

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525673	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2025
NAME OF PROVIDER OR SUPPLIER Dove Healthcare - Spooner		STREET ADDRESS, CITY, STATE, ZIP CODE 510 First St Spooner, WI 54801	

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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793</p> <p>Based on observation, interview and record review, the facility did not ensure that 1 of 4 residents (R1) reviewed for pressure injuries (PI) received care consistent with professional standards of practice to prevent potential skin breakdown and promote healing of existing PIs.</p> <p>R1 was on hospice and nearing end of life. R1 was at risk for PI; alternate support surfaces were not provided when skin issues were noted.</p> <p>Findings include:</p> <p>The facility policy, titled Pressure Injury Risk Assessment, revised [DATE], states:</p> <p>.#1. Pressure injury risk assessments will be conducted by a licensed nurse on admission, weekly times four weeks, then quarterly. Assessments will be conducted after a change in condition or after any newly identified pressure injury .#5. Residents determined as at risk for developing pressure injuries will have interventions documented in plan of care base don specific factors identified in the risk assessment .</p> <p>The facility policy, titled Documentation of Wound Treatments, revised [DATE], states:</p> <p>.#4. Additional documentation shall include, but is not limited to:</p> <p>D. Modifications of treatments or interventions.</p> <p>E. Notifications to physician and/or responsible party regarding wound or treatment changes .</p> <p>On [DATE], Surveyor reviewed R1's medical record. R1 was admitted on [DATE] with unspecified dementia with behavioral disturbance, congestive heart failure, and hypertension. R1's Minimum Data Set (MDS) assessment, dated [DATE], had a Brief Interview for Mental Status (BIMS) score of 03 out of 15 which indicated R1 had severe impaired cognition. R1's MDS section GG for functional ability indicated R1 is total dependent on staff for transfers, toileting, repositioning, and personal hygiene. MDS indicated that R1 was admitted with no skin issues, but at risk for skin breakdown.</p> <p>Surveyor reviewed R1's Potential for pressure/ulcer injury care plan dated [DATE]:</p> <p>-Conduct a full body skin inspection weekly.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525673	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2025
NAME OF PROVIDER OR SUPPLIER Dove Healthcare - Spooner		STREET ADDRESS, CITY, STATE, ZIP CODE 510 First St Spooner, WI 54801	
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Diet as ordered. Supplements per dietary recommendations.</p> <p>-Encourage physical mobility, activity, and range of motion to maximize potential.</p> <p>-Keep skin as clean and dry as possible.</p> <p>-Meds, labs, treatments as ordered.</p> <p>-Pressure reduction mattress, and wheelchair cushion.</p> <p>-Provide incontinence care after each incontinent episode.</p> <p>-Report areas of skin breakdown to nurse.</p> <p>Surveyor reviewed R1's assessments, progress notes, and weekly skin prevalence nursing assistant sheets:</p> <p>-On [DATE], admission observation noted R1 had no alterations in skin.</p> <p>-On [DATE], Braden skin assessment noted R1 had no ulcers, wounds, or skin problems. R1 scored 15 which indicated R1 was at risk for skin breakdown.</p> <p>-On [DATE], progress note indicated open area on left buttock. Placed exoderm satin on area, appears to have skin tear due to friction of sliding in wheelchair.</p> <p>-On [DATE], progress note indicated abrasion to left buttock resolved, d/c Hydrocolloid dressing.</p> <p>-On [DATE], Braden skin assessment noted R1 scored 11 which indicated R1 was at a high risk of skin breakdown.</p> <p>-On [DATE], weekly skin prevalence nursing assistant sheet indicated during shower CNA observed red excoriated area on left upper buttock.</p> <p>-On [DATE], progress note indicated R1 has open area to buttocks 1.0cm x 0.6cm superficial area to left buttock. Appears to be an abrasion due to shearing forces. Area cleansed; skin prep applied to entire wound area and covered with Hydrocolloid dressing. Will change every 5 days and as needed.</p> <p>-On [DATE], progress note indicated R1's dressing changed to abrasion of the left buttock. Area 100% epithelized, however tissue fragile, continue with Hydrocolloid dressing for protection at this time will observe again Monday.</p> <p>-On [DATE], progress note indicated . Cleansed area with normal saline and patted dry with gauze. Applied silicone sacral pad to coccyx area.</p> <p>-On [DATE], Braden skin assessment noted R1 scored 11 that indicated R1 was at a high risk of skin breakdown this is the same as the July braden assessment</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525673	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2025
NAME OF PROVIDER OR SUPPLIER Dove Healthcare - Spooner		STREET ADDRESS, CITY, STATE, ZIP CODE 510 First St Spooner, WI 54801	
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On [DATE], progress note indicated R1's abrasion to left buttock healed. D/C Hydrocolloid dressing. Continue with alternating air overlay to mattress. Repositioning and barrier cream with cares.</p> <p>-On [DATE], weekly skin prevalence nursing assistant sheet indicates R1 had redness noted to coccyx area.</p> <p>-On [DATE], progress note indicates that R1 has redness and blanching to sacral area. Due to poor intakes and positioning in her Broda chair and recliner will add a protective Meplix to sacrum to be changed every 5 days.</p> <p>Of note, resident is on hospice and at end of life with poor fluid and food intake that is unavoidable. https://hospicefoundation.org/ When death is near, signs and symptoms: Although pressure wounds can develop at any stage of a terminal illness, open wounds may appear rapidly at the end of life as the skin, like other organs, begins to stop functioning.</p> <p>Surveyor did not find any new interventions put into place on R1's care plan for R1's high risk of skin breakdown such as a change in pressure relieving support surfaces for the broda chair and bed when redness noted on [DATE].</p> <p>-On [DATE], progress note indicates that writer following up on sacral foam dressing that was applied for protection. Last week all skin was intact and pink. This week writer noted a foul odor in room. Upon observation there was shadowing to sacral foam dressing. Sacral dressing removed exposing an unstageable pressure injury to her sacrum that measures 0.8cm x 1.5cm. Wound bed with 100% black eschar. Moderate amount of seropurulent drainage. Edge of wound well defined. Peri wound red and blanchable. Writer cleansed area with wound wash, patted dry. Collagen AG applied to wound bed for bacterial control and drainage control. New sacral foam applied. Staff instructed that resident no longer to sit in recliner at this time. Side to side positioning only in bed. Continue with pressure reduction mattress. Dietary notified of new wound. R1 continues on hospice. Hospice notified. POA-HC updated. CP updated with interventions.</p> <p>Surveyor reviewed R1's pressure/ulcer injury care plan dated [DATE]:</p> <p>-R1 in Broda chair for meals only then position in bed. Position side to side. Change position every 1 hour while in bed.</p> <p>-Unstageable pressure injury to Sacrum: 1. Cleanse with wound wash. 2. Pat dry. 3. Apply skin prep to peri wound. 4. Cover wound bed with Aquacel AG or equivalent. 5. Cover with sacral foam dressing. Change daily.</p> <p>-On [DATE], progress note indicated that a call was placed to hospice to request order from provider for wound culture, Prosource 30ml three times a day with vanilla shakes, Roho cushion for recliner and wheelchair and to order wound care supplies. 4x4's, calcium alginate, small sacral foams, and wound wash.</p> <p>-On [DATE], progress note indicates preliminary wound culture results returned. Gram stain: no squamous epithelial cells. Moderate Gram stain positive cocci singly, in pairs and clusters. Rare gram-negative rods. Rare Gram-positive rods. POA-HC notified of preliminary results and will keep updated on final results and sensitives.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525673	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2025
NAME OF PROVIDER OR SUPPLIER Dove Healthcare - Spooner		STREET ADDRESS, CITY, STATE, ZIP CODE 510 First St Spooner, WI 54801	
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On [DATE], progress note indicates Many E-coli. Sent to provider for treatment. Of note, resident is incontinent and e. coli has high probability of getting into the sacral area.</p> <p>-On [DATE], progress note indicates provider orders Bactrim DS ,d+[DATE]mg oral twice a day for 7 days for wound infection.</p> <p>-On [DATE], progress note indicates unstageable pressure injury to R1's sacrum measures 2.0cm x 2.0cm, wound bed with 100% green/grey stringy slough. Large amount of purulent drainage to old dressing. Edge of wound macerated, no longer attached to base. Undermining around entire wound bed, greatest depth of undermining at 12'o clock at 1.5cm. No tunneling. Peri wound red and blanchable. Writer cleansed area with wound wash, patted dry, collagen AG tucked into undermining areas of wound and new sacral foam applied. Continue side to side positioning while in bed. Continue Prosource three times a day. Hospice and POA-HC updated on wound status.</p> <p>-On [DATE] at 3:38 PM, progress note indicates R1 had expired. Family at bedside. Resident expired 9 days after PI identified.</p> <p>Interviews:</p> <p>On [DATE] at 1:41 PM, Surveyor interviewed Power of Attorney (POA) D who indicated there was not a cushion in the Broda chair until facility requested Roho cushion for chair from hospice on [DATE]. POA D indicated there was a thin overlay mattress for pressure reduction on R1's bed before [DATE].</p> <p>On [DATE] at 3:14 PM, Surveyor interviewed Licensed Practical Nurse (LPN) C, wound nurse, and asked what LPN C process is for new wounds. LPN C indicated that LPN C places a note in the progress notes. Surveyor asked LPN C what mattress did R1 have upon admission. LPN C indicated that R1 started off with a basic overlay pressure reduction mattress. LPN C indicated that once R1 was found to have a PI in November then LPN C requested hospice bring an alternating air mattress for R1's bed.</p> <p>LPN C indicated that R1 had a basic cushion in R1's wheelchair until the Roho cushion was requested by hospice in November as well. LPN C indicated that at this point R1 needed to get off R1's bottom as it was painful and R1 became ,d+[DATE]-hour repositioning. Surveyor asked LPN C if LPN C knew why there were no new interventions put into place when R1 declined on hospice and had a noted red area on [DATE].</p> <p>On [DATE] at 4:35 PM, Surveyor interviewed Director of Nursing (DON) B. Surveyor asked DON B if R1's PI could have been prevented. DON B indicated that DON B is unsure if the PI could be prevented as R1 was on hospice declining and nearing the end of life. Surveyor asked why R1 did not have an alternating air mattress or roho in place earlier than [DATE]. DON B indicated the previous areas were not PIs and were blanchable. All areas healed with the interventions provided. DON B thought hospice was taking care of the air mattress and did not realize that R1 only had an overlay pressure reduction mattress and not the high flow alternating air mattress and ideally should have had alternate support surface when redness was noted on [DATE], and R1's condition was declining.</p>		