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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525673	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - Spooner	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.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40181 Based on observation, interview and record review, the facility did not treat each resident with respect and dignity and care for each resident in a manner that promotes his quality of life. Resident (R43) was not provided privacy when lying in bed not fully clothed and covered while being visible from the hallway. For 1 of 13 sampled residents (R43). Findings include: R43 was admitted to the facility on [DATE] following a stroke. R43 was not able to speak but was able to nod head to yes and no questions. R43 had hemiplegia (paralysis) and hemiparesis (weakness) on the right side of the body following the stroke and was dependent on staff for all cares. R43's most recent Minimum Data Set (MDS) assessment, dated 4/23/24, identified R43 showed signs of mild depression with a PHQ-9 (depression scale) score of 09. On 05/20/24 at 11:03 AM, Surveyor observed R43 lying in bed in resident room. R43 was completely uncovered and only wearing an incontinent brief. The door to the room was open with no privacy curtain pulled and R43 was visible to everyone walking in the hallway. Surveyor also observed a urine drainage bag hanging on the side of the bed and half full of urine. The bag was not covered with a dignity cover. At 11:14 AM, Surveyor observed Licensed Practical Nurse (LPN) C walk past R43's room and look in but did not enter the room to cover R43 or close the privacy curtain. From 11:14 AM until 1:00 PM, Surveyor observed multiple staff members walk past R43's room, but no one went in to cover R43 or pull the privacy curtain, and R43 remained visible to the hallway wearing just an incontinent brief. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/20/24 at 2:26 PM, Surveyor observed R43 lying uncovered in bed wearing just a brief. The door was open, the privacy curtain was not pulled, and R43 was visible to everyone walking past the room. Surveyor interviewed LPN C and asked if R43 was able to communicate. LPN C stated R43 could nod head to yes/no questions and the speech therapist made a speech tool with words on it for staff or R43 to point to aid in communication. Surveyor asked if R43 always laid in bed wearing just a brief and no cover. LPN C stated R43 was often hot and pulled off any covers that staff put over R43. Surveyor asked if they always left the door open or privacy curtain open so R43 was visible from the hall. LPN C said they always pulled the curtain when R43 was uncovered but did not know why it was not pulled at that time. LPN C walked away and did not go into R43's room to pull the privacy curtain. On 05/21/24 at 6:37 AM, Surveyor observed R43 lying in bed with just an incontinent brief on. The door to R43's room was open, and the privacy curtain was pulled back so R43 was visible from the doorway. Surveyor also observed a urine drainage bag hanging on the side of the bed, visible from the hall, with no dignity cover over it. Surveyor observed maintenance staff, Certified Nursing Assistant (CNA) E and LPN C outside R43's doorway in the hall. No staff entered R43's room to close the privacy curtain or cover R43. On 05/21/24 at 8:40 AM, Surveyor observed R43 lying in bed, uncovered wearing just an incontinent brief. The urine drainage bag was hanging uncovered on the side of bed. R43 was visible from the hallway. The privacy curtain was not pulled, and the room door was not closed. Surveyor observed multiple staff members walk past R43's room and no one went in to cover R43 or pull the privacy curtain. On 05/21/24 at 2:39 PM, Surveyor interviewed R43 and asked if R43 was okay with the staff leaving the privacy curtain opened or the door opened when R43 was lying in bed uncovered with just a brief on. R43 very clearly shook head back and forth indicating no. On 05/22/24 at 7:01 AM, Surveyor observed R43 asleep in bed with nothing on but an incontinent brief. The blanket on the bed was covering R43 from feet to knees with the rest of R43's body exposed. The door was open, and the privacy curtain was open and R43 was visible from the hallway. There was a urine drainage bag hanging on the side of the bed with urine in it and no dignity cover. All of this was visible from the hallway. Surveyor observed multiple staff members walk by R43's room and no one entered the room to pull the privacy curtain or close the door. On 05/22/24 at 9:43 AM, Surveyor interviewed Director of Nursing (DON) B and explained multiple observations over the past three days of R43 lying in bed completely uncovered except for an incontinent brief with the privacy curtain open and door open. R43 was visible from the hallway. Surveyor observed multiple staff walked by the room and did not go in to cover R43 or close the privacy curtain. Surveyor asked R43 if R43 was okay with being visible from the hallway while lying in bed with just a brief on. Surveyor explained to DON B that R43 shook head back and forth to indicate no. Surveyor asked DON B if that was a concern for R43's dignity. DON B stated yes, that was a dignity concern and staff should be more attentive to R43's privacy and dignity when lying in bed uncovered.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 40181 Based on record review and interview, the facility did not implement policy and procedures related to screening employees for a prior history of abuse, neglect, exploitation of residents, or misappropriation of resident property for 5 of 8 staff reviewed. This had the potential to affect all residents. Findings include: Facility policy and procedure entitled, Abuse Prohibition, last revised 11/28/16, stated in part, .Once an offer of employment has been made, the facility will submit a request to obtain a criminal history from the Department of Justice (DOJ). An electronic search will be conducted by the Department of Health and Family Services (DHFS) to check on the prospective employee's status in the following areas: the Nurse Aide Directory, Caregiver Finding of Abuse or Neglect of a client; or Misappropriation of a Client's Property, Denials or Revocations of Operating Licenses for Adult Programs, and any Rehabilitation Review Findings. In addition the Department of Regulation and Licensing (DRL) will also conduct an electronic search as to the status of Professional Credential(s), License(s), or Certificate(s) .Background Information Disclosure forms must be completed, and background checks shall be repeated every four years for employees who have access to residents . The policy and procedure also stated in part, .If a prospective employee is not a resident of Wisconsin, or at any time within the last 3 years preceding the date of the search that person has not been a resident of Wisconsin, the facility will make a good faith effort to obtain information from the state the person resided in, search information that is equivalent to the criminal history information specified in par. (a) 1.A or HFS 12.21 . On 05/22/24, Surveyor reviewed the caregiver background check information for eight staff members and found the following information. Dietary Aide (DA) G was hired on 07/27/22 and completed a Background Information Disclosure (BID) on 07/15/22. The Department of Justice (DOJ) Response and Integrated Background Information System (IBIS) Letter were both dated 10/06/24. On 05/22/24 at 4:50 PM, Surveyor interviewed Human Resources (HR) N and asked why the Caregiver Background Check was not completed for DA G until over two months after date of hire. HR N stated that employee was hired before HR N started working in this position and HR N did not know the reason for the delay. Housekeeper (HK) H was hired on 12/12/22 and completed a BID on 11/18/22. The BID identified HK H resided in Minnesota. The DOJ Response and IBIS Letter were both from the state of Wisconsin. On 05/22/24 at 4:50 PM, Surveyor interviewed HR N and asked if a Minnesota background check was completed for HK H prior to starting employment. HR N reviewed HK H's personnel file and did not locate a Minnesota or Federal background check. HR N stated this employee was hired before HR N started working in this position and HR N was unsure why there was no Minnesota background check completed. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Environmental Services Director (ESD) I was hired on 08/02/22 and completed a Background Information Disclosure (BID) on 07/21/22. The Department of Justice (DOJ) Response and Integrated Background Information System (IBIS) Letter were both dated 08/16/22. This was 14 days after ESD I began employment. On 05/22/24 at 4:50 PM, Surveyor interviewed HR N and asked why the Caregiver Background Check was not completed for ESD I until 14 days after date of hire. HR N stated that employee was hired before HR N started working in this position and HR N did not know the reason for the delay. Certified Nursing Assistant (CNA) J was hired on 08/05/19. The BID was completed on 05/18/24. The DOJ Response and the IBIS Letter were both dated 05/22/24, which was greater than four years since the date of hire. On 05/22/24 at 4:50 PM, Surveyor interviewed HR N and asked if CNA J had a caregiver background check completed at time of hire. HR N showed Surveyor CNA J's personnel file and confirmed a caregiver background check was done at time of hire in 2019. Surveyor asked if the current caregiver background check, dated 05/22/24, was overdue. HR N confirmed CNA J's caregiver background check was overdue and should have been done last August. CNA K was hired on 06/21/21. The BID was completed on 06/04/21. The DOJ Response and IBIS Letter were both dated 07/02/21, which was 11 days after CNA K began employment. On 05/22/24 at 4:50 PM, Surveyor interviewed HR N and asked why the caregiver background check was not completed until 11 days after CNA K started employment. HR N stated that employee was hired before HR N started working in this position and HR N did not know the reason for the delay. On 05/22/24 at 5:10 PM, Surveyor interviewed Nursing Home Administrator (NHA) A, who stated when HR N was hired last fall they identified the caregiver background checks were out of compliance and they have been working on getting them into 100% compliance since that time.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40181 Based on interview and record review, the facility did not notify the resident or the resident's representatives of a transfer and the reasons for the move in writing and in a language and manner they understand when transferred to the hospital for 5 residents (R) reviewed for hospitalization s. (R23, R43, R100, R46, R40) This had the potential to affect all 50 residents that reside in the facility. Findings include: Example 1 Record review identified R23 was admitted to the facility on [DATE] with spastic hemiplegia (partial paralysis) affecting the right side and aphasia (inability to speak) following a stroke. On 05/20/24 at 3:36 PM, Surveyor interviewed R23's legal guardian who stated R23 had frequent hospitalization s due to pneumonia. The legal guardian stated they had never received a written notice of discharge or transfer with the reason for the transfer at the time of any of R23's transfers to the hospital. R23's medical record identified R23 was transferred to the hospital on 6/27/23, 01/29/24, and 04/23/24. On 05/21/24 at 8:24 AM, Surveyor received the bedhold notification forms for R23's hospitalization s from Director of Nursing (DON) B but did not receive written notice of discharge or transfer forms. Example 2 Record review identified R43 was admitted to the facility on [DATE] with the following diagnoses, in part, cerebral infarction (stroke), encephalopathy (brain dysfunction), hemiplegia, and hemiparesis (weakness of one side of the body) following cerebral infarction affecting right dominant side. On 05/20/24 at 1:59 PM, Surveyor interviewed R43's representative who stated R43 had a recent hospitalization on [DATE]. R43's representative stated the facility staff informed them over the phone at the time of the transfer, but they did not receive anything in writing. On 05/21/24 at 8:24 AM, Surveyor received the bedhold notification form for R43's hospitalization from DON B but did not receive a written notice of discharge or transfer form. Example 3 (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Record review identified R100 was admitted to the facility on [DATE] with the following diagnoses, in part, orthopedic aftercare following surgical amputation, acquired absence of left leg above knee, osteomyelitis, Methicillin resistant Staphylococcus aureus infection, acute kidney failure, type 2 diabetes mellitus with diabetic chronic kidney disease and hyperglycemia, chronic kidney disease stage 3a. On 05/20/24 at 11:46 AM, Surveyor interviewed R100, who reported they were hospitalized multiple times in the past year. R100 did not remember getting anything in writing explaining the reason for transfer to the hospital. Record review identified R100 was hospitalized on [DATE], 03/11/24, 03/21/24, 04/18/24, and 05/09/24. On 05/21/24 at 8:24 AM, Surveyor received the bedhold notification forms for R100's hospitalization s from DON B but did not receive any written notice of discharge or transfer forms. On 05/21/24 at 2:05 PM, Surveyor interviewed Nursing Home Administrator (NHA) A, and asked if the facility gave residents or their representatives written notice of discharge or transfer at the time of transfer to the hospital. NHA A stated they have not been giving a written notice of discharge or transfer that explains the reason for transfer to hospital. 46694 Example 4 R46 was admitted on [DATE] with a Brief Interview of Mental Status (BIMS) of 11 with a diagnosis of congestive heart failure (CHF is a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply). On 05/21/24 at 2:55 PM, Surveyor reviewed R46's medical record. On 04/18/24, R46 was hospitalized with diagnoses of CHF exacerbation and acute respiratory distress. Surveyor was unable to locate a notice of transfer to the resident to include a reason for the transfer in writing the resident could understand. On 05/21/24 at 2:57 PM, Surveyor interviewed NHA A and asked for this information. NHA A replied, We are not doing this, but I think that we can change one of our forms to make that work. On 05/21/24 at 3:51 PM, DON B brought in a modified bed hold form to include this information and is working on changing this process. 47284 Example 5 R40 was admitted to the facility on [DATE] and had diagnoses that included in part unspecified mood disorder, cognitive communication deficit, illiteracy and low-level literacy, major depressive disorder, and insomnia. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Record review showed R40 was hospitalized from 1/11/24 to 1/12/24. No written notice of transfer was identified on R40's medical record.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47284 Based on record review, observation and interview, the facility did not implement a comprehensive individualized safety care plan to meet the needs of 1 of 14 residents (R). R34. This is evidenced by: R34 was admitted to the facility on [DATE] with diagnoses that included in part Alzheimer's disease, dementia, and cognitive communication deficit. On 03/24/24, a male resident was found in R34's room with his pants down urinating. One of the interventions from this incident was a stop sign barrier added to R34's entrance to her room to help prevent other residents from wandering into R34's room. R34's care plan, dated 03/24/24, with a target date of 05/29/24, states: .[R34] has a stop sign rope across doorway in room. Stop sign will prevent others from entering her room due to wondering behaviors. Intervention: Have stop sign on [R34]'s door if she is in her room at night while sleeping . R34's progress note on 03/30/24 stated, [R34] expressed concern about men going into her room. Nurse reassured resident that we would be monitoring and that we would try and avoid such an incident. She was understanding of this. When resident was in room stop sign was placed across doorway. R34's progress note on 03/31/24 stated, [R34] did not report any fears to nurse today. She has stop sign across doorway while in room to prevent entry into her room. R34's progress note on 04/01/24 stated, Stop sign to door remains in place. [R34] does not appear afraid. [R34] is in bed resting. Observations: On 05/20/24 at 11:16 AM, Surveyor observed no stop sign barrier to R34's door. R34 was lying in bed with eyes closed. No stop sign barrier found in R34's room. On 05/21/24 at 7:00 AM, Surveyor observed no stop sign barrier across R34's door. R34 was asleep in bed with door open, no staff in the room. No stop sign barrier found in R34's room. On 05/22/24 at 6:54 AM, Surveyor observed R34's room had a stop sign barrier that was hanging off to the side of the door, not across the doorway. R34 was asleep in bed, no staff in the room. R34's door was halfway open. On 05/23/24 at 6:57 AM, Surveyor observed R34's room had a stop sign barrier that was hanging off to the side of the door, not across doorway. R34's door was open. R34 was asleep lying in her bed, no staff in room. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on the interventions set in place for R34, the stop sign barrier should have been utilized and hung across the doorway to prevent other residents from wandering into R34's room. Interviews: On 05/21/24 at 12:37 PM, Surveyor interviewed Certified Nursing Assistant (CNA) E and asked where the stop sign barrier was. CNA E said R34 had it on her door for the first few weeks of the incident, but not seen since. CNA E said she was not sure where it was. On 05/21/24 at 12:39 PM, Surveyor interviewed Licensed Practical Nurse (LPN) C and asked about R34's stop sign barrier. LPN C said R34 had been known to take it down and stash in her room. LPN C said the sign had magnets that attached to the doorway and was easy to remove. Surveyor asked LPN C to show where the stop sign was. LPN C went to R34's room to look but could not find it. On 05/21/24 at 12:58 PM, Surveyor interviewed LPN O and asked if R34 needed a stop sign barrier. LPN O said yes. We use the stop sign to prevent other residents from wandering into a resident's room. Surveyor asked LPN O where R34's stop sign was. LPN O went to R34's room and looked for the stop sign. LPN O said she does not see the stop sign barrier in R34's room. LPN O said she will go to the Director of Nursing (DON) and ask if the care plan was changed or where the stop sign was. On 05/21/24 at 2:50 PM, Surveyor interviewed CNA R and asked if R34 has had the stop sign barrier across the doorway at night. CNA R said no, the stop sign barrier had not been up for a while since R34 has been moved to this hall (300 hall). On 05/22/24 at 3:22 PM, Surveyor asked DON B if R34's stop sign barrier intervention put into place since the incident on 03/24/24 was still active. DON B said yes it was. Surveyor asked DON B if R34 had the stop sign barrier up before Surveyor asked about it. DON B said no, not sure if the stop sign barrier was not moved over during the room change. DON B said R34 should have the stop sign barrier across the doorway.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807 Based on record review and interview, the facility did not review and revise the comprehensive toileting care plan for 1 of 14 sampled residents, Resident (R)7. This is evidenced by: The facility policy, entitled Incontinence, Catheters, & Urinary Tract Infections, last reviewed in January 2017, states in part: 7. The following items may be addressed in the care plan according to individualized resident needs: . interventions specific enough to guide the provision of services and treatment that are also dependent on resident choices and preference. R7 was admitted to the facility on [DATE] and has diagnoses that include hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, unspecified osteoarthritis, unspecified site, anxiety disorder, unspecified, pain in unspecified hip, and constipation, unspecified. R7's Minimum Data Set (MDS) assessment, dated 03/21/24, indicated that resident is always incontinent of bowel and bladder. On 05/20/24 at 10:42 AM, Surveyor observed the resident being transferred to bed using a Hoyer lift. After being transferred to bed Certified Nursing Assistant (CNA) T talked to the resident about having a bowel movement while in bed and that they would be back in 20 minutes to see if they had made one. R7 was expected to defecate in bed as a way to toilet the resident. On 05/20/24 at 11:00 AM, Surveyor completed record review of the care plan dated 03/27/24 indicated: approach . provide incontinence care after each incontinent episode . report any signs of skin breakdown . apply moisture barrier . The care plan was not updated to include R7's preferred method of toileting. On 05/21/24 at 9:36 AM, Surveyor interviewed CNA T as to why they don't use other modes of toileting. CNA T said they had tried other modes like the commode, toilet, and a bed pan, but those interventions were too painful for R7. They found that using the Depends brief and making sure to check and change as soon as possible has been the best for the resident. When they had tried to use the bed pan R7 would move and wiggle in pain and the bed pan was not working. Surveyor asked where the information was related to how R7 was to be toileted. CNA T said they just knew it from experience and working here. This has been the system for R7 for a while and they check often. On 05/21/24 at 12:54 PM, Surveyor interviewed R7 regarding the current toileting plan. R7 said they did not have any concerns. Surveyor asked if they had tried other methods of toileting like the commode or bedpan, R7 said yes, they did, but they were too painful for her back. R7 indicated the current procedure was the least painful and they have no concerns related to toileting. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/21/24 at 2:07 PM, Surveyor interviewed Director of Nursing (DON) B regarding R7's toileting procedure. DON B said that a while ago R7 came back from a hospital stay and started going downhill. Previously they were able to use other options for toileting but then they became too painful for the resident. R7 prefers to lay on their left side and use their Depends. Surveyor asked if the care plan should reflect the mode of toileting. DON B said yes, they would expect the care plan to reflect the way R7 prefers to be toileted, and they will change that right away. On 05/22/24, Surveyor verified with therapy services that R7 had attempted some therapy for the use of other toileting methods, but R7 chose to stop all therapies and elected for palliative care. Therapy notes revealed a progress note related to this decision to stop all therapy and pursue palliative care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observation, interview and record review, the facility did not ensure activities of daily living (ADLs) of meal set-up, repositioning, and incontinence cares were provided for 1 of 15 residents (R21) reviewed. This is evidenced by: R21 was admitted to the facility on [DATE], with diagnoses including alcohol induced persisting dementia, malignant neoplasm of esophagus, Wernicke's encephalopathy, aphasia following cerebral infarction, and depressive disorder. R21's minimum data set (MDS) assessment, completed on 04/04/24, confirmed R21 is incontinent of urine and frequently incontinent of bowels. R21 requires supervision assistance with eating. R21 is dependent on staff for personal hygiene, showering/bathing, toileting, transferring, dressing lower body, and putting on/taking off footwear. R21's care plan was initiated on 03/28/24, and included the following: BED MOBILITY: -The resident requires assist of one staff to turn and reposition in bed. -Turn/reposition as needed. EATING: -Supervision/Set-up. -Provide liquids/food as needed. PERSONAL HYGIENE: -The resident requires assistance of one with personal hygiene. DRESSING: -The resident requires assist of one with dressing upper and lower body dressing. TOILET USE -The resident requires assistance of one with utilizing bed pan/urinal for toileting. -Provide peri care as needed. TRANSFER (continued on next page)

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 05/23/2024
NAME OF PROVIDER OR SUPPLIER Dove Healthcare - Spooner		STREET ADDRESS, CITY, STATE, ZIP CODE 510 First St Spooner, WI 54801	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident requires is totally dependent on two staff for transferring. -The resident requires mechanical lift Hoyer lift with two staff assistance for transfers. INCONTINENT: -Provide incontinence care with each incontinence episode. POTENTIAL FOR NUTRITIONAL RISK: -Puree texture diet with thin liquids. -Elevate head of bed or position upright before feeding. -Observe closely for signs of choking and/or aspiration. -Provide adequate time for feeding self, assist as needed. On 05/20/24 at 9:12 AM, Surveyor observed Certified Nursing Assistant (CNA) Z deliver R21's breakfast tray to room. R21 tried grabbing a glass of milk and could not reach it. R21 was lying in bed unable to reach for items on bedside table. On 05/20/24 at 9:55 AM, Surveyor entered R21's room. Breakfast tray was sitting in front of R21. R21 only stated, Hi, when Surveyor introduced self. R21 could not speak clearly or offer any information to Surveyor. Surveyor observed R21 looked pale and fragile lying on back in bed. On 05/20/24 at 10:22 AM, Surveyor entered R21's room and observed breakfast tray sitting on bedside table not touched. R21 was still lying in bed on back, sheet over top, foot crossed, and fall mat in place. R21 was unable to reach for items on bedside table as bedside table crooked near bed. On 05/20/24 at 11:56 AM, Surveyor observed breakfast tray still on bedside and pushed away, R21 had kicked covers off, not positioned well in bed, and trying to say something but couldn't get anything out. Surveyor did not observe staff enter R21's room to assist R21. On 05/20/24 at 12:01 PM, Surveyor observed CNA Z enter R21's room. CNA Z did not check on R21 but went straight to roommate's bed and offered to assist ambulate down hall to lunch. Surveyor observed breakfast tray still in place at R21's bedside table. Surveyor observed CNA Z exit R21's room and did not check on R21. On 05/20/24 at 12:43 PM, Surveyor observed Licensed Practical Nurse (LPN) O enter R21's room to assist R21's roommate. Surveyor did not observe LPN O speak with R21 or check on R21. CNA Z stood at door and asked LPN O if R21 was a feeder. LPN O indicated R21 is an assist to feed but has not been eating good and that staff should be in room to assist R21. CNA Z stated, Ok, and walked down the hallway. (continued on next page)

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 05/23/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/20/24 at 12:58 PM, Surveyor observed CNA Z enter R21's room and asked R21 if R21 wanted lunch. R21 stated, Yes. CNA Z took breakfast tray out of room. Surveyor observed breakfast tray not touched with all food still on food tray. Surveyor observed CNA Z bring lunch tray in to R21's room and set the bedside table up closer to R21. CNA Z exited the room and walked down the hallway. Surveyor did not observe R21 try to eat anything. Surveyor did not see R21 move much at all. On 05/20/24 at 1:45 PM, Surveyor observed R21 lying in bed with lunch tray in front of R21 with no food eaten. Surveyor did not observe staff nearby or go into R21's room again. Surveyor did not observe meal assistance, repositioning, or incontinent care performed between 9:20 AM and 1:45 PM. On 05/21/24 at 1:50 PM, Surveyor interviewed CNA Z and asked about how often R21 is repositioned or provided incontinent care. CNA Z indicated that CNAs go in every so often and check on R21 but that R21 is on hospice. CNA Z indicated that CNA Z has been down the other halls and was just helping pass trays today so CNA Z was unsure when someone else checked on R21. On 05/22/24 at 8:54 AM, Surveyor interviewed Director of Nursing (DON) B and asked expectation for providing R21 repositioning and incontinent cares. DON B indicated that expectation for staff to provide repositioning and incontinent care should occur every two hours and as needed. Surveyor indicated that Surveyor did not observe repositioning or incontinent care from 9:20 AM-1:45 PM. DON B indicated expectation is that R21 should have been repositioned and provided incontinent care every two hours and as needed. Surveyor asked DON B expectation of R21 receiving assistance with breakfast meal and lunch meal. DON B indicated sometimes R21 will say if he wants breakfast or lunch and most of the time staff starts the first bite of food and then staff will drop the tray off and leave to pass other trays. Surveyor indicated to DON B that according to record review R21 has an order for dysphagia diet and care plan indicates that R21 is supposed to have assistance/supervision during meals to prevent aspiration. DON B indicated that staff are supposed to stay with R21 the entire time for meals if eating in room. DON B indicated that usually R21 comes to dining room to eat but that the last few days R21 was having behaviors and staff were keeping R21 in room instead.

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F 0684

Level of Harm - 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 48793

Based on observations, interviews and record reviews, the facility did not provide diabetic care and treatment by professional standards of practice to maintain a resident's highest practicable level of physical well-being for 1 of 14 residents (R32) reviewed.

Staff did not follow diabetic protocol to manage R32's type 1 diabetic hypoglycemia episodes by not providing glucagon when blood sugars were below 70 and re-checking low blood glucose (BG) levels within 15 minutes after intervention. Staff did not notify R32's physician when hypoglycemic and hyperglycemic episodes were occurring to change treatment. Staff did not monitor R32's vital signs, monitor and documenting signs and symptoms.

Findings include:

Surveyor reviewed the policy titled, Management of Hypoglycemia, which stated in part,

.-Symptoms of Hypoglycemia

#1. Signs of symptoms of hypoglycemia usually have a sudden onset and may include the following:

Weakness, dizziness, fainting, pale, cool, moist skin, excessive perspiration, stupor, unconsciousness, and/or convulsions, and coma.

-Management of Hypoglycemia

#2. For level 1 hypoglycemia (<70mg/dL but >54 mg/dL):

a. Give resident an oral form of rapidly absorbed glucose (15-20grams);

b. Notify the provider immediately.

c. Remain with the resident;

d. Recheck blood glucose in 15 minutes:

(3) If blood glucose remains <70 mg/dL repeat oral glucose and notify physician for further orders.

#3. For level 2 hypoglycemia (<54 mg/dL):

a. Administer glucagon (intranasal, intramuscular, or as provided);

b. Notify the provider immediately;

c. Remain with the resident;

(continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	d. Place the resident in a comfortable and safe place (bed or chair); e. Monitor vital signs; and f. Recheck blood glucose in 15 minutes as above. -Documentation #1. Document the resident blood glucose before intervention. #2. Note blood glucose after each administration of rapid-acting glucose and the follow-up blood glucose. #3. Record the resident's level of consciousness before and after intervention. #4. Document provider instructions . R32 was admitted to the facility on [DATE] with diagnoses including in part, type 1 diabetes mellitus with diabetic chronic kidney disease and ketoacidosis without coma, metabolic encephalopathy, chronic kidney disease stage 4, vascular dementia unspecified severity with agitation, paroxysmal atrial fibrillation, gastrostomy status, and dysphagia oropharyngeal phase following cerebral infarction. R32's minimum data set (MDS) assessment, completed on 01/29/24, confirmed R32 scored 11/15 during Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. R32 has an activated power of attorney for healthcare decisions. R32 is dependent on staff for nutritional needs and R32 has gastrostomy (G)-tube placement. Review of R32's medical record identified the following physician orders stated in part, . -Monitor blood glucose levels before tube feeding and at bedtime . Review of R32's medical record identified the following notes: On 01/27/24 at 3:36 PM, BG flowsheet indicated that R32's BG was 50. Surveyor did not observe any progress notes indicating interventions to treat the low blood glucose level. Glucagon was not administered for less than 54 BG levels. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 02/01/24 at 7:07 PM, BG flowsheet indicated BG 67. Surveyor did not observe any progress notes indicating interventions to treat the low blood glucose level. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 02/04/24 at 4:41 AM, Medication Administration Record (MAR) indicated Glucagon 1mg given to R32. Surveyor did not observe any progress notes indicating the BG result and why R32 was treated with Glucagon. BG was not rechecked within 15 minutes after administration of Glucagon, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 02/05/24 at 12:46 AM, MAR indicates that Glucagon 1mg was given for a BG of 77. No progress notes were observed for reasoning giving glucagon outside the BG parameters with any re-check of BG within 15 minutes, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 02/05/24 at 6:11 AM, progress note indicated, . BG dropped to 71 and glucagon administered at 4:40 AM. Rechecked BG with result 332 at 6:30 AM. No progress notes were observed for reasoning giving glucagon outside the BG parameters. BG was not rechecked within 15 minutes after administration of Glucagon, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 02/06/24 at 4:22 AM, progress notes indicated: .0030-BG 66 OJ with 3 sugar packets given via GT. 0100 BG 60 gave bolus of Jevity. 0300 BG 217 . Surveyor did not observe any other progress notes indicating the re-checks of BG results within 15 minutes of giving Jevity, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 02/10/24 at 10:54 PM, MAR indicated that an 8:00 PM dose of Glargine was held. At this time BG was 64 and at 9:00 PM BG was 80. Surveyor did not observe any progress notes indicating interventions to treat the low blood glucose level. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 02/11/24 at 4:39 AM, progress note indicated, . BG result 64 at HS on 02/10/24, Glargine given . Surveyor did not observe any progress notes indicating interventions to treat the low blood glucose level. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 02/12/24 at 4:35 AM, progress note indicated, . BG result 56. Bolus of Jevity given. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 02/12/24 at 9:18 PM, progress note indicated BG result 49. Insulin held. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Glucagon was not administered for less than 54 BG levels. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. (continued on next page)

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 05/23/2024
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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 02/13/24 at 12:19 PM, MAR indicated BG flowsheet indicated BG 53. On 02/13/24 at 12:19 PM, MAR indicated BG flowsheet indicated rechecked BG with the result of 44. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Glucagon was not administered for less than 54 BG levels. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 2/15/24 at 8:03 PM, BG flowsheet indicated BG 62. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 2/17/24 at 11:10 AM, BG flowsheet indicated BG 51. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Glucagon was not administered for less than 54 BG levels. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 02/24/24 at 8:47 PM, BG flowsheet indicated BG 62. On 02/24/24 at 8:55 PM, progress note indicated BG 62 insulin Lispro was given 3 units. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Re-check of BG within 15 minutes was not observed in progress notes. Insulin was still administered with low BG, and signs and symptoms and vital signs were not monitored. Staff did not notify R32's physican of low blood glucose level. On 02/29/24 at 5:57 AM, progress notes indicated BG 54, bolus of Jevity was given. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Glucagon was not administered for less than 54 BG levels. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 03/01/24 at 8:00 PM, MAR indicated that nurse gave insulin Lispro and Glargine. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Re-check of blood glucose was not observed in progress notes. Insulin was still administered with low blood glucose level. At 8:51 PM, BG flowsheet indicated BG 61. Staff did not notify R32's physican of low blood glucose level. On 03/02/24 at 1:28 AM, progress notes indicated BG 61 bolus of Jevity given. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 03/03/24 at 2:16 AM, Progress note indicated that on 03/02/24 at HS BG 30 and bolus Jevity given. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Glucagon was not administered for less than 54 BG levels. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 03/08/24 at 5:00 AM, progress notes indicated BG 50 and bolus given. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Glucagon was not administered for less than 54 BG levels. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 03/10/24 at 8:39 AM, BG flowsheet indicated BG 66. On 03/10/24 at 10:29 AM, progress note indicated resident had BG 66, resident did not want interventions just wanted feeding to start. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 03/14/24 at 12:38 PM, progress notes indicated BG 57 bolus Jevity given. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 03/15/24 at 10:51 AM, progress notes indicated BG 67 bolus Jevity given. On 03/15/24 at 1:02 PM, progress notes indicated BG 67 bolus Jevity given. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 03/16/24 at 11:20 AM, BG flowsheet indicated BG 62. On 03/16/24 at 1:22 PM, progress notes indicated blood sugar was very low, bolus was given, and monitored resident closely. Staff did not notify R32's physican of low blood glucose level. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 03/16/24 at 1:22 PM, progress notes indicated resident symptomatic with low blood sugars, clammy, skin cool. Gave bolus of Jevity. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 03/16/24 at 5:16 PM, BG flowsheet BG 388. Surveyor did not observe any progress notes indicating any other interventions to treat the high blood glucose level. Re-check of blood glucose was not observed in progress notes, and no monitoring of signs and symptoms, and vital signs. Staff did not notify R32's physican of the elevated blood glucose level. On 03/16/24 at 9:30 PM, BG flowsheet BG 465. Surveyor did not observe any progress notes indicating any other interventions to treat the high blood glucose level. Re-check of blood glucose was not observed in progress notes, and no monitoring of signs and symptoms, and vital signs. Staff did not notify R32's physican of the elevated blood glucose level. On 03/24/24 at 4:11 AM, progress notes indicated resident complaint of blood sugar low. BG was 66 and bolus Jevity started. At 8:00 AM, MAR indicates that the nurse administered insulin Lispro and Glargine. Staff did not notify R32's physican of low blood glucose level. On 03/24/24 at 4:50 PM, BG flowsheet indicated BG 63. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 03/24/24 at 8:12 PM, BG flowsheet indicated that BG HIGH. Surveyor did not observe any progress notes indicating any other interventions to treat the high blood glucose level. Re-check of blood glucose was not observed in progress notes, and no monitoring of signs and symptoms, and vital signs. Staff did not notify R32's physican of the elevated blood glucose level. On 3/25/24 at 4:37 PM, BG flowsheet indicated BG 60. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 3/29/24 at 3:43 PM, BG flowsheet indicated BG 57 Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 04/3/24 at 10:16 PM, BG flowsheet indicated BG 423. Surveyor did not observe any progress notes indicating any other interventions to treat the high blood glucose level. Re-check of blood glucose was not observed in progress notes, and no monitoring of signs and symptoms, and vital signs. Staff did not notify R32's physican of the eleveated blood glucose level. On 04/4/24 at 7:17 AM, BG flowsheet indicated BG 347. Surveyor did not observe any progress notes indicating any other interventions to treat the high blood glucose level. Re-check of blood glucose was not observed in progress notes, and no monitoring of signs and symptoms, and vital signs. Staff did not notify R32's physican of the elevated blood glucose level. On 04/04/24 at 11:29 AM, BG flowsheet indicated BG 364. Surveyor did not observe any progress notes indicating any other interventions to treat the high blood glucose level. Re-check of blood glucose was not observed in progress notes, and no monitoring of signs and symptoms, and vital signs. Staff did not notify R32's physican of the elevated blood glucose level. On 4/8/24 at 5:12 PM, BG flowsheet indicated BG 62. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 4/9/24 at 3:38 PM, Blood Sugar flowsheet indicated BG 67. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 4/19/24 at 5:02 AM, BG flowsheet indicated BG 54. On 04/19/24 at 5:03 AM, Progress note indicated the resident called the light on for a warning of low blood sugar. BG was 54, and 60 ml bolus of Jevity was given. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Glucagon was not administered for less than 54 BG levels. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 4/20/24 at 8:06 PM, BG flowsheet indicated BG 68. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 4/21/24 at 3:54 PM, BG flowsheet indicated BG 52. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Glucagon was not administered for less than 54 BG levels. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 04/24/24 at 4:11 AM, progress notes indicated BG result 66. Gave bolus Jevity. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. On 04/30/24 at 10:04 PM, progress notes indicated at 4:00 PM BG was 67. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. BG was not rechecked within 15 minutes after initial low BG, and did not monitor signs and symptoms, and vital signs. Staff did not notify R32's physican of low blood glucose level. Interviews: On 05/20/24 at 10:55 AM, Surveyor interviewed R32 and asked about insulin usage. R32 indicated that R32 is diabetic and sometimes staff give too much insulin at night and then R32 plummets in the night. R32 indicated that usually, the doctor will order insulin but always asks how R32 feels about the decision to change dosage or medication. R32 indicated, I am very aware of my blood sugars and how I feel when they are high or low. Lately, I have been low a lot. This morning I rang for staff to come in as I was low, and it took them 30 minutes to come in. On 05/23/24 at 8:16 AM, Surveyor interviewed Licensed Practical Nurse (LPN) Q and asked what LPN Q's process is for checking blood sugars for R32. LPN Q just documents the result and the insulin given in R32's medical record. Surveyor asked LPN Q how LPN Q follows the diabetic protocol for when R32 is hypoglycemic. LPN Q indicated that R32 has never been hypoglycemic in LPN Q's care, but that LPN Q has had R32's BG be 63ish and LPN Q just observes how R32 feels at that time and bases the insulin usage with what R32 would like. On 05/22/24 at 3:45 PM, Surveyor interviewed Director of Nursing (DON) B and asked about expectations for hypoglycemic episodes. DON B indicated that R32 is a brittle diabetic. DON B indicated that nurses were educated on diabetic protocol back in September of 2023. DON B indicated that DON B has had verbal discussions with nursing staff regarding R32's BG's but nurses keep doing what nurses want to do. (continued on next page)

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 05/23/2024
NAME OF PROVIDER OR SUPPLIER Dove Healthcare - Spooner		STREET ADDRESS, CITY, STATE, ZIP CODE 510 First St Spooner, WI 54801	

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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 0684 Level of Harm - Actual harm Residents Affected - Few	On 05/23/24 at 10:12 AM, Surveyor interviewed Endocrinologist BB and asked what expectations are for hypoglycemic or hyperglycemic episodes. Endocrinologist BB indicated that facility staff should be following the diabetic protocol within the facility. Surveyor asked Endocrinologist BB if he wanted to be contacted with BG lower than 70 and Endocrinologist BB indicated yes, Endocrinologist BB wants to be notified. Endocrinologist BB indicated that Endocrinologist BB is on call 24/7 and staff should be calling at all hours with BGs lower than 70. Surveyor asked Endocrinologist BB if Endocrinologist BB is ok with R32 making R32's own decisions about insulin usage and requesting other units to be given. Endocrinologist BB stated, Absolutely not as R32 is a brittle diabetic. Surveyor asked what the likelihood of outcome is to R32's organs or body with low blood glucose levels. Endocrinologist BB indicated that R32 has multiple health complications and that extreme fluctuations in blood glucose levels can cause worsening of complications and even death from low blood glucose levels.

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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 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** 47284 Based on observation, interview and record review, the facility did not ensure a resident received adequate supervision and assistance to prevent falls and injury. This occurred for 1 of 3 residents (R) reviewed for falls, (R40). The facility was not following the intervention of utilizing a pressure alarm that was set in place to prevent further falls for R40. This is evidenced by: R40 was admitted to the facility on [DATE] with diagnoses that included in part unspecified mood disorder, cognitive communication deficit, illiteracy and low level literacy, major depressive disorder, and insomnia. R40's care plan, dated 12/06/23, states: .[R40] is a risk for falls due to impaired balance, poor safety awareness, impulsiveness, and history of falling .Intervention: Pressure alarm for bed and chair . R40's fall risk assessment, completed on 12/06/23, showed moderate fall risk. 01/12/24 and 03/07/24 fall risk assessments showed R40 was a high fall risk. R40 fell at the facility on 12/28/23, 01/11/24, 01/17/24, and 02/25/24. R40's Physical Therapy (PT) evaluation, dated 05/08/24, stated: .Clinical impressions: Patient is safe to ambulate and perform transfers in room independently with a front wheel walker. Patient is not safe to ambulate in large open areas with inconsistent obstacles and, therefore, will continue to require assist x 1 with front wheel walker for safe ambulation in hallway of facility. Observations: On 05/20/24 at 3:20 PM, Surveyor observed R40 sitting in wheelchair in the common area near the nurse's station. No pressure alarm on R40's wheelchair. On 05/21/24 at 6:52 AM, Surveyor observed R40 sitting in wheelchair in common area near the nurse's station. No pressure alarm on R40's wheelchair. On 05/22/24 at 3:05 PM, Surveyor observed R40 sitting in wheelchair in common area by nursing station. R40's wheelchair does not have pressure alarm. R40's pressure alarm was set in place as one of the interventions to prevent falls. R40 should have had the pressure alarm to his wheelchair, but was not in place when Surveyor observed R40 sitting in his wheelchair. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Dove Healthcare - Spooner		STREET ADDRESS, CITY, STATE, ZIP CODE: 510 First St Spooner, WI 54801	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/24 at 4:15 PM, Surveyor interviewed Certified Nursing Assistant (CNA) P and asked if R40 should have a pressure alarm while sitting in his wheelchair. CNA P said she was not sure. On 05/22/24 at 4:19 PM, Surveyor interviewed Licensed Practical Nurse (LPN) Q and asked if R40 was independent in his room. LPN Q said R40 was shaking on his feet and had fallen before, so we have pressure alarms on his wheelchair. Surveyor advised LPN Q of the observations of R40's wheelchair with no position alarm while R40 was in the wheelchair. LPN Q said R40 should have the pressure alarm in place while he was in the wheelchair. LPN Q went to R40 and took him to his room and placed the wheelchair pressure alarm. On 05/23/24 at 8:48 AM, Surveyor interviewed Director of Nursing (DON) B and asked about the chair alarm if that was still an active intervention. DON B said we were going to do a trial of the alarm off, but not sure about the details. DON B said Occupational Therapy (OT) S would know more. On 5/23/24 at 9:16 AM, Surveyor interviewed OT S and asked about R40's use of wheelchair pressure alarm. OT S said R40 was very impulsive and getting up, so we added the pressure alarm. Physical Therapy (PT) evaluated R40 on 05/08/24 and deemed R40 did not do well walking independent in open areas with long distances or corners as R40 was unsteady and at risk for falls. Surveyor asked OT S what R40 utilizes when outside his room. OT S said R40 used a wheelchair when out of room and a pressure alarm needed to be in use to alert staff that R40 was rising. On 5/23/24 at 11:14 AM, Surveyor interviewed DON B and advised what the PT note stated concerning R40's ambulation in large open areas. Surveyor asked DON B how R40 moved around while outside his room. DON B said R40 usually wheeled self in wheelchair when outside his room. Surveyor asked DON B if the wheelchair pressure alarm intervention was still in place if R40 was in the wheelchair. DON B said the wheelchair pressure alarm was still an intervention that needed to be in place to R40's wheelchair. Surveyor advised DON B of the observations of R40 without the wheelchair pressure alarm. DON B said R40 should have the alarm while in his wheelchair.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40181 Based on observation, interview and record review, the facility did not ensure residents (R) with indwelling Foley catheters received care and treatment consistent with professional standards of practice to prevent complications or urinary tract infections (UTI) from the catheter. This occurred for 2 of 4 residents reviewed for urinary catheters. (R43 and R29). R43 was recently hospitalized with UTI and sepsis. Surveyor observed staff perform improper catheter care and did not use proper infection control practices for R43's catheter care. R29's Foley catheter was changed on a routine monthly basis without clinical indications and not following professional standards of practice. Findings include: Facility policy and procedure entitled, Perineal Care, last revised February 2018, stated in part, .For a male resident: a. Wet washcloth and apply soap or skin cleansing agent. b. Wash perineal area starting with urethra and working outward. c. If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches. Gently rinse and dry the area .f. Continue to wash the perineal area including the penis, scrotum and inner thighs . Facility policy and procedure entitled, Handwashing/Hand Hygiene, last revised August 2019, stated in part, . Applying and Removing Gloves 1. Perform hand hygiene before applying non-sterile gloves .3. When removing gloves, pinch the glove at the wrist and peel away from the hand, turning the glove inside out. 4. Hold the removed glove in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove. 5. Perform hand hygiene. Facility policy and procedure entitled, Catheter Care, Urinary, last revised August 2022, stated in part, .Use aseptic technique when handling or manipulating the drainage system . The Centers for Disease Control and Prevention (CDC) suggests changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised. Record review identified R43 was admitted to the facility on [DATE] with the following diagnoses, in part, cerebral infarction (stroke), encephalopathy (brain dysfunction), hemiplegia, and hemiparesis (weakness of one side of the body) following cerebral infarction affecting right dominant side, and UTI. Record review identified R43 had an indwelling urinary catheter removed on the day of admission, but had it re-inserted on 03/23/24 due to abdominal pain, inability to urinate, and urinary retention noted on bladder scan. A urinalysis and urinary culture were done at that time and R43 was diagnosed with and treated for a UTI. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The record review further identified R43 was transferred to the emergency room for abnormal lab values on 04/19/24 and admitted to the hospital for UTI and sepsis. On 05/20/24 at 1:59 PM, Surveyor interviewed R43's representative who stated R43 had a recent hospitalization due to a UTI and thinks R43 has had multiple UTIs since admission to the facility. On 05/21/24 at 9:24 AM, Surveyor observed Certified Nursing Assistants (CNA) D and E provide perineal and catheter care for R43. Both CNAs used hand sanitizer and donned gowns and gloves prior to entering the room. After preparing the resident and gathering supplies at the bedside, CNA D unfastened and pulled down R43's brief. CNA D picked up a wet washcloth, applied soap and washed R43's lower abdomen and perineal area, including the scrotum and inner thighs on both sides. CNA D then washed the scrotum under the penis. Then using the same washcloth, CNA D washed the penis from the top down to the urethra and washed around the catheter and down the catheter tubing. CNA D took a new wet washcloth and rinsed and dried R43's skin in the same order. With CNA E's assistance they rolled R43 to one side and removed the incontinent brief. CNA D proceeded to wash and dry R43's back side and rectal area. They placed a clean incontinent brief under R43, turned R43 back and fastened the brief. CNA D while wearing the same gloves worn for all perineal care, took an alcohol wipe and wiped the connection between the catheter and the bedside drainage bag tubing. CNA D attempted to disconnect the drainage bag tubing from the catheter but was having trouble getting them disconnected. CNA D stated one glove ripped during the disconnection attempt. CNA D removed only the torn glove and put on a new glove, without washing hands or using hand sanitizer between glove change. CNA D then disconnected the tubing from the catheter and attached the leg bag extension tubing to the catheter. CNA D secured the catheter and leg bag to R43's leg and then pulled up R43's pants. CNA D removed the contaminated gloves and put on new gloves without using hand sanitizer or washing hands. Then both CNAs transferred R43 to a wheelchair using a mechanical lift. Immediately following the observation of perineal and catheter care, Surveyor interviewed CNA D and asked what CNA D understood the proper order was for providing perineal care for a resident with an indwelling urinary catheter. CNA D was not sure of the proper order. Surveyor asked CNA D when they were supposed to wash hands or use hand sanitizer when changing gloves during cares. CNA D stated they were supposed to use hand sanitizer between glove changes, but sometimes forgets when busy. Surveyor asked CNA D if they should have changed gloves after providing perineal care and before changing the urinary drainage bags. CNA D was not sure. On 05/21/24 at 10:49 AM, Surveyor interviewed Director of Nursing (DON) B and explained the above observation of catheter care and no hand hygiene between glove changes. DON B stated CNA D should have washed around the urethra and catheter insertion first and then the rest of the perineal area. DON B stated the CNA D should have changed gloves after perineal care and before changing the urine drainage bags. DON B stated CNA D should have used hand sanitizer between glove changes. 47807 Example 2 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R29 was admitted on [DATE], and has the diagnoses of unspecified dementia, type 2 diabetes mellitus with diabetic nephropathy, chronic kidney disease, stage 3 unspecified, other retention of urine, presence of urogenital implants, benign prostatic hyperplasia with lower urinary tract symptoms, disorder of kidney and ureter unspecified, personal history of malignant neoplasm of prostate. R29's Minimum Data Set (MDS) assessment, dated 03/08/24, states that R7 does have an indwelling catheter. On 05/22/24 at 1:35 PM, Surveyor reviewed R29's catheter orders which stated: Change Foley catheter 18F with 10 ml balloon. Change monthly. Once A Day on the 2nd of the Month. This was an open-ended order. On 05/22/24 at 2:53 PM, Surveyor interviewed DON B regarding the order to have catheter change completed monthly. DON B said they did not realize the standard of practice changed. They believed the standard was still to be changed regularly, and when someone would come back from the hospital they would have the order changed to represent what facility policies and standards of practice that they believed to be accurate. Moving forward DON B plans to make sure the correct standard is in place, and they would expect the catheter to be changed PRN (as needed).

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NAME OF PROVIDER OR SUPPLIER Dove Healthcare - Spooner		STREET ADDRESS, CITY, STATE, ZIP CODE 510 First St Spooner, WI 54801	

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observation, interview and record review, the facility did not ensure residents (R) who are fed by enteral means receive the appropriate treatment and services of tube placement and storage of supplies to prevent complications of enteral feeding. This occurred for 2 of 2 residents observed for tube feedings. (R32 and R43). This is evidenced by: R32 was admitted to the facility on [DATE] with diagnoses including in part, type 1 diabetes mellitus with diabetic chronic kidney disease and ketoacidosis without coma, metabolic encephalopathy, chronic kidney disease stage 4, vascular dementia unspecified severity with agitation, paroxysmal atrial fibrillation, gastrostomy status, and dysphagia oropharyngeal phase following cerebral infarction. R32's minimum data set (MDS) assessment, completed on 01/29/24, confirmed R32 scored 11/15 during Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. R32 has an activated power of attorney for healthcare decisions. R32 is dependent on staff for nutritional needs and R32 has gastrostomy (G)-tube placement. Review of R32's medical record identified the following physician orders stated in part, .NPO [nothing by mouth] due to choking risk and received all medications and feedings by gastrostomy tube (GT). -Change bag daily and please date irrigation sets with black marker. - Check Tube Placement by aspirating stomach contents. Before Meals 8:00 AM, 12:00 PM, 4:00 PM . Review of R32's care plan identified the following interventions stated in part, -Change bag daily and please date irrigation sets with black marker. -Check placement of tube by auscultating air passage before each feeding or medication administration . On 05/20/24 at 10:58 AM, Surveyor observed the tube feeding gravity bag hanging on a standard bedside pole near R32's bed. The tube from the bag was disconnected from R32's gastrostomy tube and the connecting end was tucked inside the top opening of the feeding bag. The top of the feeding bag was open to air. On 05/20/24 at 11:32 AM, Surveyor observed Licensed Practical Nurse (LPN) Y enter R32's room and go into R32's bathroom. Surveyor noted the water graduate, the Jevity graduate, and syringe were sitting right side up on the bathroom counter beside the sink where staff wash their hands after cares. None of the feeding supplies were covered to prevent contamination. LPN Y washed hands and applied gloves. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor observed no label of date when tube feeding bag was opened. Surveyor observed tube feeding tubing sticking in gravity bag open to air. Surveyor interviewed LPN Y and asked how LPN Y knows when tubing and bag were opened. LPN Y indicated the bag should be labeled with open date so it can be changed out every 24 hours. LPN Y infused tube feeding to R32 and then labeled the bag after the feeding. LPN Y gathered warm water in graduate for flush and free water before tube feeding. LPN Y took the tube end which was in the tube feed bag with the top opened and pulled it out. LPN Y poured Jevity in the bag 340mls and primed the tubing. LPN Y connected the priming tube to the g-tube site and started running feeding in to R32 at 400ml/hr. Surveyor did not observe LPN Y check for placement of G-tube before the flush of free water, or before the administration of Jevity to R32. On 05/20/24 at 11:36 AM, Surveyor interviewed LPN Y and asked about the process for tube feeding with storing the tube that connects to the resident. LPN Y indicated that sometimes LPN Y places the priming tube back into the bag and leaves open, so the tubing doesn't fall and hit the ground. Surveyor asked LPN Y was it normal to leave the bag open to air between feedings and how often is bag changed. LPN Y indicated that no it is not supposed to be open, but LPN Y leaves it open. LPN Y indicated the bag gets changed every 24 hours. Surveyor observed the formula bag to be not labeled with an open date. Surveyor asked LPN Y how LPN Y knows when the bag needs to be changed out. LPN Y indicated the bag was there this morning and LPN Y assumed it was new from the night shift. LPN Y continued infusing the Jevity formula into R32 and exited R32's room, LPN Y took a marker, and labeled the bag for today's date of 05/20/24. Surveyor asked LPN Y about tube placement and LPN Y indicated that usually LPN Y checks the tube and the measurement on the tubing. LPN Y indicated that LPN Y did not measure tube or aspirate to check for placement before flushing and starting the tube feeding. On 05/21/24 at 4:01 PM, Surveyor interviewed Director of Nursing (DON) B and asked expectation for infection control measures during prepping and administering tube feeding. DON B indicated that facility's expectation is that staff use good hand hygiene. Staff are to utilize the Personal Protective Equipment (PPE) for R32's room since on Enhanced Barrier Precautions (EBP). Surveyor indicated that LPN Y was not observed donning PPE before prepping and administering tube feeding. DON B indicated that LPN Y should have used PPE before entering and then prepping and administering tube feeding to R32. Surveyor indicated to DON B that Surveyor observed tube feeding supplies were located on sink in the bathroom with graduate for feeding sitting upward with used syringe lying in the graduate. Surveyor asked DON B if DON B had any concerns with infection control practices with tube feeding supplies. DON B indicated that staff should have tube feeding supplies located outside the bathroom and maybe store on a shelf or a wheeled 3 drawer cart. Surveyor asked DON B what the expectation is for checking placement of G-tube during prepping and administering tube feeding. DON B indicated the nurses should be checking placement by aspirating contents before flushing and measuring the G-tube before administering flushes or feedings. (continued on next page)

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 05/23/2024
NAME OF PROVIDER OR SUPPLIER Dove Healthcare - Spooner		STREET ADDRESS, CITY, STATE, ZIP CODE 510 First St Spooner, WI 54801	

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor interviewed DON B and asked expectation for recapping tip of tubing during disconnecting after administering tube feeding. DON B indicated that expectation for nursing staff when disconnecting G-tube the end is recapped with a clean cap and draped over the bedside pump pole. Surveyor indicated that LPN Y was observed to have draped the end connector and tubing inside the feeding bag and bag left open to air. DON B indicated that LPN Y performed the incorrect process for recapping the tubing end and making sure the gravity bag is closed. 40181 Example 2: Record review identified R43 was admitted to the facility on [DATE] with the following diagnoses, in part, cerebral infarction (stroke), encephalopathy (brain dysfunction), hemiplegia, and hemiparesis (weakness of one side of the body) following cerebral infarction affecting right dominant side, and dysphagia (difficulty swallowing). R43 had orders for NPO (nothing by mouth) due to choking risk and received all medications and feedings by gastrostomy tube (GT). On 05/21/24 at 12:48 PM, Surveyor observed LPN C administer medications and Jevity feeding through R43's GT. LPN C provided medication and feeding using proper procedures. Surveyor noted both the water graduate and the Jevity graduate and syringe were sitting right side up on the bathroom counter beside the sink where staff empty the wash basin and wash their hands after cares. None of the feeding supplies were covered to prevent contamination. On 05/21/24 at 4:10 PM, Surveyor observed the tube feeding gravity bag hanging on a standard beside R43's bed. The tube from the bag was disconnected from R43's gastrostomy tube and the connecting end was tucked inside the top opening of the feeding bag. The top of the feeding bag was open.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47807 Based on record review and interview, the facility did not use the services of a registered nurse (RN) for at least 8 consecutive hours a day, 7 days a week. This has the potential to affect all 50 residents who reside in the facility. This is evidenced by: On 05/22/24 at 9:30 AM, Surveyor completed a record review for the month of May related to daily staff postings and noticed there were certain weekends where RN coverage hours were less than 8 hours. The dates of 05/04/24, 05/05/24, 05/18/24, and 05/19/24 all showed less than 8 hours of RN coverage. On 05/22/24 at 9:45 AM, Surveyor completed a record review of the time punches for the days of 05/04/24, 05/05/24, 05/18/24, and 05/19/24 and confirmed there were less than eight hours of coverage on those days. -On 05/04/24, only 4.5 hours were covered by a Registered Nurse. -On 05/05/24, only 4.5 hours were covered by a Registered Nurse. -On 05/18/24, only 4.5 hours were covered by a Registered Nurse. -On 05/19/24, there was no coverage from a Registered Nurse. On 05/22/24 at 1:25 PM, Surveyor interviewed Director of Nursing (DON) B and Nursing Home Administrator (NHA) A regarding the lower hours of RN coverage. They said the procedure for coving RNs is to call down the list of available RNs and if there is no one else to cover DON B or the Infection Preventionist will come in and cover the hours. Surveyor asked about the specific dates that show less than eight hours of coverage. DON B said yes they did come in, but they must not have worked for the full eight hours. NHA A confirmed they had no coverage on the date of 05/19/24 and they did not have eight hours of RN coverage on the dates listed.

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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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observation, record review and interview, the facility did not ensure that residents are free of significant medication errors for 1 of 14 residents (R32) reviewed for medication errors. R32 has a type 1 diabetes mellitus diagnosis. Facility staff administered glucagon three times with no documentation and reasoning for giving glucagon outside of blood glucose parameters. Facility staff did not administer glucagon when R32's blood glucose levels were 30 to 54. Facility staff did not follow physician orders when insulin was held and administered insulin as R32 requested. The facility did not have a physician order to allow R32 direct the amount of insulin administered. Findings include: Surveyor reviewed the policy titled, Management of Hypoglycemia which stated in part, #2. For level 1 hypoglycemia (<70mg/dL but >54 mg/dL: e. Give resident an oral form of rapidly absorbed glucose (15-20grams); f. Notify the provider immediately. g. Remain with the resident; h. Recheck blood glucose in 15 minutes: (4) If blood glucose remains <70 mg/dL repeat oral glucose and notify physician for further orders. #3. For level 2 hypoglycemia (,54 mg/dL): g. Administer glucagon (intranasal, intramuscular, or as provided); h. Notify the provider immediately; i. Remain with the resident; j. Place the resident in a comfortable and safe place (bed or chair); k. Monitor vital signs; and l. Recheck blood glucose in 15 minutes as above. -Documentation #1. Document the resident blood glucose before intervention. (continued on next page)

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 05/23/2024
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F 0760 Level of Harm - Actual harm Residents Affected - Few	#2. Note blood glucose after each administration of rapid-acting glucose and the follow-up blood glucose. #3. Record the resident's level of consciousness before and after intervention. #4. Document provider instructions . R32 was admitted to the facility on [DATE] with diagnoses including in part, type 1 diabetes mellitus with diabetic chronic kidney disease and ketoacidosis without coma, metabolic encephalopathy, chronic kidney disease stage 4, vascular dementia unspecified severity with agitation, paroxysmal atrial fibrillation, gastrostomy status, and dysphagia oropharyngeal phase following cerebral infarction. R32's minimum data set (MDS) assessment, completed on 01/29/24, confirmed R32 scored 11/15 during Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. R32 has an activated power of attorney for healthcare decisions. R32 is dependent on staff for nutritional needs and R32 has gastrostomy (G)-tube placement. Review of R32's medical record identified the following physician orders stated in part, .Monitor blood glucose levels before tube feeding and at bedtime. 01/23/24 - 02/7/24: insulin Glargine 25 units 8 am. 01/23/24 - 01/29/24 Insulin Lispro 10 units give QID simultaneously with tube feeding boluses 8 AM, 12 PM, 4 PM, and 8 PM. 01/23/24 - 01/25/24 insulin Lispro sliding scale with meals 8 12 4. 01/23/24 - 01/29/24 insulin Lispro sliding scale 8 pm. 01/29/24- 02/7/24 insulin Lispro 8 units QID give only before tube feeding 8 12 4 8. 01/29/24 - 02/20/24 insulin Lispro sliding scale QID before tube feeding (Three times a day 12p, 4pm, 8pm) . Review of R32's medical record identified the following notes: On 02/04/24 at 4:41 AM, Medication Administration Record (MAR) indicated Glucagon 1mg given to R32 with no documentation of BG results and why Glucagon was administered. On 02/05/24 at 12:46 AM, MAR indicates that Glucagon 1mg was given for a BG of 77. No notes were observed reasoning giving glucagon outside the BG parameters. On 02/05/24 at 6:11 AM, progress note indicates, . BG dropped to 71 and glucagon administered at 4:40 AM. No notes were observed reasoning giving glucagon outside the BG parameters. On 02/06/24 at 4:22 AM, progress notes indicate: .0030 BG 66 OJ with 3 sugar packets given via GT. 0100 BG 60 gave bolus of Jevity. 0300 BG 217 . (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of R32's medical record identified the following physician orders stated in part, on 02/07/24 at 1:00 PM, .Change Lantus to 11 units twice daily due to hypoglycemia. If blood sugar below 100mg.dl prior to tube feeding inject 3 units Humalog, not full dose. Continue Humalog 8 units before tube feedings if blood sugar is above or equal to 100mg/dl . On 02/08/24 at 1:35 PM, progress notes indicate, .Resident was 102 per order and was ordered to give 8 units of Lispro but residents did not want 8 units of Lispro. Order is less than 100 give 3 units of Lispro, 100 or greater give 8 units of Lispro but the resident only wanted 3 units . Staff did not follow physician orders to administer 8 units. MAR documented staff gave insulin and did not document the number of units administered. On 02/10/24 at 10:54 PM, MAR indicated that an 8:00 PM dose of Glargine was held. BG 64. Staff did not follow physician orders to administer 11 units. On 02/12/24 at 9:07 PM, MAR indicated R32 refused Lispro. BG 89. On 02/12/24 at 9:18 PM, progress note indicated BG result 49. Insulin held. Staff did not follow the diabetic protocol for hypoglycemic episode and administer Glucagon for BG under 54. On 02/13/24 at 12:19 PM, MAR indicated BG flowsheet indicated BG 53. Staff did not follow the diabetic protocol for hypoglycemic episode and administer Glucagon for BG under 54. On 02/13/24 at 12:19 PM, MAR indicated BG flowsheet indicated rechecked BG with the result of 44. Staff did not follow the diabetic protocol for hypoglycemic episode and administer Glucagon for BG under 54. On 2/17/24 at 11:10 AM, BG flowsheet indicated BG 51. Staff did not follow the diabetic protocol for hypoglycemic episode and administer Glucagon for BG under 54. On 02/21/24 at 8:37 PM, MAR indicated resident refused Glargine insulin and Lispro. Surveyor did not observe any progress notes indicating any other interventions for R32's refusal of insulin. On 02/24/24 at 8:55 PM, progress note indicated BG 62 and insulin Lispro was given 3 units. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Insulin was still administered with low BG. Staff did not follow the diabetic protocol for hypoglycemic episode. On 02/29/24 at 5:57 AM, progress notes indicated BG 54, bolus of Jevity was given. Staff did not follow the diabetic protocol for hypoglycemic episode and administer Glucagon for BG under 54. On 03/01/24 at 8:00 PM, MAR indicated that nurse gave insulin Lispro and Glargine. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Insulin was still administered with low BG. At 8:51 PM, BG flowsheet indicated BG 61. On 03/02/24 at 1:28 AM, progress notes indicated BG 61 bolus of Jevity given. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Insulin was still administered with low BG. Staff did not follow the diabetic protocol for hypoglycemic episode. On 03/03/24 at 2:16 AM, progress note indicated that on 03/02/24 at HS BG 30 and bolus Jevity given. Staff did not follow the diabetic protocol for hypoglycemic episode and did not administer Glucagon for BG under 54. On 03/08/24 at 5:00 AM, progress notes indicated BG 50. Staff did not follow the diabetic protocol for hypoglycemic episode and did not administer Glucagon for BG under 54. On 03/08/24 at 8:00 AM, MAR indicated all insulins Glargine and Lispro were given as order. At 8:39 AM, BG flowsheet indicates BG 66. On 03/10/24 at 10:29 AM, progress note indicated resident had BG 66, resident did not want interventions just wanted feeding to start. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. On 03/14/24 at 12:38 PM, progress notes indicated BG 57 bolus given. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Insulin was still administered with low BG. Staff did not follow the diabetic protocol for hypoglycemic episode. On 03/16/24 at 11:20 AM, BG flowsheet indicated BG 62. On 03/16/24 at 1:22 PM, Progress notes indicated resident symptomatic with low blood sugars, clammy, skin cool. Gave bolus. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Staff did not follow the diabetic protocol for hypoglycemic episode. On 03/24/24 at 4:11 AM, progress notes indicated resident complaint of blood sugar low. BG was 66 and bolus Jevity started. On 03/24/24 at 4:50 PM, BG flowsheet indicated BG 63. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Insulin was still administered with low BG. Staff did not follow the diabetic protocol for hypoglycemic episode. On 3/25/24 at 4:37 PM, BG flowsheet indicated BG 60. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Insulin was still administered with low BG. Staff did not follow the diabetic protocol for hypoglycemic episode. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 3/29/24 at 3:43 PM, BG flowsheet indicated BG 57. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Insulin was still administered with low BG. Staff did not follow the diabetic protocol for hypoglycemic episode. On 4/8/24 at 5:12 PM, BG flowsheet indicated BG 62. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Insulin was still administered with low BG. Staff did not follow the diabetic protocol for hypoglycemic episode. On 4/9/24 at 3:38 PM, Blood Sugar flowsheet indicates BG 67. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Insulin was still administered with low BG. Staff did not follow the diabetic protocol for hypoglycemic episode. On 4/19/24 at 5:02 AM, BG flowsheet indicated BG 54. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Insulin was still administered with low BG. Staff did not follow the diabetic protocol for hypoglycemic episode. On 04/19/24 at 5:03 AM, progress note indicated the resident called the light on for a warning of low blood sugar. BG was 54. On 4/21/24 at 3:54 PM, BG flowsheet indicated BG 52. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Insulin was still administered with low BG. Staff did not follow the diabetic protocol for hypoglycemic episode. Surveyor reviewed physician orders on 04/22/24 stated in part, .Decrease Lantus insulin Glargine to 7 units BID 8 am and 8 pm. Increase Humalog with 8am tube feed to 11 units, other tube feeds remain at 8 units. If blood sugar <100 and tube feed is planned, give 5 units. Give insulin within 10 minutes of tube feed start . Surveyor reviewed physician orders on 04/23/24 stated in part, .Humalog Lispro give 11 units with 8 am if BG below 100 give 5 units. Insulin Lispro every 6 hours BG below 100 give 5 units, over 100 8 units . On 04/24/24 at 4:11 AM, progress notes indicated BG result 66. Gave bolus Jevity. Surveyor did not observe any progress notes indicating any other interventions to treat the low blood glucose level. Provider was not notified. Re-check of blood glucose was not observed in progress notes. On 04/26/24 at 8:00 PM, BG flowsheet indicated BG 125. The MAR indicates that R32 requested Lispro 6 units. Staff administered Lispro 6 units to R32. Staff did not follow physician orders and the incorrect dose was given. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 04/27/24 at 4:00 PM, BG flowsheet indicated BG 107 and the MAR indicated R32 requested Lispro 6 units, staff administered Lispro 6 units. Staff did not follow physician orders and the incorrect dose was given. On 04/27/24 at 7:25 PM, BG flowsheet indicated BG 108. On 04/27/24 at 8:00 PM, MAR indicated R32 requested Lispro 3 units, staff administered Lispro 3 units. Staff did not follow physician orders and the incorrect dose was given. On 04/28/24 at 7:12 PM, blood sugar flowsheet BG 194. On 04/28/24 at 8:00 PM, MAR indicated Lispro was given 7 units. Staff did not follow physician orders and the incorrect dose was given. On 04/29/24 at 8:00 PM, MAR indicated resident requested Lispro 3 units, staff administered Lispro 3 units. At 8:44 PM, BG flowsheet indicated BG 76. Staff did not follow physician orders and the incorrect dose was given. On 05/04/24 at 8:44 PM, progress notes indicated R32 requested 3 units of Lispro and 5 units of Glargine for BG of 79. At 8:45 PM, the MAR indicated Lispro 3 units and Glargine 5 units was given. Staff did not follow physician orders and the incorrect dose was given. On 05/08/24 at 8:00 PM, MAR indicated Resident requested 6 units of Lispro. Staff administered 6 units of Lispro. Staff did not follow physician orders and the incorrect dose was given. On 05/08/24 at 9:07 PM, BG flowsheet indicated BG 142. On 05/13/24 at 10:03 PM, progress notes indicated R32 requested 3 units of Lispro and 5 units of Glargine for BG of 104. MAR indicated Lispro 3 units and Glargine 7 units given. Staff did not follow physician orders and the incorrect dose was given. On 05/15/24 at 11:04 PM, progress notes indicated R32 requested 4 units of Lispro and 5 units of Glargine for BG 125. MAR indicated Lispro 4 units and Glargine 5 units. Staff did not follow physician orders and the incorrect dose was given. On 05/18/24 at 11:58 PM, progress notes indicated R32 requested 3 units of Lispro and 5 units of Lantus for BS 100 at HS. MAR indicated Lispro 3 units and Glargine 5 units. Staff did not follow physician orders and the incorrect dose was given. On 05/19/24 at 8:00 PM, MAR indicated R32 requested 3 units of Lispro and was administered. At 8:43 PM, BG flowsheet indicates BG was 89. Staff did not follow physician orders and the incorrect dose was given. On 05/20/24 at 12:00 PM, MAR indicated 5 units of Lispro were given to R32. Staff did not follow physician orders and the incorrect dose was given. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 05/20/24 at 12:17 AM, progress notes indicated BG 89 and R32 requested 3 units of Lispro and 5 units of Glargine that was given by staff. Staff did not follow physician orders and the incorrect dose was given. On 05/21/24 at 10:14 PM, progress notes indicated BG 63, R32 requested 3 units of Lispro and 4 units of Glargine. Staff did not follow physician orders and the incorrect dose was given. Interviews: On 05/20/24 at 10:55 AM, Surveyor interviewed R32 and asked about insulin usage. R32 indicated that R32 is diabetic and sometimes staff give too much insulin at night and then R32 plummets in the night. R32 indicated that usually, the doctor will order insulin but always asks how R32 feels about the decision to change dosage or medication. R32 indicated, I am very aware of my blood sugars and how I feel when they are high or low. On 05/22/24 at 3:45 PM, Surveyor interviewed Director of Nursing (DON) B and asked about expectations for hypoglycemic episodes. DON B indicated that R32 is a brittle diabetic. DON B indicated all nurses are to follow the diabetic protocol and notify the physician of any changes or concerns with BGs. DON B indicated that nurses were educated on diabetic protocol back in September of 2023. DON B indicated that DON B has had verbal discussions with nursing staff regarding R32's BGs but nurses keep doing what nurses want to do. On 05/23/24 at 7:36 AM, Surveyor interviewed DON B and asked about the diabetic protocol and how it is applied to R32 when R32 is NPO. DON B indicated that nurses can still give the glucagon injection. Surveyor indicated to DON B that Surveyor reviewed MAR and MAR indicated that Glucagon was given several times with R32's BG 77, and 71 or over and Glucagon was given. DON B indicated that nurses are not following the diabetic protocol and the nurses should be. On 05/23/24 at 8:16 AM, Surveyor interviewed Licensed Practical Nurse (LPN) Q and asked what LPN Q's process is for checking blood sugars and deciding how much insulin is given to R32. LPN Q indicated that R32 has specific orders for set insulin but sometimes LPN Q steers more to how R32 feels. LPN Q asks R32 how R32 feels about insulin against BG result and if R32 doesn't feel comfortable with dosage then LPN Q gives as R32 requests. LPN Q just documents the result and the insulin given in R32's medical record. Surveyor asked LPN Q how LPN Q follows the diabetic protocol for when R32 is hypoglycemic. LPN Q indicated that R32 has never been hypoglycemic in LPN Q's care, but that LPN Q has had R32's BG be 63ish and LPN Q just observes how R32 feels at that time and bases the insulin usage with what R32 would like. On 05/23/24 at 10:07 AM, Surveyor interviewed RN AA and asked what RN AA's process is for checking blood glucose levels and deciding how much insulin is given to R32. RN AA indicated that after R32's medications were changed by the endocrinologist, RN AA gave insulin as the resident requested because RN AA felt R32 could make R32's own decisions. RN AA indicated that resident requests all the time to take less of Lispro or more depending on BG. RN AA indicates that RN AA administers insulin as resident feels that day. RN AA stated that R32 is a brittle diabetic and knows his BGs and how insulin affects R32. Surveyor asked if RN AA notifies the physician about low BGs or of the changes that resident is requesting. (continued on next page)

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 05/23/2024
NAME OF PROVIDER OR SUPPLIER Dove Healthcare - Spooner		STREET ADDRESS, CITY, STATE, ZIP CODE 510 First St Spooner, WI 54801	

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 05/23/24 at 10:12 AM, Surveyor interviewed Endocrinologist BB and asked what expectations are for hypoglycemic or hyperglycemic episodes. Endocrinologist BB indicated that facility staff should be following the diabetic protocol within the facility. Surveyor asked Endocrinologist BB if Endocrinologist BB is ok with R32 making R32's own decisions about insulin usage and requesting other units to be given. Endocrinologist BB stated, Absolutely not as R32 is a brittle diabetic. Surveyor asked what the likelihood of outcome is to R32's organs or body with low blood glucose levels. Endocrinologist BB indicated that R32 has multiple health complications and that extreme fluctuations in blood glucose levels can cause worsening of complications and even death from low blood glucose levels.

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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. 46694 Based on observation, staff interview and record review, the facility did not prepare, distribute, and serve food in accordance with professional standards for food service safety. This had the potential to affect 48 of 50 residents within the facility that took nourishment from the kitchen. Opened milk in the refrigerator not labeled with open date. Staff touching ready to eat foods with contaminated gloves during food service. Staff did not perform hand hygiene between glove changes during food service. Findings: Milk not labeled: Facility policy titled, Infection Control, Sanitation, Safety the most current revision, states in part: .E. Storage Refrigerators/Freezers .7. Food must be covered and dated when stored . 10. Commercial products must be labeled as to date of initial opening and will be discarded per manufacturer's expiration date. On 05/20/24 at 9:06 AM, during initial tour of the kitchen, Surveyor noted that a gallon of milk did not have a date opened written on the container. Surveyor interviewed Dietary Manager (DM) L and asked, What date was this opened? DM L took the opened gallon of milk and replied, Thank you. Surveyor found a second gallon of milk in the refrigerator opened without a date and asked DM L, What date was this opened? DM L took the second gallon of milk from Surveyor and replied, Thank you again. Hand Hygiene/Touching ready to eat foods: The Wisconsin Food Code states in part: .3-304.15 Gloves, Use Limitation. (A) If used, single-use gloves shall be used for only one task such as working with ready to eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. The facility policy titled, Handwashing/Hand Hygiene revised August 2019, states in part: .7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap and water for the following situations: .m. After removing gloves .Applying and Removing Gloves 1. Perform hand hygiene before applying non-sterile gloves .4. Hold the removed glove in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove. 5. Perform hand hygiene. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/21/24 at 11:31 AM, Surveyor observed [NAME] M serving the hot food service. [NAME] M had single use gloves on and touching multiple surfaces including ladles, covers for hot food, toaster, plates, spoons to plate food and bowls. [NAME] M removed gloves and put on new gloves; no hand hygiene was performed. [NAME] M had taken bread out of the bread bag after opening the twist tie that was securing the closed bag. The bread was picked up by [NAME] M with contaminated gloves and placed into the toaster. The toast was removed from toaster with same gloved hands and buttered the toast, plated the toast, and gave the staff to serve to the resident. [NAME] M removed gloves, no hand hygiene performed, and put on new gloves. [NAME] M returned to plating hot food and serving the plates to staff to serve the residents. Cook M took burned toast out of the toaster and placed onto a four wheeled serving cart. [NAME] M took bread from the bread bag with the same gloves that were used while serving. [NAME] M took the bread, made a meatball sandwich with the same contaminated gloves, and cut the meatball sandwich into four pieces. [NAME] M plated the sandwich and served to resident. Cook M then popped up the toaster, grabbed the toast with same gloved hands, buttered it, cut in half and served to the resident. Surveyor observed [NAME] M change gloves two additional times without any hand hygiene before finishing serving hot food items to residents. On 05/21/24 at 12:20 PM, Surveyor interviewed [NAME] M and asked, What is the process when wearing gloves and touching multiple potentially contaminated surfaces in the hot service area and touching ready to eat food like bread? [NAME] M replied, When I took the twist tie off to get the bread out I should have changed my gloves. Surveyor asked [NAME] M, When should hand hygiene be performed in regard to changing gloves? [NAME] M replied, As long as I am just working in this area I can just change the gloves and I don't have to wash my hands. On 05/21/24 at 12:35 PM, Surveyor interviewed DM L regarding observations made during hot food service. Surveyor asked DM, What should [Cook M] have done if working with contaminated gloves? DM L replied, [Cook M] should have changed gloves after untwisting the tie on the bread bag to get the bread out. Surveyor asked DM L, With glove changes is it ok to change gloves without hand hygiene? DM L replied, If staff are just working the hot service area, it is ok to change gloves without performing any hand hygiene. On 05/22/24 at 9:56 AM, Surveyor interviewed Director of Nursing (DON) B and asked, When in the kitchen serving food what is the expectation for hand hygiene with glove use? DON B replied, When they change gloves they should perform hand hygiene between glove changes. On 05/22/24 at 4:03 PM, Surveyor informed DON B an observation was made of [NAME] M touching multiple potentially contaminated surfaces then touching ready to eat foods. Surveyor asked DON B what the expectation in this scenario is. DON B replied, You should remove gloves and perform hand hygiene and put on new gloves before touching the toast.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observation, interview and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This had the potential to affect all 49 residents (R). The facility did not have a clear water management process or plan in effect to prevent transmission of Legionella infection. Staff provided high-contact care to residents on Enhanced Barrier Precautions (EBP) without wearing proper Personal Protective Equipment (PPE). (R32 and R17). The facility is not tracking the type of symptoms for all staff and resident infections. The facility is not providing alternative testing to rule out influenza or RSV cases when residents and staff become sick. Findings include: Facility policy and procedure entitled: Enhanced Barrier Precautions, dated 04/01/24, stated in part, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents .Gloves and gowns are applied prior to performing the high contact resident care activity .Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. transferring; d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and h. wound care (any skin opening requiring a dressing) . Example 1 On 05/21/24 at 8:57 AM, Surveyor interviewed Infection Preventionist (IP) X and asked about the facility's water management plan and policy for Legionella. IP X indicated that IP X keeps track of [NAME] water filter audits daily and has logs. IP X handed Surveyor a binder that had logs from April 2023- April 2024 that indicated [NAME] water filters maintenance was conducted every day and tracked on monthly sheets. IP X indicated that IP X would need to go get the water management plan/policy from Maintenance Director W. On 05/21/24 at 10:08 AM, Nursing Home Administrator (NHA) A gave Surveyor a water management policy. Surveyor reviewed policy and did not find detailed report on the flow system diagram for water management, audits, logs, or ways to decrease the transmission of Legionella. (continued on next page)

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 05/23/2024
NAME OF PROVIDER OR SUPPLIER Dove Healthcare - Spooner		STREET ADDRESS, CITY, STATE, ZIP CODE 510 First St Spooner, WI 54801	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/21/24 at 3:02 PM, Surveyor interviewed NHA A and Maintenance Director W and asked about hot spots, stagnation, and dead leg areas on the diagram. NHA A indicated the facility has not implemented hot spots, stagnation, and dead-leg areas on the detailed policy/plan or the flow system diagram. NHA A asked Maintenance Director W if audits and dead legs were being conducted in the facility's Intel software or anywhere else. Maintenance Director W indicated that Maintenance Director W is not documenting audits in Intel or paper for audits of dead legs, flushing and that auditing documentation needs to be done. Surveyor observed no documentation or plan to prevent the transmission of Legionella through the facility policy and flow system diagram. Example 2 On 05/21/24 at 7:50 AM, Surveyor observed Certified Nursing Assistant (CNA) D and CNA E enter R17's room to assist R17 get washed up and dressed and transferred to a wheelchair. Surveyor observed a sign outside R17's room that stated Enhanced Barrier Precautions with a PPE cart under the sign. CNA D and CNA E did not put on gowns or gloves to provide cares for R17. At 8:00 AM, Surveyor observed CNA E bring R17 to the dining room for breakfast. Surveyor observed CNA D making R17's bed. Surveyor asked CNA D which resident in this room was on EBPs. CNA D was not sure and went to the nurse's station to ask. CNA D came back and informed Surveyor R17 was on EBP for a gastrostomy tube. CNA D stated they should have put on a gown and gloves to care for R17 but forgot. On 05/21/24 at 8:24 AM, Surveyor interviewed Director of Nursing (DON) B and explained observation of CNAs D and E providing morning cares and a lift transfer for R17 without gown or gloves on. Surveyor informed DON B that CNA D was not sure which resident in R17's room required EBP when Surveyor asked. DON B stated they should have known that and should have put on a gown and gloves to provide personal cares for R17. Example 3 On 05/20/24 at 9:24 AM, Surveyor observed PPE located outside R32's room. Surveyor interviewed CNA Z and asked what precautions R32 was on. CNA Z indicated that R32 is on EBP for tube feeding and wound dressing change to foot. On 05/20/24 at 11:32 AM, Surveyor observed LPN Y enter R32's room without PPE on in EBP room. LPN Y sanitized hands, applied gloves, and checked R32's Blood Glucose. Surveyor observed LPN Y connect R32's priming tube to start the tube feeding infusion. Surveyor did not observe LPN Y wear proper PPE for R32's tube feeding. On 05/20/24 at 12:45 PM, Surveyor interviewed LPN Y and asked about the process for utilizing PPE with R32's EBP room. LPN Y indicated during tube feeding and dressing change LPN Y always wears full PPE. LPN Y indicated LPN Y realized that she did not wear PPE. LPN Y indicated it is not ok to not wear PPE in an EBP room unless LPN Y is providing minimal care that doesn't require touching R32. Example 4 (continued on next page)

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 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - Spooner	510 First St Spooner, WI 54801

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/21/24 at 11:01 AM, Surveyor received infection surveillance from the COVID-19 outbreak starting 08/28/23 to 12/26/23. Surveyor did not observe the type and time of symptoms that started for all positive staff and residents starting 08/28/23 to 12/26/23. Surveyor received infection surveillance from the COVID-19 outbreak starting 01/01/24 to 05/02/24. Surveyor did not observe the type and time of symptoms that started for all positive staff and residents between 01/01/24 to 05/02/24. Surveyor did not observe alternative testing when COVID-19 testing was negative to rule out influenza or RSV for staff and residents. On 05/21/24 at 11:35 AM, Surveyor interviewed IP X and asked about how IP X tracks the onset of symptoms and how IP X tracks when staff members are fever free, or when symptoms are decreasing so staff know when to be allowed back to work. IP X indicated that IP X is not tracking on surveillance logs the exact type of onset of symptoms or decrease in symptoms for when staff can return to work. IP X indicated that all staff call into charge nurse if IP X is not in building and IP X follows up with sick staff member once IP X is back in the building. IP X indicated that unfortunately since IP X is only at the facility 3 times a week there was a recent staff member, CNA T, who came to work the next day after vomiting. The charge nurse had not given good instructions for staff members to stay home. IP X indicated that once IP X got to the facility IP X tried touching base with CNA T who was already at the facility after vomiting the day before. CNA T did not communicate what occurred and how CNA T was feeling before returning to work. IP X indicated during the COVID-19 outbreak the charge nurse on duty would call IP X on off-hours. IP X also indicated that IP X is not testing for influenza or RSV when staff are sick with possible symptoms because IP X didn't feel like IP X needed to. Surveyor asked IP X how staff know when residents can come off precautions/quarantine since IP X is not tracking the onset of symptom type. IP X indicated the nurses just know this. Surveyor asked IP X how the staff knew this. IP X indicated that since IP X is only at the facility 3 times a week, IP X had set up a document labeled Appendix A from the CDC that describes all infections and quarantine status, and the staff follow the guidelines located near the isolation carts when they need it. On 05/21/24 at 12:41 PM, Surveyor interviewed CNA T and asked about CNA T's process for when CNA T becomes sick and has a shift to work. CNA T indicated that usually CNA T will call the charge nurse at work and let them know that CNA T is sick. CNA T indicated then after when CNA T feels better, then CNA T can come back to work. Surveyor asked CNA T about the recent day CNA T called off from work due to vomiting. CNA T indicated that she felt better the next day and hadn't vomited but only a couple of times the day before. CNA T indicated that CNA T had talked with IP X before returning to work, and IP X texted CNA T and she could come back to work. Surveyor did not observe any documentation that IP X had talked with CNA T about returning to work nor any education on symptoms and not coming to work infectious. 40181