STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525532	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - St Croix Falls	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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to thoroughly investigate an allegation of staff to resident abuse for 2 of 3 residents (R3 and R2) reviewed for abuse out of five sampled residents.Findings include:Review of the facility's policy titled, Resident Abuse, Neglect, Misappropriation of Property, and Exploitation, Prevention Program revised October 2023, revealed Investigation, all the following are promptly investigated per facility policies and practices. If at any time during the investigation, caregiver misconduct is suspected, the resident(s) will be protected and the Administrator notified.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; o Collecting and preserving physical and documentary evidence that could be used in a criminal investigation; o interviewing alleged victim(s) and witness(es); interviewing accused individual(s) (including staff, visitors, resident's relatives, etc.) allegedly responsible for mistreatment, or suspected of causing an injury of unknown source; 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; interviewing staff who worked previous shifts to determine if they were aware of an injury or incident; o Observation of resident and staff behaviors during the investigation; o Environmental considerations; and involving other regulatory authorities who may assist, (e.9., local law enforcement, elder abuse agency).1. Review of R3's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was re-admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD). Review of Facility Initial Report, dated 07/18/25 at 9:36 PM and provided by the facility, revealed on 07/12/25, was notified of an allegation that the agency Certified Nurse Aide (CNA) on R3's floor was rough when helping R3 to bed. R3 reported sitting on the bed and the staff member throwing her legs up on the bed aggressively. Review of the investigation revealed no interview with R3, or the alleged CNA. Further review of the investigation revealed no staff interviews and none of the residents were asked about the care they received by CNA1.2. Review of R2's Face Sheet located in the EMR under the Profile tab revealed the resident was re-admitted to the facility on [DATE] with diagnoses which included chronic kidney disease. Review of Facility Initial Report, dated 07/18/25 at 8:38 PM and provided by the facility, revealed on 07/12/25, was notified that R2 reported to nursing staff about an agency staff member on the overnight shift. The staff member had told R2 in the early morning that she could hold it instead of assisting R2 to the restroom. Review of the investigation revealed no interview with R2, or the alleged CNA. Further review of the investigation revealed no staff interviews and none of the residents were asked about the care they received by CNA1.During an interview on 08/13/25 at 12:35 PM The Administrator stated he was new to the position and had only been the administrator for about two months. He stated that the former Director of Operations did the investigation and that he wrote up the summary that was submitted to the state. He agreed there should have been staff interviews along with the resident who made the allegations and that the other resident interviews should have been more specific concerning the allegations and the staff identified. He stated they did try to interview the alleged CNA (CNA1) but there was no documentation of that.