

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER Dove Healthcare - Bloomer		STREET ADDRESS, CITY, STATE, ZIP CODE 2217 Duncan Road Bloomer, WI 54724	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that residents (R) received treatment and care in accordance with professional standards of practice for 1 of 1 resident (R) reviewed for wound care. (R5).The facility did not ensure weekly comprehensive wound assessments and did not assess wound treatment plan for effectiveness for R5's wound. This is evidenced by:Facility's policy titled Wound Treatment Protocols reviewed date of January 2026, read in part, With the Discovery of New Skin Issue.Document appropriately in the Skin Screen of Electronic Medical Record. Complete comprehensive skin assessment as necessary depending on classification of wound. Refer to dietary and therapies as appropriate.Documentation: Any new skin finding should have a Risk Assessment filled out in (Name of computer software). Weekly wound trackers will be completed weekly by the Certified Wound Nurse or by a designated RN (when filling in for Wound Nurse).R5 was admitted to the facility on [DATE]. R5's diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, ataxia, atrial fibrillation, congestive heart failure, chronic kidney disease stage 3A, pain in right and left hip, weakness, and history of falling. On 5/10/26, a Minimum Data Set (MDS) admission assessment documented a Brief Interview for Mental Status (BIMS) score of 13/15, meaning cognition is intact. Impairment on one side of upper and lower extremities. R5 depends on staff assistance for toileting hygiene, shower/bathe, upper and lower body dressing, footwear, and personal hygiene. Moderate staff assistance is needed for bed mobility and transfers. R5 was at risk for pressure injury and no unhealed pressure injury. The facility assessed R5 using the Braden scale for predicting pressure injury risk:05/04/26 score 17 - at risk for pressure injury. 05/11/26 score 18 - at risk for pressure injury. 05/16/26 score 15 - at risk for pressure injury.05/18/26 score 15 - at risk for pressure injury.05/25/26 score 16 - at risk for pressure injury.R5's physician orders documented:05/04/26 Regular diet, Regular - 7 texture, Regular/Thin Fluid consistency.05/17/26, I have new shearing to my right inner buttock. Please monitor healing progress. Update MD for worsening condition.06/08/26, WOUND CARE: Right Inner Buttock 1) Cleanse area with NS and Gauze 2) Apply bordered foam dressing to affected area 3) Encourage offloading as I allow every day shift every 3 day(s) for wound healing AND every 1 hours as needed for soiling.06/08/26, Behavior Note: Please document any attempts at offloading pressure from buttocks and document resident's acceptance or refusal. R5's care plan read in part:~ ACUTE SKIN CONDITION: - I was found to have shearing to my right buttock. - This area appears to be worsening - I prefer to sleep in my recliner at night, and often refuse to sleep in my bed - Staff attempt to offload pressure in my recliner, but I often refuse to allow them to place a pillow/blanket under one side - I have been switched to a ROHO cushion in my reclinerDate Initiated: 05/18/2026Revision on: 06/08/2026Interventions: Apply Calmoseptine as indicated Date Initiated: 05/18/2026 Monitor for pain treat as indicated. Date Initiated: 05/18/2026 ROHO cushion in recliner Date Initiated: 05/18/2026 Revision on: 06/08/2026 (Note: Previous intervention was EquaGel cushion in wheelchair and recliner - 5/18/26) .~ SKIN: - I am risk for skin breakdown r/t (related to) Decreased mobility; I have a history of actinic keratosis. I was admitted with scattered bruising to my body from my [NAME] home. - I prefer to sleep in my recliner and often refuse to sleep in bed. This (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
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	puts me at risk for skin breakdown Date Initiated: 05/04/2026 Revision on: 06/08/2026 Interventions: Assist with repositioning routinely with rounds Date Initiated: 05/04/2026 Check skin with care delivery. Report abnormalities to License Nurse Date Initiated: 05/04/2026. Use pillows/positioning devices as needed Date Initiated: 05/04/2026 R5's medical record documented on 05/11/26, Skin Observation: no skin concern noted. skin is warm to touch. light fading bruise remains to left upper buttocks. buttocks is pink in color. On 05/16/26, an SBAR was faxed to Nurse Practitioner (NP) [R5] was found to have a new area of skin concern to the right buttock. Appears to have shearing to the right inner buttock about midway, measures 5.0cm x 1.0cm x 0cm. Very thin layer of tissue loss present, no visible open wounds. Writer applied calmoseptine and switched placed an equagel cushion in recliner since that is where he spends a majority of his day. Resident did complain of minor pain and tenderness to affected area. Any further orders? On 05/18/26 NP noted Ok as above. On 05/16/26, Skin observation tool: Right buttock shear 5.0 x 1.0 x 0 Resident was found to have a new area of skin concern to the right buttock. Area appears to have shearing to the right inner buttock about midway, measures 5.0cm x 1.0cm x 0cm. Very thin layer of tissue loss present, no visible open wounds. Writer applied calmoseptine and switched placed an equagel cushion in recliner since that is where he spends a majority of his day. Resident did complain of minor pain and tenderness to affected area. On 05/18/26, Skin observation tool: .Shearing remains on the right inner buttock, calmoseptine applied to buttocks, skin is pink. Tenderness noted to the area. On 05/25/26, Skin observation tool: .Shearing remains on the right inner buttock; however, this is improved. Calmoseptine continues to be applied with cares. On 06/01/26, Skin observation tool: Coccyx shearing. Right buttock shearing. Resident's skin appears to be grossly intact. Known skin concerns noted to right buttock and coccyx, shearing dressed in calmoseptine after shower. On 06/08/26, Skin observation tool: Right buttock Shearing 4 x 3 x 0.1 cm Skin is clean dry and intact. Resident does have shearing to his right inner buttock, total area measures 4.0cm x 3.0cm x 0.1cm with four linear open areas of skin. New bordered foam applied after shower .Surveyor noted the skin observation tool did not document a comprehensive assessment of the wound to identify if the shearing would be caused from pressure. Measurements of the wound were not completed weekly. No description of drainage present with amount, type, color, odor. No assessment of wound bed, surrounding skin, signs of infection or pain. R5's progress notes: 6/8/2026 10:50AM, Skin/Wound Progress Note Note Text: Shearing to right buttock continues to worsen. Resident is noted to have multiple open sores to inner right buttock which measure approximately 0.25cm in depth. Resident is noted to also have a circular sore to inner left buttock that remains surface level but is open. Entirety of buttock is bright red in color and causes resident discomfort. I did notify CM, and she advised to put a 4x4 on sores to right buttock and encourage offloading. Nurse tried to offload resident with a pillow, but he stated, This is uncomfortable, I can't sit like this. So, pillow was removed and CM switched cushion in resident's chair to a roho cushion. Resident was educated about the changes in his sores and was accepting of the dressing being applied. I did also tell resident that wound nurse would most likely assess the area on Thursday to determine possibly switching course of treatment and resident was thankful for the information. On 06/09/26 at 7:46 AM, Surveyor observed R5 sleeping in recliner, covered with a blanket, lights were out and door closed. On 06/09/26 at 7:50 AM, Surveyor interviewed Licensed Practical Nurse (LPN) C about R5's dressing to buttocks. LPN C stated the order for the dressing was started and applied yesterday and it is to be changed every 3 days. On 06/09/26 at 8:15 AM, Surveyor interviewed R5 about sleeping in recliner and positioning. R5 stated that breakfast came around 7:05 AM and staff got resident up and washed up before breakfast and sat back in recliner. R5 stated they did sleep in recliner all night. Surveyor asked if staff came in and asked if R5 needs to use the toilet after breakfast. R5 stated they will put the call light on for staff to assist with going to the bathroom and they come right away. Surveyor asked if R5 is able to reposition self in recliner so not sitting in the same spot or on the open area. R5 stated they are able to move some, and this new cushion is much better and does not hurt. Surveyor observed R5 is sitting more on left buttock while in (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recliner. On 06/09/2026 9:42 AM, Surveyor interviewed Certified Nursing Assistant (CNA) D asking what time R5 got up this morning. CNA D stated R5 got up and dressed around 6AM. Surveyor asked how frequent does R5 use the bathroom. CNA D stated R5 uses the bathroom very frequently, and CNA D needs to assist R5 and apply ointment to buttocks. On 06/09/26 at 9:46 AM, Surveyor observed CNA E transfer R5 to the toilet. CNA E applied gait belt to R5. While CNA E went to the bathroom to get gloves, R5 scooted buttocks to the edge of recliner to use walker to assist to stand with CNA E holding gait belt. When CNA E pulled R5's pants and brief down Surveyor observed a boarder foam covering both buttocks and coccyx area. On 06/09/26 at 9:51 AM, R5 put call light on. CNA E assisted R5 with cleaning of peri area. CNA E assisted R5 to recliner. Surveyor interviewed CNA E asking if CNA E had any knowledge of what R5's buttock wound looks like. CNA E stated they had not seen the area and can't recall the last time working with R5 and seeing buttocks. CNA E stated she floats between the halls and does med pass most of the time. On 06/09/26 at 11:12 AM, Surveyor interviewed Director of Nursing (DON) B asking if weekly comprehensive wound assessments with measurements and wound description were completed for R5. DON B stated R5 was not seen by the wound nurse that comes to the facility. DON B stated R5's wounds would open and close. Surveyor asked where the comprehensive wound assessments were located when the area would open again. DON B stated it was noted in the progress notes. DON B stated there was a time were the computer system had assessments drop off causing the assessments not being scheduled to be completed. Surveyor asked DON B if there was a report that this occurred with R5's wound assessments. Surveyor reviewed with DON B there were skin observation tool assessments completed for 05/18/26, 05/25/26, and 06/01/26 with no measurements or description of wound characteristics. On 06/09/26 at 11:17 AM, DON B returned and stated the computer system error did not affect R5's assessments. DON B stated the wound assessments were not complete and would expect the staff to conduct a full wound assessment weekly.		

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F 0689 Level of Harm - Minimal harm or potential for 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 that 2 of 2 residents (R7 and R38) reviewed for accidents received adequate supervision and assistance to prevent accidents. The facility did not follow fall interventions identified in R7's care plan. The facility did not implement interventions or educate staff after R38 sustained an injury during a transfer with a mechanical lift. Findings include: The facility's policy titled, Incident and Accidents (Risk Management) read in part, The purpose of incident reporting can include: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care. Example 1R7 was admitted to the facility on [DATE], with diagnoses included traumatic brain injury, epilepsy, cerebrospinal fluid drainage device, abnormalities of gait and mobility, paralysis of right side following a stroke, and history of falling. R7 scored 00/15 during Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. R7 has an activated Power of Attorney (POA) to assist with decision making. R7's care plan included: I am at risk of falling due to my decreased level of functioning following my stroke. I fall down sometimes because I am impulsive since my stroke, so I think I can do more than I am able. My right sided weakness does not allow me to stand on my own, but I do not remember this, so I will stand and fall. I am known to self-transfer after my visitors leave, so they now report to the nursing staff when they leave. I still have had multiple falls doing many things without a pattern that causes me to fall. Interventions included: Wheelchair should be left next to the bed and recliner with brakes locked when not in wheelchair, revised 06/03/26. Assist to bathroom before and after meals and encourage to rest in recliner following the bathroom, initiated 05/28/26. Ensure that I am up before 9:00 AM whenever possible, revised 03/31/26. Do not leave me unattended in my room unless I am in my recliner or bed, revised 06/05/25. Use wall bar in bathroom during transfers, initiated 02/13/26. Fall mat on floor next to me while I am unattended in my room on my recliner or bed, revised 02/13/25. Remind visitors to alert staff when they are leaving the room, initiated 02/13/25. On 06/08/26, Surveyor reviewed R7's falls and noted: -04/22/25, during a transfer. -05/07/25, fall out of bed. -05/30/25, assisted to the floor. -09/05/25, fall while ambulating to the bathroom. -05/07/26, assisted fall. -05/27/26, unwitnessed fall behind nurses' station. -06/01/26, unwitnessed fall in the dining room. Surveyor reviewed R7's record and noted R7 was hospitalized on [DATE] and 04/25/26 for stroke-like symptoms. Both hospitalizations concluded that R7 did not suffer from a stroke, but R7 continued to have intermittent stroke-like symptoms. The facility monitored R7 daily for stroke-like symptoms and R7 continued with follow-up neurology appointments. On 06/09/26 at 7:46 AM, Surveyor observed R7 in the dining room while eating breakfast. R7 was seated in her wheelchair at a table and eating independently with modified utensils. On 06/09/26 at 8:15 AM, Surveyor observed R7 in her room, seated in her wheelchair, an overbed table was next to her. Surveyor observed no staff present in the room and no fall mat placed on the floor. Surveyor continued to observe R7 for 19 minutes. On 06/09/26 at 8:34 AM, Surveyor observed Registered Nurse (RN) G enter R7's room. Surveyor interviewed RN G. Surveyor asked RN G if R7 was toileted after breakfast per her care plan. RN G reported R7 was not as R7 had been having stroke-like symptoms in the dining room during breakfast, and R7 had been brought to her room for monitoring. RN G stated she had been on the phone with R7's provider as R7 has a neurology appointment this morning. Surveyor asked RN G if R7 was to be supervised in her room if she was not in her bed or recliner. RN G stated R7 had her call light with her. Surveyor asked RN G if R7 was to be unsupervised in room if she was in her wheelchair. RN G stated no, she didn't think she was supposed to be unsupervised. On 06/09/26 at 9:32 AM, Surveyor interviewed Director of Nursing (DON) B. DON B reported R7 was brought to her room so nursing staff could assess R7 and update the provider. Surveyor asked DON B if R7 was safe in her room, while in (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her wheelchair and also reportedly having stoke-like symptoms. DON B stated sometimes R7 has absence seizures which resemble stroke-like symptoms.DON B stated she spoke with RN G about R7 being left in her room in her wheelchair unsupervised. DON B stated due to the situation RN G made a judgement call to leave R7 unsupervised in her room, while RN G called the provider. Example 2R38 was admitted to the facility on [DATE], with diagnoses including paralysis of left side of the body following a stroke.During Brief Interview for Mental Status (BIMS), R38 scored 12/15 indicating moderately impaired cognition. R38 makes his own health care decisions.R7's care plan included:I have 0.5cm x 0.5cm skin tear to my left lateral forearm. It was pinched during a transfer, staff reported immediately, initiated 05/26/26.Interventions: Apply treatment as ordered, monitor and document as ordered, update provider with worsening.I have an ADL self-care deficit related to hemiplegia, limited mobility, stroke, and obesity, revised, 02/04/26.Interventions: left sided hemiparesis and hemiplegia, initiated 02/04/26. Transfer, Hoyer lift assist of two, revised 05/05/26.R38's progress notes on 05/21/26 read, Situation: Resident sustained a new skin tear to the lateral left forearm, measures 0.5cm x 0.5xm x 0.1cm. Very minimal bleeding noted, skin flap intact and attached. Area was cleansed with NS and gauze, RN applied xeroform and bordered foam dressing. Root cause was residents' arm was pinched in the Hoyer sling when being sat down in his W/C. Resident has hemiplegia and is flaccid on the left, causing residents arm to lay different in the Hoyer sling. Resident was unaware of skin tear.On 06/09/26 at 8:42 AM, Surveyor interviewed R38. R38 reported his arm fell out of the Hoyer sling and onto the bar of the Hoyer lift, and that is how it got pinched. Surveyor noted the injury occurred on R38's left arm, which R38 cannot function due to a stroke. R38 reported he felt like it was a matter of educating him and staff to watch and make sure his arm is placed appropriately. R38 reported he was not sure if staff received any education.On 06/09/26 at 8:59 AM, Surveyor interviewed CNA H. CNA H stated he was not present when R38 was injured during a transfer. CNA H stated he learned about it in report, and that R38's arm fell out of the sling when staff were transferring him into a chair. Surveyor asked CNA H if staff received training on transferring R38 after his injury, CNA H stated staff did not receive training but are to make sure someone is on R38's left side when transferring. CNA H stated staff receive training on mechanical lift transfers upon hire, and he has been working at the facility approximately seven months.On 06/09/26, Surveyor interviewed DON B. DON B stated after R38 sustained a skin tear during the Hoyer lift transfer, CNA education was completed at a CNA meeting. DON B will provide that to Surveyor. DON B stated the education was related to proper Hoyer use, arm placement in sling, and cueing R38. Surveyor reviewed the training provided by DON B. CNA meeting agenda held on 05/27/25, note date is correct and not an error. Agenda included an area highlighted by DON B, Cares: remind to explain what you are doing to residents before you perform the task. Ensure arms and legs are in safe positioning. We want residents to know what to expect during specific care prior to moving them. We remind residents to voice their concerns at the time of the incident so that the employees can remember for next time. There was no signature sheet included with training material.Surveyor reviewed Resident Council minutes dated 05/27/26, and areas highlighted by DON B included the following: reminder State Survey is due any day. An NHA intern would be starting at facility. High school and college students would be working more since school is out. Review of the grievance process.This Surveyor's investigation determined there was no education provided to staff on transferring R38 with Hoyer lift and no individual interventions added to R38's care plan to reduce potential for future injuries.		