding the allegation of abuse.On 9/10/25 at 7:27 AM, Surveyor interviewed RN D regarding the incident between R15 and R26. RN D indicated she had worked the night shift and was logged out of the computer and was getting ready to leave the facility when R26 reported to her that between 3:00 AM and 5:00 AM, R15 came into R26's room and attacked R26. RN D indicated she called NHA A to report this incident. RN D indicated after calling NHA A, RN D obtained more information. RN D indicated she was made aware that R26 stated R15 poured urine into R26's shoes. RN D indicated R26's shoes were wet. RN D indicated R26's shoes were taken to laundry to get cleaned. RN D indicated the oncoming nurse, LPN H, was aware of the incident. Surveyor asked RN D why she called NHA A at the end of her night shift (approximately 6:30 AM) regarding R26's statement. RN D stated I called the admin (NHA A) because this may need to have been reported in the 2-hour window because of potential abuse. RN D indicated this incident flagged her that it could be abuse.On 9/10/25 at 9:25 AM, Surveyor interviewed SS G regarding this incident. SS G indicated she was made aware of the incident on 9/2/25 after returning from the Labor Day weekend. SS G indicated she saw the note written on 8/31/25 by LPN H. SS G indicated this could have been abuse but she does not make that decision. SS G indicated NHA A makes the decision on abuse and reporting.On 9/10/25 at 9:41 AM, Surveyor interviewed NHA A regarding this incident. NHA A indicated she received a call in the middle of the night or early in the morning from the nurse on 8/31/25. NHA A indicated the nurse told her R26 stated R15 came into his room and R15 spilled urine on R26's shoes. NHA A indicated she asked the staff to verify if urine was spilled on R26's shoes and staff informed NHA A that R26's shoes were wet. NHA A indicated it did not make sense because the floor was not wet. NHA A stated she used the flowchart to see if this was reportable and determined it was not because the nurse said the residents were fine and everything was normal. Surveyor reviewed the Resident-to-Resident Altercation Flowchart (DQA form) with NHA A. Surveyor referenced the Note box on the flowchart that states Use of this flowchart must provide for immediate reporting (see F609) or the facility must clearly document the rationale for not reporting. Surveyor asked NHA A for the documented rationale for not reporting. NHA A indicated she did not have documentation for not reporting. NHA A stated, It's hard to say what actually transpired. Surveyor asked NHA A if a resident stated another resident poured urine on his shoes and now his shoes are wet, would that count as an allegation of abuse. NHA A stated I feel like there is a lot of grey area there. Aside of wet shoes, there wasn't any evidence. Surveyor reviewed the nurses progress note written by LPN H dated 8/31/25 with NHA A. NHA A indicated staff had not mentioned R15 was yelling at R26 and when NHA A spoke with R26, on 9/2/25, R26 had not said anything about it. NHA A indicated after reviewing the Resident-to-Resident flowchart and reading the progress notes with the surveyor, in retrospect, I would have done things differently. NHA A indicated she should have reported this incident as an allegation of abuse and did not.

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	09/10/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the Facility did not have evidence all alleged violations of mistreatment were thoroughly investigated for an allegation of abuse involving 2 residents (R26 and R15)On 8/31/25, R26 reported to the facility staff that another resident came into his room and was yelling at R26 and poured urine on R26's shoes. The facility did not thoroughly investigate this allegation.This is evidenced by:The facility's policy titled, Resident Abuse, Neglect, Misappropriation of Property, and Exploitation Prevention Program, last revised on 10/23, states: Alleged violation is a situation or occurrence that is observed or reported by staff, resident.but not yet been investigated. 5. Investigation: All of the following are promptly investigated per facility policies and practices. All resident accidents and incidents including: .Any other incident occurring to a resident. All concerns including loss or misuse of a resident personal belongings or money; and any concern/grievance brought forward by or to facility staff related to resident care and/or safety. All investigations will be thorough, well-documented, and immediate to determine if mistreatment occurred and, if so, to what extent. A thorough investigation may include: Identifying staff responsible for the investigation; collecting and preserving physical and documentary evidence. Interviewing alleged victim(s) and witness(es); interviewing accused individual(s) (including staff, visitors, resident's relatives, etc.) allegedly responsible for mistreatment. interviewing other residents to determine if they have been abused or mistreated; interviewing staff who worked on the same shift as the accused to determine if they ever witnessed any mistreatment by the accused; observation of resident and staff behaviors during the investigation; environmental considerations. Conduct and document interviews of staff and residents that include actual words of interviewees. A complete written report of the investigation will be retained by the facility.R26 admitted to the facility on [DATE] with diagnoses including diffuse traumatic brain injury (brain injury caused by an outside force) and mild cognitive impairment (a brain condition that causes noticeable but mild memory problems).R26's 7/16/25 Brief Interview for Mental Status (BIMS) has a score of 12, indicating R26 has moderate cognitive impairment.R15 admitted to the facility on [DATE].R15's 8/21/25 BIMS has a score of 11, indicating R15 has moderate cognitive impairment.R26's nurses progress note, written by LPN H (Licensed Practical Nurse), dated 8/31/25 at 9:47 AM, states: Resident (R26) voiced to therapy aide that another resident, [R15], went into residents' room (R26's room) early this morning and was yelling at him. Resident (R26) states that he isn't able to put on any pairs of his shoes because they are wet with urine. Resident (R26) states that [R15] spilled his urinal out on his (R26) shoes and now he (R26) cannot wear any of his shoes. [R15] was questioned and states he never went into residents (R26) room. [R15] was not noted by staff to have been in [R26] room.On 9/9/25 at 3:00 PM, Surveyor called LPN H and was unsuccessful in contacting LPN H.On 9/9/25 at 3:20 PM, Surveyor interviewed DON B (Director of Nursing) regarding the incident between R15 and R26. DON B indicated the incident could be viewed as an allegation of abuse because it was a resident-to-resident altercation. DON B indicated she believed SS G (Social Services) and NHA A (Nursing Home Administrator) investigated the incident.Surveyor reviewed the facility's grievance/complaint log for August 2025 and September 2025. There was no grievance listed for R26 related to this incident.On 9/9/25 at 4:00 PM, SS G handed surveyor a redacted, hand-written grievance form. The grievance form states the following: Date occurred: 8/31/25 appox 5 am (Approximately 5:00 AM). Discovery date 8/31/25. Reported by: RN D (Registered Nurse). Concern: [R26] told a nurse that his neighbor [R15] entered his room and emptied a urinal into [R26]'s shoes . Investigation: [R15] stated: Resident stated I had nothing to due [sic] with this. [R26] stated: see attached.Of note, the attached paper included two progress notes from R26's electronic medical record. One progress note was the note from LPN H dated 8/31/25 at 9:47 AM.The second note, dated 9/2/25 at 10:45 AM, was a late entry written by NHA A, states: This writer spoke to [R26] on 9/2/25 and asked him about this incident. [R26] was unable to provide detail on this (continued on next page)

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	09/10/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident other than he stated that the neighboring resident, [R15], had entered his room at some point during the night or early morningand [sic] emptied a urinal into his shoes. He also stated to staff that maybe it could have been water, but he didn't think so. Writer asked [R26] if his shoes had been cleaned appropriately, and he stated yes, writer offered new shoes, and he refused. Writer also asked [R26] if he had any concerns about his safety around the other resident. [R26] laughed and said it was fine, and not to worry about it. Writer offered to file grievance on his behalf and he stated, ?it was in the past' and not to worry about it. Writer asked [R15] if he had been in [R26] room and emptied urine into his shoes. [R15] stated he didn't do this and that he didn't know what I was talking about. [R15] does not have any previous history of entered other residents' rooms anddisturbing [sic] their personal property. Informed [R26] that if [R15] entered his room again or made any statements that made him feel uncomfortable to please tell staff right away. Of note, this note was entered on 9/9/25 at 3:50 PM. This was 20 minutes after surveyors interviewed DON B regarding the allegation of abuse.On 9/10/25 at 7:27 AM, Surveyor interviewed RN D regarding the incident between R15 and R26. RN D indicated she had worked the night shift and was logged out of the computer and was getting ready to leave the facility when R26 reported to her that between 3:00 AM and 5:00 AM, R15 came into R26's room and attacked R26. RN D indicated she called NHA A to report this incident. RN D indicated after calling NHA A, RN D obtained more information. RN D indicated she was made aware that R26 stated R15 poured urine into R26's shoes. RN D indicated R26's shoes were wet. RN D indicated R26's shoes were taken to laundry to get cleaned. RN D indicated the oncoming nurse, LPN H, was aware of the incident. Surveyor asked RN D why she called NHA A at the end of her night shift (approximately 6:30 AM) regarding R26's statement. RN D stated I called the admin (NHA A) because this may need to have been reported in the 2-hour window because of potential abuse. RN D indicated this incident flagged her that this could be abuse.On 9/10/25 at 9:25 AM, Surveyor interviewed SS G regarding this incident. SS G indicated she was made aware of the incident on 9/2/25 after returning from the Labor Day weekend. SS G indicated she saw the note written on 8/31/25 by LPN H. SS G indicated this could have been abuse but she does not make that decision. SS G indicated NHA A makes the decision on abuse and reporting.On 9/10/25 at 9:41 AM, Surveyor interviewed NHA A regarding this incident. NHA A indicated on 9/2/25 she spoke with R15 and R26 regarding the incident. NHA A indicated she received a call in the middle of the night or early in the morning from the nurse on 8/31/25. NHA A indicated the nurse told her R26 stated R15 came into his room and R15 spilled urine on R26's shoes. NHA A indicated she asked the staff to verify if urine was spilled on R26's shoes and staff informed NHA A that R26's shoes were wet. NHA A indicated it did not make sense because the floor was not wet. NHA A stated, It's hard to say what actually transpired. Surveyor asked NHA A if a resident stated another resident poured urine on his shoes and now his shoes are wet, would that count as an allegation of abuse. NHA A stated I feel like there is a lot of grey area there. Aside of wet shoes, there wasn't any evidence. Surveyor asked for documentation of an investigation and NHA A indicated she did not have documentation of an investigation. Surveyor asked NHA A if an immediate and thorough investigation would have helped to determine the facts in the incident and NHA A indicated she should have reported and investigated this incident as an allegation of abuse and did not.