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	08/13/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure proper documentation and communication for discharge for 1 of 2 residents reviewed (R42).-Facility did not provide documented reasoning in the medical record for what needs could not be met for R42.-The facility did not provide and document sufficient preparation and orientation to R42 to ensure safe and orderly transfer or discharge from the facility. -Facility did not communicate with hospital staff after transfer to ensure R42 no longer needed skilled services.Findings include:Facility policy titled, Transfer and Discharge Requirements, last reviewed January 2020, reads in part: Medical record documentation will include the following.the basis for the transfer.as applicable, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs and the service available at the receiving facility to meet the need(s).If the transfer is due to a significant change in the resident's condition, but not an emergency requiring immediate transfer, then prior to any action, [Facility Name] must conduct the appropriate assessment to determine if a new care plan would allow the facility to meet the resident's needs.R42 was admitted to the facility on [DATE], with diagnoses including metabolic encephalopathy (brain disorder secondary to sepsis), Parkinsons's disease, depression, and acute kidney failure.R42's pertinent medications include Pramipexole and Duloxetine.R42's most recent Minimum Data Set (MDS), dated [DATE], did not have a Brief interview for Mental Status (BIMS) score available. MDS did indicate R42 to be cognitively independent with daily decision making.R42's care plan prior to any noted concerns/behaviors included alteration in mood and risk for adverse effects related to antidepressant medication use and history of hallucinations, and potential for alteration to mood pattern. Interventions included report to physician signs of adverse reaction such as decline in mental status, behavioral health consults as needed, monitor me for changes in my mood or behavior. Notify my Medical Doctor (MD), Registered Nurse (RN) and Social Worker (SW) if you see concerns, and monitor/record mood to determine if problems seem to be related to external causes such as medications.On 05/30/35 at 9:00 PM, progress note indicated R42 attempted inappropriate touching and verbalized sexual comments to a female staff member during cares. Care plan was revised to include R42 to have 2 staff members for peri care on 05/30/25.On 05/31/25 at 4:30 AM, progress note indicated R42 had made a call to 911 stating R42 was being held captive by the facility, wanting to leave, and was hallucinating. Redirection of R42 was ineffective but R42 calmed when Family Member (FM) D arrived. Nurse Manager (NM) C was contacted. NM C informed staff R42 needed to go to the emergency room (ER) related to new onset behaviors.On 05/31/25 at 8:30 AM, progress note indicates ambulance was called. NM C was in facility and discussed with FM D that discharge is needed to meet R42's needs and facility would not be able to continue care.On 05/31/25 at 9:21 AM, progress note reads in part: Discharging hospital stated R42 had some hallucinations the night before discharge and it was attributed to infection and new setting. NM C did speak with FM D in regard to behaviors and how facility is unable to meet R42's needs at this time and that memory care would be more appropriate if after ER evaluation R42 is determined not to need further medical intervention.Of note, there is no physician documentation as to why R42's needs are unable to be met and the reason (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525715	A. Building B. Wing	08/13/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for discharge.On 05/31/25 at 10:40 AM, progress note states R42 was sent to ER and will not be returning to the facility.On 05/31/25 at 3:31 PM, progress note states FM D returned to the facility and stated two doctors evaluated R42 and reported there is absolutely nothing wrong with him. R42 was cleared by ER staff to return home with FM D.R2's record review did not show any indication of communication between facility and hospital staff after transfer for evaluation to determine if R42 would need to return to the facility.Record review indicated general behavior monitoring was in place since admission with each shift prior to morning of discharge marked NB (no behaviors observed). The AM shift the day of discharge, general behavior monitoring indicated VP (verbalizing persistent beliefs that are not true) and NI (no interventions attempted.)Surveyor noted no new interventions to help R42 with his behaviors demonstrated on 5/30/25.On 08/13/25 at 11:35 AM, Surveyor interviewed FM D. FM D stated the facility admitted R42 knowing about the diagnoses of Parkinson's and sepsis, as well as the episodes of hallucinations R42 had the night prior to admission to the facility and they accepted him. FM D was called to facility in relation to behaviors. FM D stated facility was sending R42 to ER for increased aggression and behaviors as they (the facility) did not know how to handle it. FM D stated facility told FM D the orders came from upper management that R42 could not stay there and not to bring him back. FM D was unable to name staff member but stated it was the same person that completed R42's admission paperwork. FM D was asked if she wanted R42 to return. FM D indicated after the way they were treated, she did not want to bring R42 back but instead took him home to care for him where he is still residing and doing well.On 08/13/25 at 1:23 PM, Surveyor interviewed DON B. DON B stated the whole situation happened really fast from behavior onset to transfer. DON B stated the reason for transfer was due to behaviors/combativeness and to evaluate for infection or something else. DON B stated the facility would not be able to meet R42's needs if R42 continued to be combative/behavioral. DON B stated the facility does not have any additional documentation to support statement of behaviors and interventions prior to transfer. DON B stated there was no contact to provider prior to transfer or documentation for the reason for discharge because it happened too fast. The facility should have had more documentation to demonstrate observation of behaviors.Record review indicates 4 hours between R42's 911 call by and staff call for transport via ambulance to ER.On 08/13/25 at 1:26 PM, Surveyor interviewed NM C. NM C stated R42 had been admitted to facility for short-term rehab and over the weekend had a change of condition. NM C stated R42 had called 911 stating R42 was held against R42's will and was verbally abusive to staff. NM C stated R42 wanted to go home and was combative, not allowing staff to touch R42. NM C stated R42 had been sexually inappropriate the evening prior to discharge. NM C stated R42 had a cognition change around 4:00 AM on 05/31/25. NM C did confirm R42 did not hit anyone in the facility. NM stated NM C arrived at the facility on 05/31/25 around 8-8:30 AM. NM C stated R42, FM D, and ambulance staff were present in R42's room and R42 was beginning to clear. NM C stated after R42 had made sexual comments to staff, the care plan was changed to two-assist with cares. NM C stated no physician orders were obtained for transfer, R42 was agreeable to discharge, and charge nurse was in contact with ER. NM C stated, regarding care plan changes, that R42 was 1:1, but not technically. NM C stated NM C had a conversation with FM D that R42's behaviors are not typically something they care for at the facility. NM C stated, in relation to ER staff being contacted, that FM D called later that day and said there was nothing wrong with R42. NM C stated NM C was the nurse who had done the admission paperwork for R42.On 08/13/25 at 2:44 PM, Surveyor interviewed Director of Nursing (DON) B. DON B stated the charge nurse has the responsibility to determine appropriateness for transfer and no provider notification/order is needed. DON B stated they were unable to find any additional documentation related to R42's discharge. DON B stated no behaviors were documented as R42 was only there for 2 days.

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	08/13/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not notify the resident (R) or the resident's representative(s) of the transfer/discharge reason, the duration of the bed-hold policy, and the reserve bed payment in writing. This has the potential to affect all 37 residents. R34 was transferred to the hospital on [DATE] and did not receive written notice of transfer or bed hold reserve payment notice. R42 was transferred to the hospital on 5/13/25, and R42 nor Family Member (FM) D received any written notice of transfer or bed hold reserve payment notice. R8 was transferred to the hospital on 7/24/25 and did not receive written notice of transfer or bed hold reserve payment notice This is evidenced by: Facility policy titled, “Transfer and Discharge Requirement,” with a reviewed date of 01/2020, states in part: “Notice Before Transfer: Before a resident transfer or discharges, Dove Healthcare will – a) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Contents of the Notice: It is the policy of Dove Healthcare that the written notice of transfer or discharge must include the following: a) The reason for the transfer/discharge: b) The effective date of transfer/discharge: c) The location to which the resident is transferred/discharged : d) A statement of the resident's appeal rights including the name, address (mailing and email) and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request: e) The name, address, and telephone number of the State Long-Term Care Ombudsman…” Example 1 R34 was admitted to the facility on [DATE] with pertinent diagnoses of atrial fibrillation and constipation. R34's quarterly Minimum Data Set (MDS) assessment, dated 07/01/25, noted a Brief Interview for Mental Status (BIMS) score of 14/15 indicating cognition intact. On 07/11/25, R34 was transferred to the hospital via ambulance with nausea/vomiting and irregular heart rate and admitted to the hospital for treatment. R34 returned to the facility on [DATE]. Ombudsman notified. No documentation of written transfer notice or bed hold. On 08/13/25 at 11:52 AM, Surveyor interviewed Director of Nursing (DON) B regarding bed hold notice and written transfer notice. DON B stated that no written transfer notices were being provided to residents and was unaware of this requirement. DON B stated that bed hold notices are included with the admission packet but not given to residents at time of transfer. Example 2 (continued on next page)

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	08/13/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R42 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (brain disorder secondary to sepsis), Parkinsons's disease, depression, and acute kidney failure. Most recent Minimum Data Set (MDS), dated [DATE], did not have a Brief Interview for Mental Status (BIMS) score available. MDS did indicate R42 to be cognitively independent with daily decision making. On 05/31/25, R42 was transferred to the hospital via ambulance with change in condition and increased behaviors. On 08/13/25 at 11:35 AM, Surveyor interviewed Family Member (FM) D. FM D stated R42 nor FM D received any paperwork upon leaving facility for transfer to hospital. On 08/13/2025 at 1:23 PM, Surveyor interviewed Director of Nursing (DON) B. DON B stated the whole situation happened really fast from behavior onset to transfer. DON B stated there was no contact to provider prior to transfer as everything happened too fast. On 08/13/2025 at 1:26 PM, Surveyor interviewed Nurse Manager (NM) C. NM C stated NM C did not get any discharge or leaving AMA paperwork, and no paperwork was given to R42 or FM D at the time of leaving. NM C also stated NM C did not go over a bed hold. Example 3 R8 was admitted to the facility on [DATE]. R8's current diagnoses include acute kidney failure, type 2 diabetes mellitus, chronic peripheral venous insufficiency, and weakness. On 07/24/25, R8 was transferred to the hospital with no urine output and increased edema. R8 returned to the facility on [DATE]. Review of R8's chart identified no documented bed hold notice including the daily rate cost and the notice for reason of transfer. On 08/11/25 at 11:24 AM, Surveyor interviewed R8 about written notice of bed hold and reason for transfer. R8 stated did not receive written notices.