

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION This was a risk-based inspection, not a standard inspection. A risk-based inspection is a shorter visit by a smaller inspection team and is only done for high-performing facilities.	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER Dove Healthcare - Rice Lake		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 interview and record review, the facility did not ensure a resident received treatment and care in accordance with professional standards of practice for 1 out of 4 sampled residents (R10). -The facility did not comprehensively assess R10's non-pressure wounds weekly. -An intervention to prevent R10 from scratching their skin was discontinued, the facility did not implement a new intervention, and R10 continued to scratch at their skin. -Staff did not place elbow and heel protectors on R10 when R10 was up in their broda chair. -Staff did not place device in R10's hand to provide palm protection and prevent further contracture. -R10's treatment was discontinued and staff continued to provide treatment for 27 days after order was discontinued. -The facility did not implement a plan to ensure clear communication with hospice services. Findings include: R10 was admitted to the facility on [DATE]. Diagnoses included Parkinson's disease, contractures causing skin breakdown, anxiety, and history of pressure ulcers. R10 received hospice services to provide comfort for end-of-life care. R10's Minimum Data Set (MDS) assessment completed on 06/30/26, confirmed R10 scored 06/15 during Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. R10 makes their own healthcare decisions. WOUNDSThe facility policy titled Documentation of Wound Treatments, read, Wound evaluations are documented upon admission, weekly, and as needed if the resident or wound condition deteriorates. The following elements are documented as part of a complete wound evaluation: Type of wound (pressure injury, surgical site, etc.) and anatomical location.Stage of wound, if pressure injury or the degree of skin loss if non-pressure.Measurements: height, width, depth, undermining, tunneling.Description of wound characteristics. R10's care plan included:Activities of Daily Living (ADL) self-care deficit and risk for skin breakdown related to fragile skin. History of scratching posterior right thigh and causing injury and bleeding. R10 refuses to have nails trimmed. Interventions: Elbow protectors to both arms, on in the AM, off HS. Date initiated 11/13/24.Encourage to report itchy skin to staff. Date Initiated: 01/09/25.Encourage to not scratch skin. Alert nursing to itching. Date Initiated: 01/17/25.Inner dry over personal foam dog. Thumb and index finger around head of dog. Picture of correct placement in closet. Date initiated: 01/28/26.White heel protectors on AM, off HS. Date initiated: 01/28/26. R10's weekly wound documentation included:-09/02/25, WEEKLY WOUND TRACKER, right thigh. L=0, W=0, D=0. Overall wound is improving, there are no signs of infection, no exudate, no odor. Wound edges are well defined. (Note, there are no measurements). -09/16/25, WEEKLY WOUND TRACKER, right thigh. L=0, W=0, D=0. Wound seems to be worsening. No signs of infection, no exudate, no odor. Wound edges are irregular. (Note, previous assessment completed on 09/02/25). -09/30/25, WEEKLY WOUND TRACKER, back of right thigh. L=0, W=0, D=0. There have been no changes in wound from previous week. No signs of infection, no exudate, no odor. Wound edges are irregular. (Note, previous assessment completed on 09/16/25). -10/16/25, WEEKLY WOUND TRACKER, back of right thigh. L=0, W=0, D=0. There have (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been no changes in wound from previous week. Wound edges are attached at base. (Note, previous assessment completed on 09/30/25). Note no further weekly wound tracker assessments related to thigh wound, documentation was in progress notes, which was not comprehensive and not weekly. -11/18/25, PROGRESS NOTE: Posterior (R) thigh no drainage, wound beds are red in color, 30 x 15 x 0. (Note, missing assessments from 10/16/25-11/18/25). -11/25/25, PROGRESS NOTE: Resident continues to have areas where she scratches, new Tx orders received today. Skin Tx: 1. Wash right thigh wounds with normal saline and pat dry 2. Apply non-stick to affected areas 3. Cover with 8x12 Tegaderm. (Note, no wound documentation from 11/25/25-04/07/26. Treatment order was current is R10's orders as of 07/02/26). -04/07/26, PROGRESS NOTE: (R)posterior thigh measures 26 x 12 x <0.1. There are 2 areas that are open, wound bed is red in color, no drainage. (Note, previous assessment completed on 11/18/25). -05/03/26, WEEKLY WOUND TRACKER, left hand/base of thumb. L=0.5 x W=0.5, D=0.1. Wound is improving. No signs of infection, no exudate, no odor. Wound edges are attached at base. (No weekly assessment in previous week, wound is documented as improving). -05/05/26, PROGRESS NOTE: (R) posterior thigh wound measures 27 x 13 x <0.1. No drainage present. (Note, last assessment on 04/07/26). 05/11/26, PROGRESS NOTE: Resident has scratched the dressing off right thigh, and it is bleeding. I spoke to resident's [husband] about the mitt. They had brought the mitt in for resident to wear to protect from scratching thigh. 05/12/26, PROGRESS NOTE: Mitts cannot be used as resident cannot remove them. DON ordering alternative fingertip protectors. On 07/01/26 at 10:10 AM, Surveyor observed R10 had long painted fingernails and did not have on fingertip protectors. R10's record did not include an order or task to place fingertip protectors. R10's care plan did not include an intervention of fingertip protectors. On 07/01/26 at 1:42 PM, Surveyor interviewed Director of Nursing (DON) B. DON B reported R10's fingertip protectors had been ordered in May and were in the medication room. DON B and Surveyor counted R10 had 40 fingertip protectors. Surveyor asked for evidence of the items ordered and documentation of administration and effectiveness of fingertip protectors. DON B reported 40 fingertip protectors were ordered, and it should be an order in R10's treatment record. DON B stated this would be her responsibility and she did not enter it. Surveyor repeated to DON B, 40 fingertip protectors were ordered, and 40 fingertip protectors were counted, indicating the fingertip protectors had not been used, and DON B stated yes. -05/17/26, WEEKLY WOUND TRACKER, left hand/base of thumb. Wound is now healed. (No weekly assessment since 05/05/26). -05/21/26, Treatment order, Apply split gauze over left hand base of thumb and forefinger palm guard open area daily and PRN until healed. -05/27/26, WEEKLY WOUND TRACKER, left hand, first web space. L=0.5, W=0.5, D=<0.1. Wound is improving, no signs of infection, scant amount of serous exudate, no odor. Wound edges epithelializing. -06/04/26, WEEKLY WOUND TRACKER, left hand, first web space. Wound is healed. Discontinue skin treatment of split gauze over left hand base of thumb and forefinger palm guard open area daily, continue treatment of inner dry placed over foam dog that is placed in palm of hand for protection related to contracted left hand is always moist. (Note, order was not discontinued in R10's record.) On 07/01/26, Surveyor reviewed R10's Treatment Administration Record (TAR) and noted licensed nursing staff were completing daily treatments of split gauze over left hand base of thumb and forefinger guard. On 07/01/26 at 2:09 PM, Surveyor interviewed DON B. DON B reported R10's order to discontinue the treatment was not discontinued in the system by Licensed Practical Nurse (LPN) H, and DON B was not sure why, but stated she would discontinue the order on this date. On 07/02/26 at 7:42 AM, Surveyor interviewed LPN H. LPN H could not remember why she did not discontinue R10's treatment order and confirmed R10's wound to left hand first web was healed. -06/16/26, PROGRESS NOTE: Right thigh (rear), self-scratched: Length = 40, Width = 12, Depth = (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<0.1, - Stage Unstageable. This is not a new skin alteration for resident. Upon examination found (R) posterior thigh-self scratched area has a couple open areas noted. This entire area measures 40 x 12 x <0.1. No drainage noted. Area cleaned, tx per TAR. (Note, last assessment 05/05/26). -06/23/26, WEEKLY WOUND TRACKER, 1st web of left hand, 0.5 x 0.5 x 0.1. Wound is improving. First identified on 04/25/26, facility acquired, healed. (Note, assessments show wound started on 05/27/26). On 07/02/26 at 7:42 AM, Surveyor interviewed LPN H. LPN H stated they do weekly assessments for pressure wounds Stage 1 and up and then continue to follow weekly. LPN H reported they do not do weekly assessments on skin tears, moisture associated skin damage, and non-pressure wounds. LPN H stated on bath days nursing staff should be doing a weekly skin check and documenting, including measurements, for any non-pressure related wounds. LPN H stated that sometimes R10 will scratch the skin open, and sometimes it is just scabbed and healing, and a lot of the time it is just redness. LPN H stated R10's posterior thigh wound is scattered, and when LPN H measures the area, the largest area and the smallest area are measured. LPN H reported other licensed nurses measure the entire area which is why the measurements for the wound are inconsistent. Surveyor asked LPN H if the weekly measurements would be accurate since staff are measuring differently, and LPN H stated the measurements would not be accurate. LPN H again stated, if a resident has a new skin opening, nursing staff should be documenting and measuring every time it is identified and weekly follow up should continue until it is healed. Surveyor asked what healed means and LPN H stated when scabbing is gone. On 07/02/2026 at 9:05 AM, Surveyor interviewed DON B. DON B stated weekly wound tracking should be completed for any wounds that are open, even redness, until healed. DON B stated, We recognized wound tracking is something we need to improve on, we are trying to revamp our weekly wound tracking system. DON B reported the facility had not implemented a performance improvement plan at the time of the Survey. On 07/02/26 at 10:27 AM, Surveyor observed LPN H complete wound care on R10's thigh. Surveyor asked LPN H to state the measurements and description of the wound. LPN H reported R10's wound to measure 20 x 4 and reported the area to be red with a small superficial area that was open, with no signs of infection. Surveyor observed the measurements to be correct; the area was red with a small open area measuring approximately 0.1 x 0.1. MEDICAL DEVICES On 07/01/26 at 10:10 AM, Surveyor observed R10 in her room. R10 was seated in a Broda chair, facing the television. R10 was neat and clean, wearing white socks on their feet, and feet resting on the footrest of the wheelchair. R10 answered most questions with yes/no answers. R10 answered yes when asked if staff are kind, treat her well, and provide adequate care. R10 answered no when asked if there were any concerns about the care provided. Surveyor observed that R10 was not wearing elbow and heel protectors. Surveyor observed R10 did not have inner dry over personal foam dog in left hand, as indicated in the care plan. Surveyor observed a picture in R10's closet, showing a stuffed [NAME] dog, approximately 4-6 inches long, the dog appeared to be stuffed with soft material, like a squishy stress toy. The dog was wrapped in a light layer of gauze and placed in R10's left hand. On 07/01/26 at 11:12 AM, Surveyor observed certified nursing assistants (CNAs) C and D assist R10 with cares before lunch. Surveyor observed CNA C place heel protectors on R10. On 07/01/2026 at 12:47 PM, Surveyor interviewed CNA E. CNA E reported R10 has protective gear in place, elbow pads, heel pads and dog for contracture of left hand. CNA E reported that R10 gets up for the day approximately 6:30 AM-7:30 AM. CNA E stated she did not get R10 up this morning and was not sure why R10 did not have elbow and heel protectors on and foam dog for left hand contracture. On 07/01/2026 at 12:53 PM, Surveyor interviewed CNA C. CNA C reported R10 gets up in the morning between 6:00 and 7:30 AM. CNA C reported R10 has elbow pads, heel pads, and dog for left hand. CNA C reported she did not get R10 up this morning and that CNA D and CNA E assisted (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R10 with getting up. CNA C did not know why R10 did not have elbow and heel protectors on, or foam dog in left hand. On 07/01/2026 at 12:56 PM, Surveyor interviewed CNA D. CNA D stated she and CNA C got R10 up this morning between 6:30AM-7:30 AM. CNA C stated R10's elbow protectors were in the laundry, and R10 did not want shoes on and did not want anything on their feet. CNA C stated she reported this to Licensed Practical Nurse (LPN) F, the charge nurse before lunch. CNA C then stated R10's heel protectors were in the laundry, not the elbow protectors, because R10 has elbow protectors on right now. CNA C stated she could only find one heel protector and that is why R10 did not have heel protectors on. CNA C stated Surveyor asked CNA C to clarify what was in the laundry, the heel protectors or elbow protectors. CNA C said, heel protectors. Surveyor asked CNA C, you could only find one elbow protector this morning then. CNA C said yes, but she found another one when getting R10 ready for lunch. Surveyor asked CNA C if R10 only has one set of each elbow and heel protectors and CNA C said yes. CNA C stated R10 does not allow staff to place dog in their left hand. CNA C stated she put a pillow under R10's legs this morning, but Surveyor did not observe a pillow under R10's feet or legs and did not observe a pillow on R10's floor. On 07/01/2026 at 1:34 PM, Surveyor interviewed LPN F. LPN F reported CNA C reported to her around 9:00 or 10:00 AM, that R10 did not have heel protectors. LPN F said CNA C did not report anything about elbow protectors or the dog to be placed in R10's hand. LPN F stated CNA C should have reported this earlier when getting R10 up and not waited. LPN F stated R10 has only one set of heel protectors and usually residents have a backup set, and she was not sure why R10 did not have a backup pair of heel and elbow protectors. LPN F stated R10 has a history of skin issues, and pressure injuries to heels. On 07/01/26 at 2:09 PM, Surveyor interviewed DON B. DON B reported R10 should have more heel and elbow protectors, and she could order more. DON B stated if staff do not tell her she does not know if a resident needs more. DON B reported she would order more supplies for R10, as the expectation is staff will apply these to R10 every morning to prevent skin damage or pressure injuries. HOSPICE The facility policy titled Coordination of Hospice Services, read, The plan of care will identify the care and services each entity will provide in order to meet the needs of the resident. The facility will communicate with hospice and identify, communicate, follow and document all interventions put into place by hospice and the facility. The facility will maintain communication with hospice as it relates to the resident's plan of care and services to ensure each entity is aware of their responsibilities. R10's care plan included: I am enrolled in Hospice. Date Initiated: 05/21/26. I will experience relief from physical, emotional and spiritual pain through next review date. Date Initiated: 05/21/26. I will have minimal symptoms of depression and anxiety through the next review date. Date Initiated: 05/21/26. My comfort will be maintained through the review date. Date Initiated: 05/21/26. Administer medications as ordered, monitor for side effects and/or adverse effects. Date Initiated: 05/21/26. On 07/01/26, Surveyor reviewed R10's hospice care plan. Surveyor noted the care plan did not identify what services hospice would be completing and how often. For example, hospice staff provide a shower one time weekly, every Wednesday. On 07/10/26, Surveyor reviewed R10's hospice communication in the electronic health record, miscellaneous tab. Surveyor noted hospice communication included hospice aide provided R10 a shower on 05/28/26 and 06/25/26. There was no other documentation in R10's record related to what services and dates hospice provided services. On 07/02/2026 at 6:43 AM, Surveyor interviewed Medication Technician (MT) G. MT G reported hospice calls the day before and informs licensed nursing staff when hospice staff will arrive the next day, what residents they will be seeing and what tasks they will be performing. MT G stated R10 does not have a hospice paper chart and documentation is in the electronic record, R10's hospice care and facility progress notes completed by licensed nursing staff, related to any hospice communication. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MT G stated the facility CNAs would not know what hospice staff completed, as it is in the computer and CNAs do not have access to notes, and hospice staff does not document in the facility electronic record. On 07/02/2026 at 6:46 AM, Surveyor interviewed LPN I. LPN I reported all hospice documentation scanned into the resident's electronic record. LPN I stated when hospice staff leave the facility, they complete documentation on paper about what was completed, shower, dressing, etc. LPN I stated licensed nursing staff receive the paper documentation from hospice and scan into the resident's electronic record. LPN I was not sure if facility CNAs had access to the scanned items in a resident's record, but she did not think they did. On 07/02/2026 at 8:05 AM, Surveyor interviewed CNA C. CNA C reported hospice staff will call the night before and say what they will be doing the next day. Surveyor asked CNA C if they knew what the hospice care plan says. CNA C stated, There is a hospice care plan? No, I don't know what is says. Surveyor asked CNA C if the hospice staff documents in R10's electronic record. CNA C stated no. Surveyor asked CNA C, who documents R10's showers which hospice staff give resident. CNA C stated no one. Surveyor asked CNA C, how did they know if hospice trimmed nails, provided oral care, applied splints/braces, toileted, or assistance with meals. CNA C stated, we don't. CNA C stated the facility staff provide weekly shower for R10 on Tuesday evenings. CNA C stated facility staff do not know when hospice staff provide R10 with a shower or other care and it is not documented in R10's record. CNA C did not know what services hospice provided for R10, except for a shower. On 07/02/2026 at 8:08 AM, Surveyor interviewed CNA D. CNA D stated there is no communication between facility CNAs and hospice. CNA D stated hospice staff have been coming on Thursdays, but the CNAs don't know what tasks hospice completed. CNA D stated CNAs do not have access to nurses notes in the electronic record and there is no documentation when hospice provides cares. On 07/02/2026 at 10:00 AM, Surveyor interviewed hospice CNA O. Hospice CNA O stated per hospice provider hospice aides are to call the day prior and state who they are seeing and what they will be doing. Hospice CNA O thought communication with the facility was good. Hospice CNA O fills out a paper communication tool and gives it to the facility licensed nursing staff; she was not sure what happened to the paper communication tool after she gave it to the staff.		