STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525715	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - Rice Lake	910 Bear Paw Ave Rice Lake, WI 54868

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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** Based on observation, interview, and record review, the facility did not ensure the resident environment remains as free of accident hazards as possible and each resident receives adequate supervision and assistive devices to prevent accidents for 1 of 1 resident (R) reviewed (R36).R36 was a 1 person assist with a 2 wheeled walker (WW) for transfers. Certified Nursing Assistant (CNA) transferred R36 without use of a gait belt and two wheeled walker, and R36 fell resulting in a displaced intertrochanteric fracture of right femur. R36 was transferred to another hospital requiring surgical repair of the fracture. This is evidenced by:Facility's policy titled Fall Prevention Program with a revised date of 01/2026 documented: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.5. Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. B. The plan of care will be revised as needed.R36 was admitted to the facility on [DATE]. R36's current diagnoses include intertrochanteric fracture of right femur, dementia, osteoarthritis of knee, difficulty in walking, and history of falling. R36's Minimum Data Set (MDS) assessment, dated 03/18/26, documented a Brief Interview for Mental Status (BIMS) score of 9/15, indicating moderate cognitive impairment. MDS documented R36 requires staff assistance with transfers. R36's care plan states the resident has an Activities of Daily Living (ADL) self-care performance deficit r/t (related to) recurrent falls and UTI (Urinary Tract Infection). Interventions initiated on 12/10/25 included Ambulation/Locomotion: Assist of 1 with 2WW (Wheeled Walker).R36's fall risk evaluation was completed on 05/03/26 with a score of 13 meaning to be at medium risk for falling. On 06/23/26, fall risk evaluation was completed with a score of 17 meaning high risk for falls.On 05/26/26 at 6:45 AM, facility's incident report documented Certified Nursing Assistant (CNA) K transferred R36 from the shower chair without a gait belt while in the tub room. Registered Nurse (RN) J was called to the shower room and found R36 lying flat on her back. CNA K reported R36 was transferring from the shower chair to the wheelchair and sat down on floor. CNA K reported R36 was lowered to the floor. CNA K reported they considered this a near fall, and CNA K felt like they stopped R36 from sustaining any injury. R36 did not hit their head. R36 landed on their buttocks. Skin intact. R36 had been dressed except to have their pants pulled up. R36 was wearing gripper socks. R36 requested to sit up. R36 denied neck pain. R36 was unable to describe any painful areas. R36 was transferred with a Hoyer lift with 2 CNAs and transferred to the wheelchair. R36 did not complain of pain while in the wheelchair. Gait belt was applied to R36, and walker was given to R36 to attempt to stand and pull up pants. When R36 applied weight on her legs, R36 said they were not able to stand due to pain in their right hip. RN J further examined R36 and R36 complained of severe pain with any movement of the right leg. R36's right leg was noted to be shortened and externally rotated. The facility called 911 and R36's Power of Attorney who was notified of the transfer. Emergency Medical Services (EMS) transferred R36 to local hospital. Review of Emergency Department note dated 05/26/26 documented at 7:49 AM, Chief Complaint: c/o (complained of) R (right) hip pain after R36 was assisted in shower this morning at (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 0689 Level of Harm - Actual harm Residents Affected - Few	[Name] due to a fall. Pt (Patient) has a history of dementia. No loc (loss of consciousness) reported. Pt landed on bottom. R leg is shortened and externally rotated compared to L (Left) leg. Doppler pulses present. X-ray of the right hip with pelvis shows: Impression 1. Comminuted moderately displaced versus impacted right proximal femur intertrochanteric fracture.4. Subjectively decreased bone density.we recommended orthopedics evaluation and patient will be transferred to [Name of hospital] for further evaluation and care and probable ORIF (Open Reduction Internal Fixation) of the hip. On 07/01/26 at 11:11 AM, Surveyor observed CNA L check the care plan before entering R36's room to assist with transfer to bed. CNA L used the walkie talkie to call for another CNA to assist with transfer. CNA L brought Hoyer lift into room. CNA M entered room, sanitized hands, and assisted CNA L with attaching R36 in sling, and they transferred R36 to bed according to the plan of care.On 07/02/26 at 9:43 AM, Surveyor interviewed RN J about R36's fall causing injury. RN J stated they were the charge nurse and were called in to the tub room. CNA K said they caught R36, and it was not a fall. R36 denied pain and was assessed briefly. R36 was mostly dressed and had gripper socks on. R36 was transferred from the floor with a Hoyer lift to the wheelchair. CNA K and CNA E tried to stand R36 up to pull up their pants and when R36 applied pressure to their R leg R36 said, Ow, can't. The CNAs transferred R36 to bed and noticed R36's leg was shorter. RN J called EMS and transferred to R36 to the emergency room (ER). RN J emailed the entire leadership team of the fall and transfer to ER. It all happened really fast, and RN J did not realize CNA K did not follow the care plan until filling out the fall report. RN N called asking about the fall and RN N came to the facility. Surveyor asked if RN J talked with CNA K about not using a gait belt. RN J stated CNA K is an experienced CNA and there was no reason to doubt CNA K. Surveyor asked if RN J received any training after this incident. RN J stated Director of Nursing (DON) B spoke with RN J about assessing and reporting, and there were quizzes to take. On 07/02/26 at 10:20 AM, Surveyor interviewed CNA E about R36's fall on 05/26/26. CNA E stated it was called over the walkie talkie that a Hoyer and sling were needed on the short-term wing. CNA E stated they were the second person to help get R36 off the floor and put R36 in the wheelchair. RN J had instructed to get R36 off the floor. R36 was dressed in pants which were not pulled all the way up and wearing grippy socks. Surveyor asked if R36's right leg was shorter than the left. CNA E stated they could not see this at that time. When R36 was in the wheelchair they were going to have R36 stand, and this is when it was noticed there was no gait belt in the room. Usually there is a bag attached to the walker or wheelchair that would have the gait belt. R36's gait belt was in the bag on R36's walker in R36's room. A gait belt is required when a resident is an assist of 1 staff. When they tried to have R36's stand R36 said, No. ow ow, and when Hoyer lifted to bed R36 complained of pain. When R36 was in bed, the nurse saw R36's right leg was shorter. CNA E stated they believed this all happened before breakfast between 6:30 AM and 7:30 AM. On 07/02/26 at 11:14 AM, Surveyor interviewed DON B about the timeline of R36's fall with injury. RN J had emailed DON B and RN O about R36's fall. CNA K got R36 ready in the morning in R36's room. R36 started to self-transfer and CNA K didn't use a gait belt or walker and transferred R36 to the shower chair and brought them to shower room for a shower. CNA K did not use a gait belt and walker after R36's shower. CNA K said they lowered R36 to the floor and felt by lowering to the floor there would be no injury. They got R36 off the ground with a Hoyer and placed R36 in the wheelchair. When R36 went to stand from the wheelchair R36 complained of pain when bearing weight to the leg. RN K was in the mind set of R36 was an easy lower to the floor that there were no injuries. CNA K did not use a gait belt, walker and R36 was standing on a towel. CNA K was removed from work that day and during the investigation. CNA K is no longer employed by the facility. DON B stated all nursing staff were educated, and nurses and CNAs completed the education. Nursing Home Administrator (NHA) A sent out a text message to all staff of the education needed to be completed. RN J was educated on process of reporting, interviewing the CNA, and gathering what happened. RN J did not find out about the gait belt not being used. Education of reporting right away and to pull staff from the floor. DON B stated RN K should have called DON B when the fall with injury occurred. Surveyor reviewed facility's (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	investigation of incident. The facility's interventions started on 05/26/26 with suspending CNA K, local police notified, physician notified, POA notified, staff interviews completed, staff education regarding safe transfers and care plan adherence was initiated and ongoing with casual staff, and transfer audits were conducted. The facility completed audits on 05/31/26, staff education on 06/01/26, and the investigation on 06/01/26. Based on Surveyor's investigation, the facility was not in compliance related to preventing accidents when staff did not follow R36's care plan for transfers resulting in a fall with actual harm. The facility recognized the deficient practice, conducted an investigation, put interventions in place, and provided staff education. The facility has no current noncompliance. This is cited at past noncompliance actual harm/isolated.