

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Dove Healthcare - St Croix Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 750 E Louisiana St St Croix Falls, WI 54024	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>41945</p> <p>Based on record review and interview, the facility did not provide care and treatment in accordance with professional standards of practice related to resident assessment after a fall incident for 1 resident (R) (R7) of 3 residents reviewed for falls.</p> <p>R7 sustained a fall, and when reported, the facility's licensed nursing staff did not assess R7.</p> <p>This is evidenced by:</p> <p>On 05/14/24, Surveyor reviewed R7's medical record concerning a fall. R7's nurse's notes state on 3/10/2024 at 1:14 p.m., R7 verbalized to staff that R7 fell . R7 complained of left hip pain to the nurse on 03/10/24. R7 said R7 fell yesterday, 03/09/24. R7 said R7 was transferring from the wheelchair to the bed. R7 went to grab the arm of the wheelchair and fell to the ground on R7's left side. R7 stated, The blonde girl went and got the cherry picker, then hooked R7 up, and then staff lifted R7 back to the wheelchair. Nursing took R7's vital signs and notified Director of Nursing (DON) B. R7 rated pain level at 5 out of 10. Nursing gave R7 Tylenol, which was effective in managing pain. Nursing notified R7's spouse of R7's fall, and R7's spouse stated R7 had already told R7's spouse about it. Nursing apologized for the late notice on the fall, but R7's spouse stated no worries as R7 told R7's spouse that the Girls were in the room when the incident happened. DON B updated again. Nursing left a message for the on-call physician concerning R7's fall.</p> <p>Surveyor noted the facility has no documentation of R7 falling on 03/09/24.</p> <p>R7's nurse's progress note states on 03/11/24 at 8:44 p.m., R7's left hip had a bruise measuring 15cm in length and 8cm in width with swelling noted. The facility contacted the nurse practitioner (NP), who ordered a left hip x-ray. The left hip x-ray on 03/12/24 showed negative results for fracture.</p> <p>R7's medical record nurse's progress notes document R7 continued complaining of pain in the left hip. The facility contacted the NP. NP ordered a left hip and femur x-ray and Lidocaine Patch 4% to the left hip. Patch on 12 hours/off 12 hours. On 03/22/24, the x-ray results note no acute fracture or focal osseous lesion. Results state no dislocation; the joint spaces are normal soft tissue. The soft tissues are unremarkable. Impressions: No acute osseous process.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 525532
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R7's medical record does not document any assessment of R7 for the fall report nursing received from R7 on 03/10/24. The only documentation related to the fall is the vital signs taken on 03/10/24 and pain medication given to R7.</p> <p>On 05/14/24 at 11:15 a.m., Surveyor interviewed Licensed Practical Nurse (LPN) C and asked if Certified Nursing Assistants (CNAs) or other staff report falls to nursing. LPN C stated that staff reports falls, and if a fall occurs, nursing contacts the doctor, completes a fall form/assessment, completes a risk assessment, records the fall in the resident's progress notes, and passes the fall information to following shifts through shift report. Surveyor asked how long LPN C has worked at the facility, and LPN C stated, Six weeks.</p> <p>On 05/14/24 at 2:15 p.m., Surveyor interviewed LPN E and asked what the facility process is when a resident has a fall. LPN E stated the nurse assesses the resident, calls the doctor, calls the family, informs DON, and sends the resident to the hospital if needed.</p> <p>Surveyor interviewed CNA D, CNA H, and CNA I and asked what they would do when a resident has a fall. The CNAs stated the CNAs contact the nurse, and the nurse assesses the resident. The resident is then lifted into a wheelchair or bed and sometimes needs to go to the hospital.</p> <p>The facility's licensed nursing staff did not complete an assessment when R7 reported that R7 had fallen.</p> <p>On 05/15/24 at 1:20 p.m., Surveyor updated DON B on findings regarding R7's fall. DON B was not aware of the lack of the assessment. Surveyor asked DON B what the facility process is when a resident has a fall. DON B stated the nurse is notified, assesses the resident, calls the physician, calls the family, notifies administration, documents the fall, completes a fall report, and sends for treatment if needed. DON B stated the facility monitors resident post-fall.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807</p> <p>Based on observation, interviews and record reviews, the facility did not ensure the resident environment remained as free of accident hazards as possible. The facility did not assess the resident's ability to use cigarettes after determining the resident used nicotine products. This occurred for 1 of 3 residents (R) 7 reviewed for assessments related to nicotine use.</p> <p>This is evidenced by:</p> <p>The facility policy, entitled Smoking - Residents & Visitors which was not dated, did not have any information regarding assessing residents who chose to smoke while attending the facility.</p> <p>Surveyor requested a policy for nicotine use. Facility had no policy related to nicotine use.</p> <p>On 05/14/24 at 5:30 PM, Surveyor observed R7 smoking out in the parking lot as they were leaving for the day. R7 was able to smoke without any concerns to safety of the resident.</p> <p>On 05/15/24 at 11:40 AM, Surveyor entered R7's room to interview regarding staffing and shower concerns and noted that R7 had a container of [NAME] wintergreen chewing tobacco sitting on the overhead table next to his bed, within reach of the resident. Surveyor interviewed R7 asking if they used chewing tobacco and also smoked to which the resident said yes they did both, smoke and use chewing tobacco.</p> <p>R7 was admitted to the facility on [DATE], with a primary diagnosis of hemiplegia and hemiparesis following cerebral infraction affecting the left non-dominant side. R7's most recent MDS indicates they have a BIMS of 10 and can be understood and understood per MDS on 03/06/24 completed on admission. When R7 entered the facility they were not smoking and had orders for nicotine patches.</p> <p>Progress notes recorded on 03/26/24 stated, Mood/Behavior: Resident remained in his room for most of this shift with no complaints. He often goes out to smoke occasionally. He is friendly and cooperative with cares.</p> <p>On 05/15/24 at 2:34 PM, Surveyor interviewed Director of Nursing (DON) B about R7's tobacco use. DON B said they suspected the resident was smoking and discontinued the order for the nicotine patch. After they discontinued the order DON B asked the nursing staff to complete a smoking assessment. DON B could not give Surveyor an exact date that they asked for the smoking assessment.</p> <p>Record review regarding R7's discontinued orders revealed that R7's nicotine patch that was used for cessation was discontinued on 03/25/24.</p> <p>At the time of exit the facility was not able to provide a care plan or smoking assessment to surveyors; the facility said they would be completing them as soon as possible.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41945</p> <p>Based on record review and staff interviews, the facility did not provide pharmaceutical services, including services that assure the accurate dispensing and administering of all drugs and biologicals, to meet the needs of 4 of 4 residents reviewed for medication administration (R) (R1, R2, R5, R6).</p> <p>This is evidenced by:</p> <p>Example 1</p> <p>On 05/14/24, Surveyor reviewed R1's medical record. R1 was readmitted to the facility on [DATE] at 1:50 p. m., with diagnoses including acute embolism and thrombosis of unspecified deep veins of right lower extremity, acute on chronic congestive heart failure with reduced ejection fraction, and right heart dysfunction, type 2 diabetes mellitus with hypoglycemia without coma, type 2 diabetes mellitus with diabetic neuropathy-unspecified, other pulmonary embolism without acute cor pulmonale, presence of other vascular implants and grafts, presence of aortocoronary bypass graft, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.</p> <p>Surveyor reviewed R1's orders in the hospital discharge summary dated 02/21/24 and compared these orders with R1's medication administration record at the facility. The facility did not administer the medications per physician orders:</p> <p>*Flomax oral capsule 0.4mg- Give 2 capsules by mouth once a day (PM Shift). R1 did not receive medication on the PM shift of 02/21/24.</p> <p>*Metoprolol Succinate 30mg extended-release oral tablet once daily. Hold till follow-up appt. The facility did not transcribe the order in the medication record.</p> <p>*Lantus Solostar U-100 insulin 100units/ml. Inject 34 units subcutaneously once a day. Order not transcribed onto medication record. R1 has not received any doses and no clarification or change of order documentation in the medical record.</p> <p>*Nystatin powder. Apply topically to affected areas two times a day. The facility did not transcribe the order for nystatin powder in the medication record, and R1 did not receive medication on the PM shift of 02/21/24.</p> <p>*Atorvastatin Calcium Oral Tablet 40 MG (Atorvastatin Calcium) Give 1 tablet by mouth in the evening. The facility did not transcribe the order into the medication record until 02/22/24. On the PM shift, R1 did not receive the medication as ordered for 02/21/24.</p> <p>*Prednisone 5mg oral tablet once daily with a meal. The facility did not transcribe the order in the medication record until 02/23/24.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*Sertraline 100mg oral tablet. Take 125mg by mouth once daily. R1 did not receive medication until 02/23/24.</p> <p>*Humalog KwikPen subcutaneous solution pen injector 100 units/ml. Inject per sliding scale. This order continued from the previous admission and was not reordered by the physician when discharged from the hospital on 02/21/24. R1 received three sliding scale doses until the order was clarified with the physician on 02/22/24 at 2:04 p.m., with a verbal order. Doses received were as follows: 02/21/24 at 4:00 p.m., 2 units; 02/22/24 at 7:00 a.m., 13 units; and 02/22/24 at 11:00 a.m., 2 units.</p> <p>*Entresto 49-51mg oral tablet two times daily. (Hold until follow-up appt). Medication not transcribed onto medication record. No documentation clarifies the order in R1's medical record since readmission.</p> <p>R1's progress note documented one note on 02/22/24 at 1:33 p.m., stating R1 had some incorrect orders, and the nurse notified the charge nurse for guidance if nursing should hold the medications due to possible incorrect orders. Documentation indicates nursing can't complete the orders as the orders are not accessible from the hospital. Documentation states the nurse asked and did not receive nor found the orders. The note states that the facility is waiting for an order from a nurse practitioner (NP).</p> <p>The facility documentation for orders from NP is on 02/22/24 at 2:04 p.m., and the Leuprolide Acetate intramuscular kit is 45mg. Inject 45 mg intramuscularly in the morning every 6 months starting on the 1st for 1 day (hold 02/22/24-02/27/24), Humalog kwik pen subcutaneous solution pen injector 100 units/ml. Inject as per sliding scale (hold 02/22/24 2:04 p.m.- 02/23/24 2:03 pm for clarifying orders), and hydrocortisone acetate rectal suppository 25mg. Insert suppository rectally two times a day for rectal bleeding (hold 0222/24 2:04 p.m.- 02/23/24 at 2:03 p.m. for clarifying orders).</p> <p>R1 had an error on the medication record for Humalog KwikPen subcutaneous solution pen injector 100 units/ml. Inject per sliding scale. This order continued from the previous admission and was not reordered by the physician when discharged from the hospital on 02/21/24. R1 received three sliding scale doses until the order was clarified with the physician on 02/22/24 at 2:04 p.m., with a verbal order.</p> <p>R1's medical record has no further clarification documentation for readmission orders on 02/21/24 to ensure accurate medication administration.</p> <p>Example 2</p> <p>R2 was admitted to the facility on [DATE] with diagnoses including venous insufficiency (chronic) (peripheral), ventricular fibrillation, chronic venous hypertension (idiopathic) with ulcer of unspecified lower extremity, personal history of pulmonary embolism, and essential (primary) hypertension.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/14/24, Surveyor reviewed R2's medical record. R2's physician's order states that the oral Metoprolol Tartrate tablet should be 25mg twice daily. The facility transcribed the order in R2's medical record as Metoclopramide HCl oral tablet 25mg two times a day. R2 received one dose of Metoclopramide HCl 25mg on 03/08/24 on the PM shift. Metoclopramide HCl was the wrong medication. The facility did not transcribe the order for metoprolol tartrate 25mg oral tablet twice daily in R2's medical record until 03/09/24. R2 did not receive three doses of Metoprolol Tartrate 25 mg orally per the physician's order.</p> <p>There is no documentation in R2's medical record indicating if R2 had any side effects from the facility administering the wrong Metoclopramide HCl 25mg medication, and R2 did not receive three doses of Metoprolol Tartrate 25mg.</p> <p>Example 3</p> <p>On 05/14/24, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus with unspecified complications, long-term (current) use of insulin, chronic coronary microvascular dysfunction, and vascular dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.</p> <p>R5's physician's orders state as follows:</p> <p>*Insulin Lispro subcutaneous pen injector 100 units/ml. Inject 15 units subcutaneously in the afternoon.</p> <p>*Insulin Lispro subcutaneous pen injector 100 units/ml. Inject 15 units subcutaneously in the evening.</p> <p>The facility dated a box of Novolog insulin from R5's home stock on 02/29/24.</p> <p>On 03/09/24 at 9:04 a.m., nursing documents in R5's progress note that R5 has an order for Insulin Lispro subcutaneous solution pen-injector 100 units/ml. Inject 25 units this am. Documentation states R5's Insulin Lispro is not in the medication cart, and the only medication for insulin is Novolog. The facility documents that nursing removed two pens of Novolog from the cart and retrieved Insulin Lispro from the emergency kit in the medication room. Nursing documentation states that it is unknown if R5 received the Novolog in error due to the pen in the cart.</p> <p>R5's medication administration record documents the administration of Insulin Lispro. The facility did not order Insulin Lispro from the pharmacy for R5, nor was there any in the medication cart with R5's name.</p> <p>R5 received Novolog insulin 15 units in the afternoon and 15 units in the evening from 03/01/24 through 03/08/24 (16 doses).</p> <p>Example 4</p> <p>On 05/14/24, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE], with readmission on 01/12/24, with diagnoses including essential (primary) hypertension.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R6's hospital discharge summary with physician's orders dated 01/12/24 states as follows:</p> <p>Lisinopril 20mg tablet. Take 0.5 tablets (10mg) by mouth once daily.</p> <p>The facility transcribed the physician's order as Lisinopril 20mg tablet by mouth one time a day. R6 received Lisinopril 20mg daily from 01/13/24 through 03/11/24 (58 doses) until nursing identified the error. The facility notified the physician, who clarified R6's Lisinopril dose as 10mg orally once daily.</p> <p>On 05/14/24 at 11:15 a.m., Surveyor interviewed Licensed Practical Nurse (LPN) C and asked what the facility admission/readmission process is. LPN C stated the facility has a checklist for the nurse to complete. Surveyor asked who puts the physician's orders into the resident's medical record. LPN C stated the nurses put the orders in the system if the resident comes with the orders or if the hospital faxes the orders to the facility. LPN C stated that a second nurse verifies the orders. Surveyor asked if a resident's insulin was not in the medication cart, what is the facility process. LPN C stated the insulin needed would get out of the emergency kit or drop-ship it to the facility. Surveyor asked if LPN C had witnessed or identified any medication errors. LPN C stated that LPN C had only been working at the facility for six weeks and had not known of any medication errors.</p> <p>On 05/14/24 at 2:15 p.m., Surveyor interviewed LPN E and asked what the facility admission/readmission process is. LPN E stated the facility has a checklist for the nurses. Surveyor asked who puts the orders into the resident's medical record. LPN E stated the Director of Nursing (DON) B or the Minimum Data Set (MDS) put the orders in on the day shift before the resident admits. LPN E stated that if an admit comes in on another shift, the floor nurse enters the medications in the resident's record. LPN E stated there is confusion with other nurses as to who puts the orders in the computer. Surveyor asked if LPN E had witnessed or known of any medication errors. LPN E stated LPN E doesn't know of any medication errors. Surveyor asked if a resident's insulin was not in the medication cart what would LPN E do. LPN E stated LPN E would check the refrigerator in the medication room for extra insulin for the resident. LPN E stated that if the resident had no extra insulin, the nurse would remove the insulin from the emergency kit and call the pharmacy to order the resident's insulin.</p> <p>On 05/15/24 at 1:20 p.m., Surveyor interviewed DON B about R1, R2, R5, and R6's medication errors. Surveyor asked if DON B knew that R1 did not receive R1's medications as ordered by the physician upon readmission. DON B stated DON B knew R1 received some of the medications, and nursing entered the rest of the orders later. Surveyor asked what the admission/readmission process is. DON B stated that DON B or the MDS Coordinator tries to get the resident's medications before admission, so the orders are in the system. DON B stated that if the facility can't get the orders ahead of time, the nurse on the floor puts the orders in. Surveyor asked if it is per process in which the nurse enters the medications into the record and administers the medications as the physician ordered. DON B stated that is how it should go, but it doesn't always happen that way.</p> <p>Surveyor asked if DON B was aware R1 had an error on the medication record for Humalog KwikPen subcutaneous solution pen injector 100 units/ml. Inject per sliding scale. This order continued from the previous admission and was not reordered by the physician when discharged from the hospital on 02/21/24. R1 received three sliding scale doses until the order was clarified with the physician on 02/22/24 at 2:04 p.m., with a verbal order. Doses received were as follows: 02/21/24 at 4:00 p.m., 2 units; 02/22/24 at 7:00 a.m., 13 units; and 02/22/24 at 11:00 a.m., 2 units. DON B was not aware.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Surveyor asked DON B if DON B was aware R2's medication of Metoprolol Tartrate 25mg orally twice daily was transcribed by nursing into R2's medical record as Metoclopramide HCl 25 mg orally twice daily and that R2 received one dose of Metoclopramide, but due to the transcription error, did not receive three doses of Metoprolol Tartrate. DON B was not aware of the error.</p> <p>Surveyor asked if DON B if DON B knew of R5 receiving Novolog insulin instead of Humalog insulin for eight days, twice a day. DON B stated DON B was aware. DON B stated R5 did not have any side effects from the insulin. Surveyor asked if the facility documented any nursing education or completed a medication error document with the root cause of the error. DON B stated DON B would check and get back to the Surveyor.</p> <p>Surveyor asked DON B if DON B knew of R6's readmission order for Lisinopril 20mg tablet. Take 0.5 tablets (10mg) orally daily. Nursing transcribed the order in R6's medication record as Lisinopril 20mg tablet orally daily. R6 received Lisinopril 20mg daily from 01/13/24 through 03/11/24 (58 doses) until nursing identified the error. The facility notified the physician, who clarified R6's Lisinopril dose as 10mg orally once daily. DON B was not aware.</p> <p>DON B stated DON B would look into these medication errors and get back to Surveyor.</p> <p>DON B provided to Surveyor a note dated 03/11/24 for R5 stating, wrong meds removed from cart and new meds put in place. NP notified. No issues or concerns noted in monitoring. Note was signed by DON B.</p> <p>Surveyor received no further information on the medication errors.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47807</p> <p>Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. The facility did not ensure that potentially hazardous foods were served at temperatures that would reduce the chance of illness for residents. This has the potential to affect all 47/47 residents residing in the facility.</p> <p>Findings include:</p> <p>The facility policy entitled, Record of Food Temperatures dated August 2022, states in part, 4. Potentially hazardous cold food temperatures will be kept at or below 41 degrees Fahrenheit .7. when holding hot foods for service, food temperature should be measured when placing it on the steam table line . 9. Potentially hazardous food that is cooked and cooled must be reheated so that all parts of the food reach and internal temperature of 165 degrees F for at least 15 seconds before holding for hot service.</p> <p>On 05/14/24 at 11:55 AM, Surveyor entered the kitchen to observe meal distribution. Prior to serving the food to residents, Surveyor did not observe any food temperatures being taken. Cook K started serving the food to residents. During service, Cook K had to get the second tray of chicken that was warming in the oven. After removing the chicken from the oven the breaded chicken did not undergo temperature checking before being added to the steam table for residents to consume. Later in the service process, Cook K needed to reheat an alternative meal choice for a resident. The alternative meal was meatballs that had been in the refrigerator. After taking the meatballs out of the refrigerator Cook K reheated them in the microwave that was located to the right of the server at the steam table. After the meatballs were reheated, they were served onto a resident's plate and distributed for service without temperature being checked.</p> <p>During meal service Surveyor noticed the potato salad, which was divided into individual servings in small clear cups, had been taken out of the refrigerator at 12:03 PM and was still out at the end of service at 1:00 PM that day. The potato salad included all consistencies regular, mechanical, and puree. After the service Surveyor asked the Dietary Manager (DM) J for a copy of any temperatures taken related to residents' food for service.</p> <p>Surveyor asked for a test tray and received the last tray to leave the kitchen at 1:00 PM. On 05/14/24 at 1:05 PM, Surveyor observed, tasted, and checked the temperature of the test tray received from the kitchen. The test tray consisted of breaded chicken, green beans, potato salad, and strawberry shortcake. There were no concerns with the taste or presentation of food. The chicken, green beans, and strawberry shortcake showed no concerning temperatures. The potato salad temperature was recorded at 55 degrees Fahrenheit.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Dove Healthcare - St Croix Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 750 E Louisiana St St Croix Falls, WI 54024	
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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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 05/14/24 at 1:30 PM, Surveyor completed a record review of the food temperatures that were received. There was no evidence of food temperatures being taken at the point of service. There was no evidence of when the food temperatures were taken before service to ensure the food was cooked to the proper temperature. There was no evidence that cold food temperatures were being taken at any time during the day.</p> <p>On 05/15/24 at 10:30 AM, Surveyor interviewed DM J regarding the issues noted during food service. When asked about the potato salad, DM J said they were concerned with the temperature of the potato salad after Surveyor had left with the test tray. They then checked the potato salad and the temperature they found was 56 degrees. Surveyor then asked if there were any hazardous foods found in the potato salad, and DM J said yes both eggs and mayonnaise. DM J said they would expect the potato salad to cool down and typically they would have kept it in the fridge and brought it out right before service, but today they did not as they were focused on other tasks. Surveyor asked about the food temperatures not being taken before point of service. DM J said there was a time they were doing it, but they felt over time it did not make sense to temp foods twice as they went from being checked to make sure they were fully cooked to a newer steam table that has been working well.</p> <p>DM J agreed that taking temperature before service would be a way to ensure that food was held at or above the correct temperature. Surveyor then asked about the cold food temperatures being taken and DM J noted they typically kept cold food in the refrigerator before service and they specifically made sure the milk was always in the fridge until service, but they did not temp and record because the fridge was assumed to be working and holding foods at proper temperature. DM J agreed that temping the cold food before service would ensure the food was at the proper temperature and ready to eat.</p> <p>The facility follows the standards set by, The Wisconsin Food Code, which states,</p> <p>3-501.19 Time as a Public Health Control</p> <p>If time without temperature control is used as the public health control for a working supply of</p> <p>If time without temperature control is used as the public health control up to a maximum of 4 hours:</p> <p>(1) The FOOD shall have an initial temperature of 5 C (41 F) or less when removed from cold holding temperature control, or 57 C (135 F) or greater when removed from hot holding temperature control; P</p> <p>(2) The FOOD shall be marked or otherwise identified to indicate the time that is 4 hours past the point in time when the FOOD is removed from temperature control</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Dove Healthcare - St Croix Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 750 E Louisiana St St Croix Falls, WI 54024	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 05/15/24 at 2:34 PM, Surveyor interviewed Nursing Home Administrator (NHA) A about the food temperature concerns. NHA A brought to the attention of the surveyor that they followed the Wisconsin Food Code and it did allow for food to be out for a maximum of four hours after leaving refrigeration and being held at 41 degrees Fahrenheit. Although this is true there was no way to know that the food was at or below 41 degrees Fahrenheit as staff did not take the temperature of the food when removed from the refrigerator.</p> <p>The food code also specifies that food must be marked or otherwise identified to indicate the time that is four hours past the point in time when the food is removed from temperature control; in this case it was not. The facility policy also contradicted the Wisconsin food code; the facility policy required food to be held at or below 41 degrees. There were no times noted on the daily food log; there was no way to know when hot food temperatures were taken before service.</p>		

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NAME OF PROVIDER OR SUPPLIER Dove Healthcare - St Croix Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 750 E Louisiana St St Croix Falls, WI 54024	
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<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ staff that are licensed, certified, or registered in accordance with state laws.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41945</p> <p>Based on interview and record review, the facility did not ensure 1 of 12 nurses reviewed had the proper licensure in accordance with Wisconsin state law licensing requirements. This had the potential to affect all 47 residents in the facility.</p> <p>This is evidenced by:</p> <p>On [DATE], Surveyor requested and received licensure information for 12 nurses at the facility. Upon reviewing nursing licensures, Surveyor reviewed documentation for Licensed Practical Nurse (LPN) N. The facility did not have documentation of a Wisconsin license for LPN N. The facility did provide documentation for ACT 10 (temporary licensure), which stated LPN N started employment at the facility on [DATE]. The form was not signed by the Director of Nursing (DON) B until [DATE]. ACT 10 expired [DATE].</p> <p>LPN N has worked at the facility full-time since [DATE] without an active Wisconsin nursing license and works throughout the building.</p> <p>On [DATE] at 8:41 a.m., Surveyor contacted Department of Safety and Professional Services (DSPS). Surveyor spoke with DSPS representative regarding LPN N's nursing licensure. DSPS stated LPN N completed the ACTS 10 form on [DATE] but did not complete the nursing license application. DSPS noted LPN N has gone onto the DSPS site but has not completed an application for licensure. DSPS stated LPN N does not have an active nursing license in Wisconsin.</p> <p>On [DATE] at 9:00 a.m., Surveyor contacted DON B and informed DON B of findings from DSPS, that LPN N does not have an active license to practice nursing in Wisconsin. Surveyor informed DON B that LPN N is not covered for temporary licensure under ACT 10 because ACT 10 licensure expired [DATE], and LPN N has not completed an application for licensure. DON B indicated LPN N would be off of the schedule and no longer working as an LPN. DON B stated DON B thought the application was completed. DON B stated LPN N had an email from DSPS dated [DATE] that an application was completed, so it was assumed the application was in process. Surveyor asked if the facility followed up on it. DON B didn't know.</p> <p>On [DATE] at 10:05 a.m., LPN N returned a call to Surveyor. Surveyor asked LPN N if LPN N filled out an application for practical nursing licensure. LPN N stated, Yes. LPN N stated a couple of items needed to be completed. Surveyor informed LPN N that DSPS states LPN N does not have an active license and no application has been completed, so no application is being processed. LPN N stated DON B called LPN N and informed LPN N of the same. LPN N stated that LPN N would call DSPS to ensure licensure is in process and to determine what other information DSPS may need.</p>		