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	07/23/2025

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 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. Based on observation, interview and record review, the facility did not ensure proper sanitation practices to prevent the outbreak of foodborne illness which had the potential to affect all 45 residents.-The facility did not ensure dishes were dried appropriately.-The facility did not ensure proper cleaning of portable steam tables before replacing clean covers.Findings include:The facility policy entitled, Dishwashing, (no date) reads in part: All items are air dried in racks before storing.The facility policy regarding steam tables (no date, no title), reads in part: Wash top of steam table with warm soapy water and cloth. Spray sanitizing solution.empty water.wash all covers after each meal. On 07/22/25 at 9:20 AM, Surveyor entered the kitchen to observe dish washing. Surveyor observed plastic containers stacked together in the clean area near the 3-compartment sink. Visible moisture inside of the outside container. On 07/22/25 at 9:23 AM, Surveyor observed [NAME] Q stack slotted plastic dinner plates together immediately upon them coming out of the dish machine. Several plates were still visibly wet. Surveyor observed [NAME] Q place a clean cover for a portable steam table onto the steam table which still contained the water from prior to breakfast and had not been cleaned. Surveyor observed no pan in steam table when clean cover was replaced.On 07/22/25 at 9:27 AM, Surveyor interviewed [NAME] P. [NAME] P stated the portable steam tables get cleaned once a day at the end of the day, and once per week with Lime. [NAME] P stated the same water remains in them throughout the whole day. On 07/23/25 at 11:34 AM, Surveyor entered kitchen for follow up. Surveyor observed plastic containers now on the clean dishes shelf, still stacked, moisture present. On 07/23/25 at 11:42 AM, Surveyor interviewed Dietary Manager (DM) N. DM N stated all dishes should air dry completely prior to them being put away. DM N stated steam tables should at least be wiped down if visibly dirty and there should be a pan inside if the lid is on. On 07/23/25 at 12:05 PM, Surveyor interviewed Director of Nursing (DON) B. DON B stated she agreed that dishes should be completely dry and the clean lids on the dirty steam tables could have the potential for bacteria concerns.

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 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** Based on interview and record review, the facility failed to ensure it maintained an infection prevention and control program designed to help prevent the development and transmission of communicable disease and infections such as COVID-19. This had the potential to affect all 45 residents. -The facility did not test staff or residents with symptoms of COVID-19. -Staff did not use a barrier under the graduate when emptying the catheter for R3.-The facility did not ensure proper infection control measures were conducted when providing a shower and during catheter care for R3 who is on Enhanced Barrier Precautions (EBP). Example 1 The facility policy titled, “COVID-19 Prevention, Response, and Reporting,” last reviewed 01/2025, read in part, ”It is the policy of this facility to ensure that appropriate interventions are implemented to prevent the spread of COVID-19 and promptly respond to any suspected or confirmed COVID-19 infections. 2. Staff will be alert to signs of COVID-19 and notify the resident’s physician/practitioner if evident: a. Fever or chills b. cough c. Shortness of breath d. Fatigue e. Muscle or body aches f. Headache g. New loss of taste or smell h. Sore throat i. Congestion or runny nose j. Nausea or vomiting k. Diarrhea 28. The Infection Preventionist, or designee, will monitor and track COVID-19 related information to include, but not limited to: a. The number of residents and staff who exhibit signs and symptoms of COVID-19. b. The number of residents and staff who have suspected or confirmed COVID-19 and date of confirmation.” (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy titled, COVID-19 Response Plan, last reviewed 02/2025, read in part .”4. Residents and staff with a suspected or probable case of COVID-19 will receive viral testing in accordance with current CDC guidance.” On 07/22/25, Surveyor reviewed the facility’s line list from 06/2024-07/2025. Surveyor noted the last facility outbreak of COVID-19 was in 02/2025. Surveyor noted since 04/2025, there were no suspected or confirmed cases of COVID-19 on the line list. On 07/22/25 at 12:02 PM, Surveyor interviewed Infection Preventionist (IP) D via phone, as IP D was not present in the facility during the survey. Surveyor asked IP D how she was monitoring and tracking COVID-19 infections. IP D stated she was not testing residents and staff for COVID-19 infections as the community transmission level was low. IP D stated at the end of summer she would begin testing for COVID-19. Surveyor asked how long IP D has not been monitoring or tracking suspected or confirmed cases of COVID-19, [NAME] President (VP) of Clinical Operations E stated, “Sometime in April.” VP of Clinical Operations E agreed this was not the practice of the facility. On 07/22/25 at 3:00 PM, Surveyor held Resident Council meeting. Surveyor asked residents about respiratory symptoms and how the facility manages illnesses in the facility. R36 stated respiratory symptoms come but facility does not test or swab resident to see what he has. R36 was just told to stay in room for 48 hours then he could come out. Surveyor reviewed 04/2025-07/2025-resident line list and noted: -03/28/25, R56 had S&S of nausea and vomiting, with no indication of testing. -04/20/25, R16 had a fever with signs and symptoms (S&S) of the common cold, with no indication of testing. -05/27/25, R50 had diarrhea, with no indication of testing. Surveyor reviewed 04/2025-07/2025-staff line list and noted: -04/18/25, staff with fever and diarrhea, no indication of testing. -No date, staff with symptoms of sore throat with no indication of testing. -05/02/25, staff with cough and fever with no testing. -05/09/25, staff with symptoms of nausea and vomiting with no indication of testing. -06/07/25, staff with cough and nausea with no testing. -06/09/25, staff with vomiting, no indication of testing. -06/13/25, staff with fever and diarrhea, no testing. -06/16/25, staff with gastrointestinal complaints, no testing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-06/20/25, staff with nausea and vomiting, no testing. On 07/23/25 at approximately 7:30 AM, DON B shared an email from IP D. The email stated the following: “I spent a good bit of time last night trying to find guidance from the CDC that indicates that testing should be dependent on levels of transmission in the local or regional area. All the guidance I could find was last updated a year ago. If we followed that guidance, we would have people out of work for three days so that we could test them and then test them 48 hours later with any kind of symptoms. It just is impractical and doesn’t correlate with the levels of Covid transmission. I am monitoring the state’s respiratory reports of transmission levels on a weekly basis and will begin Covid testing again when transmission levels begin to rise. For weeks and maybe even months they have been minimal for Covid influenza and RSV throughout the state and have been stable. When [resident] was coughing I know they did test her for Covid. But we really haven’t had anybody else that we needed to test for Covid in terms of residents. There were a handful of staff members that tested for Covid in the past few months. Anyone who did test for Covid is noted either on the absence report or in PCC. I don’t think that we should get cited for not testing for Covid.” On 07/22/25 at 4:18 PM, Surveyor interviewed VP of Clinical Operations E and Director of Nursing (DON) B. VP of Clinical Operations E and DON B confirmed resident and staff testing had not been completed since sometime in 04/2025. VP Of Clinical Operations E and DON B were not sure where IP D found a resource indicating residents and staff with suspected or confirmed cases of COVID-19 did not require testing. VP of Clinical Operations and DON B acknowledged this was not a standard of practice and stated IP D would receive education. Example 2 The facility policy, titled “Emptying of Catheter,” last revised on 08/01/24, states: “It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use.” Under Section 4: Procedure Steps: states in part: . Place a barrier (e.g., paper towel or disposable pad) on the floor under the drainage bag. Place the graduate cylinder on the barrier and open drain to allow the urine to flow into the graduated cylinder. Place a clean barrier on a level, flat surface. Place the graduated cylinder on the barrier and with the graduated cylinder at eye level, read the amount of output. R3 was admitted on [DATE] and has diagnosis of Renal Insufficiency, Neurogenic bladder, History of Multi-Drug Resident Organism (MDRO) of Extended Spectrum Beta Lactamase (ESBL) resistance. R3’s current care plan states R3 has an indwelling catheter related to urinary retention that lists interventions of “FYI Cath Care” and “monitor and document intake and output as per facility policy.” On 07/22/2025 at 1:59 PM, Surveyor observed Certified Nursing Assistant (CNA) C conduct catheter care for emptying and measuring urine output from urinary drainage bag for R3. CNA C, after donning PPE and conducting hand hygiene, placed a graduated cylinder on floor without barrier and open drain to allow the urine to flow into the graduated cylinder. CNA C picked up graduated cylinder and brought (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to bathroom, and without placing a barrier down, placed the graduated cylinder on bathroom sink counter and read the amount output. On 07/22/2025 at 2:16 PM, Surveyor interviewed CNA C regarding the facility's expectation/policy on infection control and using a barrier between floor and graduated cylinder, CNA C stated was not aware of the facility policy or recent education on catheter care and need of using a barrier. On 07/23/2025 at 9:45 AM, Surveyor interviewed DON B regarding observation of CNA C emptying R3’s urinary bag without a barrier placed between flat service and graduated cylinder. DON B stated the expectation would be to place a barrier under the graduated cylinder, stating usually a paper towel is used. Example 3 On 07/21/25 at 11:58 AM, Surveyor observed EBP signage on door and Personal Protective Equipment (PPE) bin outside hallway of R3's room. On 07/22/25 at 7:52 AM, Surveyor observed CNA C, after preparing R3 for a shower, removed PPE of gown and gloves before exiting resident room and bringing R3 to shower room. During shower process, CNA C was observed not placing on PPE or wearing PPE during showering of R3. On 07/22/25 at 8:05 AM, upon taking R3 back to resident room, CNA C asked Surveyor, “I didn’t wear a gown in shower, was I supposed to?” Surveyor responded with asking what the facility policy was related to wearing PPE during resident shower who is on EBP. CNA C stated not aware of policy. On 07/22/25 at 8:25 AM, Surveyor interviewed CNA F, who entered R3’s room to assist with a transfer, regarding expectation of PPE during a shower. CNA F stated the expectation is PPE should be worn during a shower for R3. On 07/23/2025 at 9:45 AM, Surveyor interviewed DON B regarding expectation of wearing PPE on a resident who is under EBP during a shower. DON B stated expectation would be do wear PPE during a shower.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not notify the physician on call of R40's new break in skin on right great toe for 1 of 12 residents (R) reviewed for activities of daily living (ADL) (R40).Findings include:R40 was admitted to the facility on [DATE] with diagnoses including in part, acute respiratory failure with hypoxia, type 2 diabetes mellitus, obstructive sleep apnea, venous insufficiency, morbidly obese, bilateral osteoarthritis of hip, and prostatic hyperplasia. R40's care plan was initiated on 04/15/25 and included the following: DIABETIC:-Nursing to complete nail care on Tuesday evening. Surveyor reviewed R40's skin prevalence reports that did not note any skin issues. Surveyor reviewed diabetic foot checks weekly documentation:-On 07/07/25, R40's skin was intact.-On 07/14/25, R40's skin was intact.-On 07/15/25, R40's skin was intact.-On 07/21/25, R40's foot check was completed with right and left foot dry, not cracked, with slight edema which is not new to R40.-On 07/22/25, R40 had scant bleeding noted to right great toe, inflammation along line of toenail. Unable to determine exact open area for measurement due to placement of toenail/inflammation. No purulent drainage noted. Immediate action taken was cleansed right great toe with normal saline, applied band aid, gauze tube per R40's request. Added resident to weekly wound rounds, made appointment for R40 to be seen by provider due to resident being diabetic.Surveyor reviewed R40's progress notes and did not find any documentation that a staff member notified provider of new skin changes or assessed the new skin changes on R40's right great toe.Observations and interviewsOn 07/21/2025 at 10:36 AM, Surveyor interviewed R40. Surveyor asked if R40 had any sores or open areas on body. R40 reported to Surveyor that at this time R40 does not have any skin issues except R40's great right toe has a sore from podiatrist cutting toe nail off. Surveyor observed band aid and kerlix wrapped on great right toe.On 07/22/25 at 6:50 AM, Director of Nursing (DON) B asked if any Surveyor wants to observe wound dressing changes on any residents. Surveyor reported to DON B that Surveyor wanted to see what was going on with R40's band aid on great right toe. DON B reported to Surveyor that DON B would ask the Registered Nurse (RN) to bring Surveyor in once RN goes into R40's room.On 07/22/2025 at 7:23 AM, Surveyor observed Registered Nurse (RN) M walk out of R40's room. RN M reported to Surveyor that RN M was not aware of R40's right great toe and that the toe injury is new. Surveyor observed wound care supplies laid all over R40's bed when Surveyor entered. Surveyor asked RN M if RN M knew about the injury prior to today, 07/22/25. RN M reported that RN M did not know about it and that it is newly developed. RN M reported usually CNAs will let wound care nurse (RN M) know about it right away and no one has let RN M know yet. Surveyor asked RN M at what point did someone place a band aid on R40's right great toe. RN M stated, I am unsure. Surveyor asked RN M if there was any documentation in the chart to show the condition of R40's right great toe. RN M stated that RN M would look into it after dressing R40's wound. RN M stated to Surveyor that RN M would notify the on-call doctor to peek on R40 during virtual rounds. Surveyor asked RN M if RN M knew who placed the band aid on R40 and did not report it to RN M or provider. RN M reported to Surveyor that RN M is unsure but will call the shifts prior to day shift today. On 07/22/2025 at 7:45 AM, RN M reported to Surveyor that last skin checks documented for R40 were skin was intact. Surveyor asked where notes were that someone placed a band aid on R40. RN M reported that RN M would keep looking through the Electronic Health Record (EHR).On 07/22/2025 at 1:30 PM, Surveyor interviewed RN M and asked if RN M spoke with the staff who placed band aid on and why it was not reported to provider or another staff member. RN M reported to Surveyor that RN M has not heard back from staff yet. RN M reported to Surveyor that RN M contacted physician on call and will be completing a virtual visit to assess R40's diabetic toe. RN M reported that RN M will assess the skin issue, complete a Braden skin assessment, and update care plan as needed. On 07/23/25 at 8:01 AM, Surveyor (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interviewed RN M and asked if RN M spoke with the staff who placed band aid. RN M reported that no one has called back yet.On 07/23/2025 at 12:32 PM, Surveyor interviewed DON B and asked DON B's expectation of assessing R40's diabetic toe and then reporting it to physician. DON B reported to Surveyor that DON B's expectation is that whoever finds a new skin issue on any resident then it is reported immediately to next shift, physician on call, and DON B. Surveyor asked DON B's expectation for assessing and documenting new skin issues on R40. DON B reported to Surveyor that DON B expects staff to assess a new skin issue thoroughly, measure, cleanse, document, and notify on call provider. Surveyor asked DON B if DON B knew who placed the band aid on and who didn't report this upon finding the new skin issue on R40. DON B reported to Surveyor that RN M was reaching out to all previous shifts and had to leave messages. DON B reported so far there are no call backs.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on staff interview and record review, the facility did not provide Advanced Beneficiary Notice (ABN) of non-coverage and/or Notice of Medicare of Non-Coverage (NOMNC) appropriately for residents (R) whose Medicare Part A coverage was discontinued with benefit days remaining for 2 of 3 residents (R) reviewed. (R55, R46) R55 had a skilled Medicare A Service Episode with a start date of 03/19/25 and last covered date of 04/19/25. The facility/provider initiated the discharge from Medicare A Services when benefit days were not exhausted. The facility checked the box on the SNF Beneficiary Protection Notification Review form that asked the question Was a Skilled Nursing Facility (SNF) Advanced Beneficiary Notice (ABN), Form CMS-10055 provided to the resident? The facility checked the box No with an explanation handwritten, Was given, however cannot find it in paper form or Electronic Medical Record (EMR). On the box on the SNF Beneficiary Protection Notification Review form that asked the question Was a Notice of Medicare of Non-Coverage (NOMNC) provided to the resident?, the box labeled No was checked with an explanation handwritten, Was given, however cannot find it in paper form or EMR. R46 had a skilled Medicare A Service Episode with a start date of 02/01/25 and last covered date of 03/19/25. The facility/provider initiated the discharge from Medicare A Services when benefit days were not exhausted. The facility checked the box on the SNF Beneficiary Protection Notification Review form that asked the question Was a Skilled Nursing Facility (SNF) Advanced Beneficiary Notice (ABN), Form CMS-10055 provided to the resident? The facility checked the box YES. On the box on the SNF Beneficiary Protection Notification Review form that asked the question Was a Notice of Medicare of Non-Coverage (NOMNC) provided to the resident? The box labeled YES. R46 received and dated the NOMNC on 03/18/25, which was only 1 day notice instead of the required 2-day notice. On 7/23/25 at 9:15 AM, Surveyor interviewed Social Worker (SW) G, regarding process of issuing and obtaining a NOMNC and ABN, SW G indicated that once a document is signed it is scanned into the system and SW G confirmed inability to locate the documents for R55. SW G stated the expectation of presenting a NOMNC to a resident for signature is a minimum of 2 days prior to last covered day. SW G was made aware of R46 signing the NOMNC the day prior to last covered day. SW G accessed computer system and confirmed document was signed 1 day prior and not 2 days prior to last covered day. On 07/23/2025 at 9:45 AM, Surveyor shared inability to find R55's NOMNC and ABN. Surveyor interviewed DON B and confirmed the facility was unable to locate the documents. Surveyor also shared observation of R46's NOMNC was not signed until 1 day prior to last covered day.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 of 5 residents reviewed (R2) was free from unnecessary medications.-Facility did not ensure adequate indication for use of psychotropic medications.Findings include:R2 was admitted to the facility on [DATE] with diagnoses of dizziness and giddiness, and dementia (moderate) without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.Most recent Minimum Data Set (MDS) shows a Brief Interview for Mental Status (BIMS) score of 13/15 indicating R2 is cognitively intact.Facility policy titled, Psychotropic Medication Evaluation and Utilization, last reviewed 12/2024, reads in part: Psychotropic medications and other medications with black box warnings are specifically identified as requiring additional monitoring.these medications require more in-depth review.due to the potential for limited effect and higher potential for significant side effects.all of these medications require individualized monitoring which may include.targeted behavior monitoring.Care Plan in part (prior to start of psychotropic medications):Focus: R2 is at risk for falls r/t syncopal episodes, medication use, and history of falling. (Last revised on 02/05/25) Interventions include 1:1 supervision provided related to fall and encourage R2 to use call light system for assistance (last reviewed on 02/05/2025)Record review indicated no targeted behavior monitoring in place prior to starting Lorazepam and Escitalopram. No previous diagnosis of anxiety or depression prior to beginning these medications.General behavior monitoring 30 days prior to start of medications indicated 4 episodes of anxiousness.Physician orders indicated R2 was on an antibiotic for a urinary tract infection (Nitrofurantoin Macro crystal) from 05/09/25-05/23/25.Progress note, from 05/21/25, indicates staff spoke with R2's daughter. R2's daughter requested a mood stabilizer. R2's daughter was not activated power of attorney (POA) at this time. Progress note, from 05/21/25, indicates R2 was sent to the emergency room for evaluation related to loss of consciousness/syncope. Progress note, from 05/22/25, indicated facility staff left message with clinic manager at hospital for R2's physician to address possible medication for mood stabilization. Progress note, from 05/22/25, indicated facility staff received a call from R2's physician for new orders for Escitalopram, Lorazepam, and a new diagnosis of depression with anxiety.Power of Attorney signed and activated on 05/22/25.Care plan initiated after new diagnosis/start of psychotropic medications on 05/22/25:SIDE EFFECT MONITORING: ANTIANXIETY-Monitor for side effects: Dizziness, Nausea, Drowsiness, Blurred Vision, Confusion, Weight Gain, Psychomotor Agitation, Panic AttacksSIDE EFFECT MONITORING: ANTIDEPRESSANT-Monitor for side effects: Nausea, Dizziness, Headache, Constipation, Weight gain, Drowsiness, Insomnia, fatigue, diarrhea, irritability, restlessnessSIDE EFFECT: ANTICOAGULANT-Monitor for side effects: Blood in urine/stool, black stool, severe bruising, prolonged nosebleeds, bleeding gums, vomiting/coughing up blood.Focus: I use antidepressant medication r/t mixed anxiety/depressive disorder with interventions including monitoring for change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal, decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea, gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls, dizziness/vertigo, fatigue, insomnia, appetite loss, weight loss, nausea/vomiting, dry mouth, and dry eyesProgress note, from 05/24/25, indicated R2 was feeling dizzy and nauseated and stayed in the nurse's station for 15 minutes to be observed. Progress note, from 05/28/25, indicated R2 reported feeling dizzy but did not have nausea, and declined supper.Progress note, from 06/11/25, indicated a pharmacy recommendation was made to discontinue the as needed Lorazepam. R2's provider discontinued as recommended and gave new orders for Lorazepam daily scheduled at night.Progress note, from 06/17/25, indicated R2 was experiencing hallucinations and confusion.Progress note, from 06/17/25, indicated staff spoke with R2's power of attorney regarding dose of Lorazepam. R2's POA agreed the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	current dose was working.Record review indicated 1 episode of confusion and repetition of questions on 06/18/25 with neutral facial expressions and limited eye contact.Progress note, from 06/18/25, indicated staff contacted R2's physician in relation to increased anxiety and behaviors. R2's physician gave verbal orders to increase Lorazepam to twice daily.Progress note, from 06/22/25, indicated R2 experienced confusion.R2 was sent to emergency room on [DATE], after an unwitnessed fall and complaints of right hip and elbow pain. R2 returned to facility with order for antibiotic for a urinary tract infection. Intervention added to care plan: Offer to assist R2 to lay down after lunch. (06/22/2025)Progress note, from 07/06/25, indicated R2 had an unwitnessed fall. Intervention added to care plan: Anti-roll back bars on wheelchair (07/06/2025)Progress note, from 07/12/25, indicated R2 experienced hallucinations and restlessness.Progress note, from 07/15/25, indicated R2 experienced confusion, was roaming around R2's room, and undressing.R2 sent to emergency room on [DATE], after an unwitnessed fall. R2 returned to facility same day with no new orders. Intervention added to care plan: 1:1 supervision provided related to fall (07/20/2025) Resident Posting/Sign: Call, don't fall sign in room. (07/20/2025) Pharmacy review of medications. (07/21/2025) On 07/23/25 at 10:12 AM Surveyor interviewed R2. R2 stated she was frustrated that she keeps falling but is glad she has no broken bones. R2 stated she gets infections in her urine, and she gets turned around at times. R2 could not recall dates of falls, number of falls, or names of the new medications but did say they make her stopped up. R2 said when that happens it upsets her stomach, and she doesn't feel like eating.On 07/23/2025 at 11:21 AM, Surveyor interviewed Certified Nursing Assistant (CNA) O. CNA O stated R2 has always been anxious since she has been at the facility. CNA O stated CNA O hasn't noticed any changes in general, better or worse. CNA stated R2 is hit or miss for sleep and will sometimes sleep in the bed and sometimes in the recliner. CNA O stated they use pressure alarms on the bed and in the recliner, and a string alarm while in the wheelchair. CNA O also stated R2 was moved closer to the nurse's station for safety as well. CNA O stated they carry a copy of the resident care plan while working and stated those get updated as needed when things change. On 07/23/2025 at 11:27 AM, Surveyor interviewed Registered Nurse (RN) M. RN M stated R2 is anxious at baseline but seems to be becoming more confused. RN M stated she believes the behaviors R2 has seem to ebb and flow. There isn't consistency. RN M also stated they have noticed behaviors are more often in the evening and are planning to discuss possible sundowning with the provider. RN M stated the number of falls prior to, and post psychotropic meds are about the same. RN M stated a lot of symptoms and falls have correlated with when R2 had UTIs. RN M stated some of the interventions in place for safety are alarms, offering activities, dycem in the wheelchair, and physical and occupational therapy assessments. On 07/23/2025 at 12:07 PM, Surveyor interviewed Director of Nursing (DON) B. DON B stated facility staff receive yearly and as needed education on the procedure/expectations for psychotropic medications. DON B stated they assess the resident, look at their history, implement non-pharmacological interventions, and discuss with physician before starting on psychotropic medications. DON B stated behavior monitoring should be completed prior to starting the medication. DON B stated R2 has had the same provider for a long time, and he knows her and her family well. DON B stated R2's physician is aware of her history and possibly that is why he prescribed the medications so quickly. Surveyor located no behavior monitoring prior to the medication or rationale prior to the use of the psychotropic medication.

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	525673	A. Building B. Wing	07/23/2025

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 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** Based on observation, interview and record review, the facility did not ensure activities of daily living (ADLs) of toileting and incontinence cares were provided for 1 of 12 residents (R6) reviewed. This is evidenced by:R6 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease unspecified, dementia, type 2 diabetes mellitus, essential hypertension, major depressive disorder, and dysphagia.R6's minimum data set (MDS) assessment, completed on 07/05/25, confirmed R6 is incontinent of urine and frequently incontinent of bowels. R6 requires supervision assistance with eating. R6 is substantial or maximal assist on staff for personal hygiene, showering/bathing, toileting, transferring, dressing lower body, and putting on/taking off footwear. R6's care plan was initiated on 02/05/25, and included the following: BED MOBILITY:-2 assist EATING:-Set-up assistance DRESSING:-2 assist TOILET USE:-2 assist TRANSFER:-1 assist [NAME] steadyOn 07/22/2025 at 6:40 AM, Surveyor observed R6's room door closed. Surveyor knocked and no one answered so Surveyor entered and observed R6 lying in bed on back. On 07/22/2025 at 7:53 AM, Surveyor observed R6's room door closed. Certified Nurse Assistant (CNA) H walked into room and asked if R6 wanted to participate in men's breakfast. R6 shook head no. CNA H let R6 rest in bed. On 07/22/2025 at 12:08 PM, Surveyor observed R6's room door closed. Surveyor observed R6 in bed, moving covers around, leaning part way off bed. Surveyor observed fall mat in place. On 07/22/2025 at 12:44 PM, Surveyor observed R6's room door closed. Surveyor observed CNA H go into R6's room and ask if R6 was ready to get up. R6 shook head no to CNA H. CNA H indicated to R6 that CNA H will be back into room to get R6 up for the day but would let him rest a little longer. Surveyor observed CNA H exit R6's room.On 07/22/2025 at 12:47 PM, Surveyor interviewed CNA H and asked CNA H if R6 has been up yet for the day as Surveyor saw R6 lying in bed since Surveyor came into building at 6:40 AM and did not see R6 eat breakfast or lunch thus far. CNA H reported to Surveyor that R6 is a late owl and didn't go to bed till 6 AM this morning. R6 use to work night shifts in his younger years on the railroad. CNA H reported that R6's usual is getting up around 1pm-2pm. CNA H reported to Surveyor that CNA H will be getting R6 up soon. CNA H indicated that is when R6 will get up for the day and eat. On 07/22/25 at 2:20 PM, Surveyor observed new evening staff on for their evening shift and day shift leaving. Surveyor observed R6 still lying in bed awake fiddling with covers and hanging part way off bed. Fall mat was in place. Surveyor did not observe any staff go into R6's room during the continuous observation to provide incontinent care or offer toileting. Observation from second Surveyor:On 07/22/25 at 2:58 PM, Surveyor observed R6's room door closed. Surveyor knocked and no one answered so Surveyor entered room. Surveyor saw R6 leaning off bed which was in its lowest position and just above another mattress that is positioned on R6's right side. On 07/22/25 at 3:07 PM, CNA J and CNA I entered room and Surveyor followed CNAs and noted R6 lying with just an incontinent brief totally on top of the mattress that was positioned next to bed and fall alarm sounding. Surveyor observed CNA I go into bathroom and begin to gather supplies to conduct ADL care. CNA I knelt on floor next to R6 and proceeded to wash R6. Surveyor observed incontinent brief was urine soaked.R6 was assisted to toilet by CNAs and continuation of cares was conducted. Surveyor observed soiled incontinent product of urine only was removed and deterioration of product was visible with numerous flakes of inner lining/filling of incontinent product falling onto bathroom floor, sticking to resident's skin and noted numerous additional flakes near and on mattress next to bed. Bed mattress was noticeable urine soaked and confirmed by CNA J. CNA J stated that per 1st shift, R6 had been in bed all day as he was up all night until earlier this AM.On 07/23/2025 at 6:59 AM, Surveyor observed R6 sleeping in wheelchair in lounge area near nurse's station. On 07/23/2025 at 7:20 AM, Surveyor observed Director of Nursing (DON) B offer R6 to use bathroom, change shirt, and get ready for breakfast. DON B stated to R6, I know you have been up all night. Let's get a clean shirt, breakfast, and then you can lie down. DON B wheeled R6 to room and began changing R6's shirt. (continued on next page)

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Dove Healthcare - Spooner	510 First St Spooner, WI 54801

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor interviewed DON B and asked how R6 does in the day. DON B reported to Surveyor that R6 use to work the railroad and was a night shifter. DON B reported that sometimes R6 sleeps all day. Surveyor asked DON B's expectation for checking on R6 and providing cares during the day when sleeping in room. DON B reported that staff should be checking on R6 and offering toileting or incontinent cares at least every 2-3 hours. DON B reported that staff should still be offering meals through the day. On 07/23/2025 at 7:23 AM, Surveyor observed CNA K enter R6's room and assist DON B with R6's transfer to toilet. CNA K took R6's pants down, placed wet brief in trash can, then placed R6 on toilet to use the bathroom. DON B and CNA K gave R6 a few minutes to use the bathroom.On 07/23/2025 at 7:27 AM, Surveyor interviewed CNA H and asked CNA H what time day shift laid R6 down on 07/22/25 since R6 had been up all night the previous night on 07/21/25. CNA H reported night shift laid R6 down right before day shift arrived around 5:30 AM or so. Surveyor asked CNA H what time CNA H went in yesterday on day shift of 07/22/25. CNA H reported that CNA H went into R6's room around 8:30 AM and provided incontinent cares. Surveyor asked CNA H if CNA H went in at any point further through the day to provide incontinent cares or offer toileting. CNA H reported that CNA H did not go in again to provide cares or toilet R6 and that usually depends on R6 and how he feels if we toilet or not. Surveyor asked CNA H if breakfast and lunch were offered to R6 throughout the day while R6 was in room. CNA H stated to Surveyor, Well you saw me go in around lunch time and ask if [R6] wanted to get up for lunch. He declined getting up for lunch. Surveyor asked CNA H what common practice is when offering toileting or providing incontinent cares to R6. CNA H reported to Surveyor that it just depends on how R6 is feeling, but CNA H should have gone in again to provide cares. On 07/23/2025 at 7:35 AM, Surveyor observed CNA L enter R6's room to assist CNA K with R6's transfer. CNA L asked CNA K if R6 is going to bed since he has been up all night. CNA K responded to CNA L and stated, [DON B] wants [R6] to stay up for breakfast and then we can lay [R6] down. Surveyor observed CNA K and CNA L lift R6 off toilet. CNA L noted smearing of bowel movement (BM) on R6's bottom so CNA L cleansed R6's bottom of BM. CNA L placed clean brief on R6 and then pulled shorts up. Surveyor did not observe peri cares completed on R6's groin area after incontinent episode of urine in R6's brief. Surveyor observed CNA K and CNA L transfer R6 back into wheelchair. CNA K wheeled R6 to dining room for breakfast. On 07/23/2025 at 11:36 AM, Surveyor interviewed CNA L and asked CNA L's process for performing peri cares. CNA L reported to Surveyor that CNA L performs peri care from front to back when changing an incontinent soiled brief. Surveyor asked CNA L if CNA L cleansed R6's genital area after changing R6's wet brief and toileting R6. CNA L reported that CNA did not wipe R6's front area when toileting R6. On 07/23/2025 at 2:03 PM, Surveyor interviewed DON B and asked expectation for performing peri cares on R6 after an incontinent episode. DON B reported to Surveyor the expectation is for CNAs to clean the whole peri care area front and back.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility did not provide appropriate skin assessments and treatment by professional standards of practice to maintain a resident's highest practicable level of physical well-being for 1 of 12 residents (R40) reviewed.Staff did not assess or document R40's new break in skin on great right toe or treat the skin injury appropriately.Findings include:R40 was admitted to the facility on [DATE] with diagnoses including in part, acute respiratory failure with hypoxia, Type 2 Diabetes Mellitus, obstructive sleep apnea, venous insufficiency, morbidly obese, bilateral osteoarthritis of hip, and prostatic hyperplasia.R40's care plan was initiated on 04/15/25, and included the following:DIABETIC:-Nursing to complete nail care on Tuesday evening. Surveyor reviewed R40's skin prevalence reports that did not note any skin issues. Surveyor reviewed Diabetic foot checks weekly documentation:-On 07/07/25, R40's skin was intact.-On 07/14/25, R40's skin was intact.-On 07/15/25, R40's skin was intact.-On 07/21/25, R40's foot check was completed with right and left foot dry, not cracked, with slight edema which is not new to R40.-On 07/22/25 R40 has scant bleeding noted to right great toe, inflammation along line of toenail. Unable to determine exact open area for measurement due to placement of toenail/inflammation. No purulent drainage noted. Immediate action taken was cleansed right great toe with normal saline, applied band aid, gauze tube per R40's request. Added resident to weekly wound rounds, made appointment for R40 to be seen by provider due to resident being diabetic.Surveyor reviewed R40's progress notes and did not find any documentation that a staff member assessed the new skin changes on R40's right great toe. Observations and interviewsOn 07/21/2025 at 10:36 AM, Surveyor interviewed R40. Surveyor asked if R40 had any sores or open areas on body. R40 reported to Surveyor that at this time R40 does not have any skin issues except R40's great right toe has a sore from podiatrist cutting toe nail off. Surveyor observed band aid and kerlix wrapped on great right toe.On 07/22/25 at 6:50 AM, Director of Nursing (DON) B asked if any Surveyor wants to observe wound dressing changes on any residents. Surveyor reported to DON B that Surveyor wanted to see what was going on with R40's band aid on great right toe. DON B reported to Surveyor that DON B would ask the Registered Nurse (RN) to bring Surveyor in once RN goes into R40's room.On 07/22/2025 at 7:23 AM, Surveyor observed Registered Nurse (RN) M walk out of R40's room. RN M reported to Surveyor that RN M was not aware of R40's right great toe and that the toe injury is new. Surveyor observed wound care supplies laid all over R40's bed when Surveyor entered. Surveyor asked RN M if RN M knew about the injury prior to today, 07/22/25. RN M reported that RN M did not know about it and that it is newly developed. RN M reported usually CNAs will let wound care nurse (RN M) know about it right away and no one has let RN M know yet. Surveyor asked RN M at what point did someone place a band aid on R40's right great toe. RN M stated, I am unsure. Surveyor asked RN M if there was any documentation of an assessment in the chart to show the condition of R40's right great toe. RN M stated that RN M would look into it after dressing R40's wound. Surveyor asked RN M if RN M knew who placed the band aid on R40 and did not report it to RN M or provider. RN M reported to Surveyor that RN M is unsure but will call the shifts prior to day shift today. On 07/22/2025 at 7:45 AM, RN M reported to Surveyor that last skin checks documented for R40 were skin was intact. Surveyor asked where notes were that someone placed a band aid on R40 or assessed the toe. RN M reported that RN M would keep looking through the Electronic Health Record (EHR). On 07/22/2025 at 1:30 PM, Surveyor interviewed RN M and asked if RN M spoke with the staff who placed band aid on and why it was not reported to provider or another staff member. RN M reported to Surveyor that RN M has not heard back from staff yet. RN M reported that RN M will assess the skin issue, complete a Braden skin assessment, and update care plan as needed. On 07/23/25 at 8:01 AM, Surveyor interviewed RN M and asked if RN M spoke with the staff who placed band aid. RN M reported that no one has called back yet.On 07/23/2025 at 12:32 PM, Surveyor (continued on next page)

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	525673	A. Building B. Wing	07/23/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interviewed DON B and asked DON B's expectation for assessing and documenting new skin issues on R40. DON B reported to Surveyor that DON B expects staff to assess a new skin issue thoroughly, measure, cleanse, document, and notify on call provider. Surveyor asked DON B if DON B knew who placed the band aid on and who didn't report this upon finding the new skin issue on R40. DON B reported to Surveyor that RN M was reaching out to all previous shifts and had to leave messages. DON B reported so far there are no call backs.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure acceptable parameters of nutritional status to maintain usual body weight. This occurred for 1 of 3 residents reviewed for nutritional status, Resident (R) R6.R6 was not weighed weekly to assess if he was maintaining his usual body weight. R6 had significant weight loss that was not assessed appropriately. Based on record review and interview, the facility did not ensure acceptable parameters of nutritional status to maintain usual body weight. This occurred for 1 of 3 resident reviewed for nutritional status. Resident (R) R6.R6 was not weighed weekly to assess if he was maintaining his usual body weight. R6 had significant weight loss that were not assessed appropriately. This is evidenced by:R6 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease unspecified, dementia, type 2 diabetes mellitus, essential hypertension, major depressive disorder, and dysphagia.R6's minimum data set (MDS) assessment, completed on 07/05/25, confirmed R6 is incontinent of urine and frequently incontinent of bowels. R6 requires supervision assistance with eating. R6 is substantial or maximal assist on staff for personal hygiene, showering/bathing, toileting, transferring, dressing lower body, and putting on/taking off footwear.R6's care plan was initiated on 02/05/25, and included the following:EATING:-Set-up assistance DENTAL CARE initiated on 02/05/25,-Consult with RD and follow recommendations.-Keep physician and significant other/designated family member informed of significant weight loss (.4% of previously obtained weight).-Monitor for weight loss. POTENTIAL FOR ALTERED NUTRITIONAL initiated on 07/05/25,-Diet as ordered CCHO, mechanical soft diet texture, thin liquids.-Eating: Independent, with supervision/set up-Provide and serve supplements as ordered.-Weights as ordered. Update RD/MD with weight gain/loss per facility protocol. Weekly weight report printed and examined.Surveyor reviewed R6's physician orders:-On 01/28/25, Weekly weights ordered.Surveyor reviewed R6's weights from 01/02/25 to present 07/22/25. -On 01/11/25 211 lbs.Staff missed 3 weeks of weights for R6.-On 02/07/25 223.7 lbs.-On 02/14/25 223 lbs.Staff missed 2 weeks of weights for R6.-On 03/07/25 224.3 lbs.-On 03/10/25 205 lbs.-On 03/19/25 208.6 lbs.-On 03/26/25 207.2 lbs.-On 03/31/25 208.3 lbs.Staff missed 2 weeks of weights for R6.-On 04/15/25 205.2 lbs.-On 04/22/25 206.6 lbs.-On 05/02/25 204.7 lbs.-On 05/08/25 208.6 lbs.-On 05/14/25 204.6 lbs.Staff missed 1 week of weights for R6.-On 05/30/25 200.5 lbs.-On 06/04/25 200.6 lbs.-On 06/10/25 201.2 lbs.Staff missed 2 weeks of weights for R6.-On 07/03/25 192.1 lbs.Surveyor calculated weight loss in percentage as follows: - On 02/07/2025, the resident weighed 223.7 lbs. On 05/02/2025, the resident weighed 204.7 lbs. which is a -8.49% loss.- On 02/07/2025, the resident weighed 223.7 lbs. On 07/11/2025, the resident weighed 200 lbs. which is a -10.59% loss.Surveyor reviewed Nutritional At Risk (NAR) reports from 01/03/25 to 07/18/25 for dietary in assessing and intervening for residents at risk or with weight loss. Surveyor did not find R6 noted on Dietary Manager (DM) N's NAR reports that she prints and brings to weekly meetings to the interdisciplinary team. Surveyor reviewed R6's progress notes:-On 02/28/25, Nutritional note: Diet CCHO, regular texture, thin liquids.eating independently with supervision/ set up. Intakes are quite varied, 25-100% of meals. Fluids are 240-720cc per meal. No issues chewing/swallowing noted. Weight: 223#, BMI of 33- obese. Care plan has been reviewed/updated. No new recommendations, RD to f/u and monitor prn.-On 04/17/25, Dietary note, Nutritional note: ST trial of Mech soft texture through 4/21/25 breakfast, monitoring for better meal intakes, re-eval at that time.-On 07/06/25, Nutritional risk assessment completed and noted R6 will proceed with nutritional diagnosis. Nutritional risk related to, if applicable: dysphagia related to difficulty swallowing as evidenced by requires modified texture diet. Care plan has been reviewed/updated. recommend offering sugar free house supplement BID, RD to follow up and monitor prn.Surveyor found no documentation for follow up on the trial for mechanical soft from 04/17/25 until 07/06/25 after R6 lost significant amount of weight. Surveyor did not find any documentation addressing R6's weight loss and updated care plan with new interventions until (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/05/25. On 07/23/25 at 12:01 PM, Surveyor interviewed DM N and asked DM N to explain process for monitoring weight loss in residents. DM N reported to Surveyor that DM N goes into EHR and follows weights. DM N will track trends and see who is at risk for weight loss or is actively losing weight and then documents in reports called NAR reports. DM N reported that the NAR reports go to the Registered Dietician (RD) and then interventions are put into place once RD reviews. DM N then reported that a dietary profile, mini nutrition assessment, and nutritional check assessment is concluded quarterly and annually. Surveyor asked DM N if R6 was on DM N's NAR reports. DM N reviewed NAR reports and stated, No R6 is not on NAR reports from 01/03/25 to present. Surveyor asked how R6 was missed for having significant weight loss. DM N was not sure how the significant weight loss was missed. On 07/23/2025 at 12:13 PM, Surveyor interviewed Director of Nursing (DON) B. Surveyor informed DON B of review of R6's nutrition and significant weight loss and the interview with DM N who reported somehow R6 did not populate as weight loss to review and intervene for further weight loss. Surveyor asked DON B's expectation of staff addressing the weight concerns for R6. DON B reported to Surveyor that DON B's expectation is that staff communicate about weight changes. DON B reported that CNAs tell the nurse the weights and if nurse sees a significant change that dietary is notified right away. DON B reported that DM N has her own way of assessing weights and then reporting significant changes to residents on a consistent basis. DON B reported that DON B would review and address R6's daily living and adjust schedule to preferences of sleep, eating, etc. VP of Clinical Operations E reported to Surveyor that VP of Clinical Operations E completed education regarding NAR reports, weight loss, nutrition in a meeting with all staff on 05/23/25.