STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525479	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - Bloomer	2217 Duncan Road Bloomer, WI 54724

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observation, record review and interview, the facility did not ensure that residents are free of significant medication errors for 1 of 7 residents (R6) observed for medication pass. R6 was given 8 units of Insulin Aspart (Novolog) short-acting insulin an hour before breakfast. R6 was to have received 8 units of Insulin Aspart (Novolog) 15-30 minutes before breakfast, to prevent hypoglycemia (low blood sugar). This is evidenced by: Surveyor reviewed the policy Insulin administration dated 03/13/24 which states in part, Please ensure that all residents receive a meal within 30 minutes of receiving insulin . Surveyor reviewed the policy Protocol for Diabetes Management last reviewed 06/2023 which states in part, .Hypoglycemia signs and symptoms (remember that some residents may not experience symptoms or may only experience confusion or lethargy making their symptoms harder to recognize) #1-17: Confusion, lethargy poor concentration, hallucinations, generalized weakness, aggression, blurred vision, nausea, falling, hunger, seizures, shakiness, sweating, tachycardia, tingling in extremities, numbness around kips, and/or dizziness . R6 was admitted on [DATE] with a diagnosis in part, of pressure-induced deep tissue injury to the right heel, chronic kidney disease stage 3, and type 2 Diabetes Mellitus (DM) with foot ulcer, kidney complication, and diabetic neuropathy associated. R6's minimum data set (MDS) assessment completed on 01/23/24, confirmed R6 scored 15 during the Brief Interview for Mental Status (BIMS), indicating R6 is cognitively intact. Surveyor reviewed physician orders printed on 03/14/23 that included: -On 02/01/24 Blood sugar check as needed -On 02/09/24 Insulin Aspart (Novolog) 8 units of subcutaneous injection twice a day before meal for DM2. (continued on next page)

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 02/23/24 Insulin Aspart (Novolog) units per sliding scale four times a day before meals. 200-249=1 unit 250-299=2 units 300-349=3 units 350-399=4 units greater than 400=5 units and notify MD Surveyor reviewed the physician progress notes stated in part, .On 07/31/23 glucose range from 07/21/23-07/28/23 BG's 68-330 mg/dl less than 100mg/dl 10 times over one week, reduce insulin glargine and aspart, update labs in November. On 09/13/23 reviewed glucose levels and no changes. On 10/04/23 reviewed glucose levels and noted [R6] has had some relative hypoglycemia with recent changes, and we need to reduce [R6's] dose of insulin glargine. Reduce insulin glargine to 24 units subcutaneously every night. On 11/07/23 reviewed glucose levels and no changes. On 02/29/24 reviewed glucose levels were low 100s before breakfast, 200 range at lunch, 300-500 at supper, and 192-493 at bedtime. If it is covered, [R6] might be a good candidate for Farxiga to manage BG's . Surveyor reviewed blood sugar results for morning (AM) and bedtime (HS) results in the past week stated in part, -03/07/24 AM result at 8:29 AM 89 -03/07/24 HS result at 8:27 PM 296 -03/08/24 AM result at 8:05 AM 85 -03/08/24 HS result at 9:03 PM 167 -03/09/24 HS result at 9:06 PM 67 -03/10/24 AM result at 9:34 AM 62 -03/10/24 HS result at 10:03 PM 66 -03/11/24 AM result at 9:48 AM 80 -03/11/24 HS result at 10:57 PM 266 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-03/12/24 AM result at 9:39 AM 90 -03/12/24 HS result at 9:09 PM 250 Surveyor noted during review of recent blood sugars, R6 had low morning blood sugars. Observations: On 03/13/24 at 8:27 AM, Surveyor observed Medication Aide (MA) G enter R6's room and gather Blood Sugar (BG) monitoring supplies. R6's BG result was 108. R6 stated, I am not feeling well this morning, and am extra tired. MA G indicated to R6 that maybe R6 was just tired. On 03/13/24 at 8:58 AM, Surveyor observed MA G enter R6's room, grab the Novolog insulin pen and administer 8 units in the upper left quadrant of R6's abdomen. Surveyor asked R6 if R6 had breakfast yet. R6 indicated that R6 had not had breakfast yet but R6 was super sleepy. R6 stated, I am seeing things and not feeling well, what is today's date. MA G indicated to R6 that MA G would relay this information to the charge nurse as that did seem odd that R6 was seeing things that were not there. On 03/13/24 at 9:01 AM, Surveyor interviewed MA G and asked if it was a normal process to give insulin before breakfast was delivered. MA G indicated that R6 will get R6's breakfast tray shortly after giving insulin. MA G indicated that R6 usually receives meals right after giving insulin. On 03/13/24 at 9:05 AM, Surveyor observed MA G go to Licensed Practical Nurse (LPN) C and state that R6 was acting kind of weird and seeing things that were not there. LPN C indicated that LPN C would go in and check on R6 in a little while. On 03/13/24 between 8:58 AM to 9:52 AM, Surveyor observed R6 did not have breakfast nor had been offered breakfast. Surveyor did not observe anyone go into R6's room to re-check on R6 for the possible symptoms of hallucinations and tiredness. On 03/13/24 at 9:52 AM, Surveyor did not observe R6 eating or a breakfast tray in R6's room. Surveyor interviewed LPN C and asked if R6 had received breakfast yet as R6 received R6's 8 units of Novolog insulin at 8:58 AM. LPN C indicated that LPN C would ask R6. Surveyor observed LPN C enter R6's room and ask R6 if R6 had eaten breakfast and R6 stated, Not yet I am not very hungry, but I will take a banana as I don't feel good. LPN C exited R6's room to grab a banana. LPN C asked R6 about R6 seeing things that were not there. R6 indicated that she doesn't feel good and doesn't know why she is seeing things. LPN C stated to R6 that maybe anxiety medication needed to be adjusted. LPN C also indicated to Surveyor that R6 should not have had insulins before R6's breakfast meal if R6 was not eating breakfast. On 03/13/24 at 9:54 AM, LPN C exited R6's room to grab a banana for R6. On 03/13/24 at 9:57 AM, Surveyor observed LPN C enter R6's room and handed R6 a banana. LPN C exited R6's room and approached MA G explaining that insulin is to not be given unless food is given to R6 first. LPN C instructed MA G to recheck R6's BG in 15-20 minutes. Surveyor did not observe a BG check immediately performed once LPN C knew R6 did not have breakfast after administering short-acting insulin and was symptomatic. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/13/24 at 10:15 AM, Surveyor observed MA G enter R6's room and recheck BG. R6's BG result was 108, 18 minutes after R6 ate the banana. On 03/13/24 at 11:48 AM, Surveyor interviewed Director of Nursing (DON) B and asked what expectations are for nursing staff administering fast-acting insulins to residents before meals. DON B indicated that nursing staff is to follow physician orders for any special orders about insulin administration, but that the standard of practice is that fast-acting insulin be given no earlier than 15-30 minutes before meals. Surveyor informed DON B that R6 received R6's Novolog an hour before R6 was offered food. DON B indicated that R6 has special orders regarding R6's insulins as R6's BG's have been fluctuating. R6 has had low blood sugars at times. DON B indicated that R6 visits an endocrinologist and since R6 does sleep in a lot she receives long-acting insulin in a more scheduled controlled environment but R6 should not be receiving R6's short-acting any earlier than 30 minutes before R6's meals.

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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. 47807 Example 1 Based on observations and interview, the facility did not ensure dietary staff prepared and distributed food in accordance with professional standards of practice. This has that potential to affect all 44 residents. The facility did not ensure that the hot water dishwashing machine was reaching adequate temperatures to prevent the spread of disease. Dietary staff observed not washing hands in between glove use. Dietary staff touching food with contaminated gloves. Findings include: On 03/13/24 at 11:43 AM, Surveyor reviewed the dishwashing temperature log and noted that for the month of March, there were four rinse cycle temperatures recorded below 180 degrees +/- 2 degrees. The dates of the low temperatures were 03/05/34, 03/06/34, 03/08/24, and 03/12/24. On 03/13/24, Surveyor reviewed the manual for dishwasher CMA-180VL which recommends that the rinse cycle for the hot water dishwasher be between 180 degrees Fahrenheit and 195 degrees Fahrenheit. On 03/13/24, Surveyor reviewed the dishwashing temperature log for the month of February. In February there were 46 instances out of 96 opportunities where temperatures recorded were lower than the recommended 180 degrees. On the February log, it documents the Dietary Manager (DM) H does a weekly check of the proper rinse cycle temperature. On 03/13/24 at 1:30 PM, Surveyor interviewed Dietary Aide (DA) L regarding dishwashing. DA L stated the rinse cycle is running at about 180 degrees and if it is lower they will tell DM H. DA L was not sure how low the temperature would need to be to alert DM H. On 03/13/24 at 1:33 PM, Surveyor interviewed DA M regarding dishwashing. DA M said staff do record the temperatures for the rinse and wash cycle and when. Surveyor asked what temperature staff would need to record to alert DM H of a concern. DM H stated, probably around 140 degrees Fahrenheit. On 03/13/24 at 1:39 PM, Surveyor interviewed DM H regarding the dishwasher temperatures. DM H said the rinse cycle should be above 180 degrees. Surveyor asked why they had many recorded temperatures that did not reach the 180-degree threshold. DM H said staff are not recording the proper temperatures. DM H said they do weekly checks to make sure the machine is working properly. DM H expects that any temperature below 180 degrees be reported, so they can make sure the dishwasher is working properly. 43352 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Example 2 The facility policy, entitled Nutritional Services Procedure General Food Handling Guidelines, with an effective date of January 2017, reads in part 1. Single-use gloves, tongs, deli paper or another barrier will be utilized when handling food directly. 4. Hands are to be washed when entering the kitchen and before putting on single-use gloves. The facility policy, entitled Nutritional Services Procedure General Food Handling Guidelines, with an effective date of January 2017, reads in part 1. Single-use gloves, tongs, deli paper or another barrier will be utilized when handling food directly. 4. Hands are to be washed when entering the kitchen and before putting on single-use gloves. On 03/12/24 at 11:40 AM, Surveyor entered kitchen to observe lunch preparation. Surveyor observed [NAME] I put on gloves, open a drawer, grab a knife, open the butter dish then buttered 4 pieces of bread with the same contaminated gloved hands that had just touched other contaminated surfaces. At 11:50 AM, Surveyor observed [NAME] I with gloved hands grab a metal container off the shelf, with same gloved hands opened the sealed plastic on a rack of buns and picked up the buns with the same gloved hands that just touched other contaminated surfaces. [NAME] I picked up each bun and put them into the metal container. [NAME] I removed gloves, went and got a second container to put the remaining buns in the container. [NAME] I put on a new pair of gloves without washing her hands and picked up the rest of the buns in the package and moved them to a metal container. On 03/12/24 at 12:00 PM, Surveyor observed [NAME] J wash hands, put on gloves, open up the steam table lids to start serving lunch, then open a loaf of bread. [NAME] J grabbed 2 slices of bread from the package with her same gloved hands that had just touched other surfaces. [NAME] J continued dishing up the rest of the meal with the same contaminated gloves. [NAME] J took a meal ticket, then a bun with the contaminated gloved hands. [NAME] J then went to the warmer, opened the door grabbed a bowl out, then with the same contaminated gloved hands grabbed a bun from the container, tore up the bun into bite size pieces and continued serving lunch. [NAME] J did not change gloves, wash hands or put on new pair of gloves. 48793 Example 3 On 03/12/24 at 12:03 PM, Surveyor observed [NAME] K grab a plate with [NAME] K's left gloved hand, and then [NAME] K grabbed buns with [NAME] K's left gloved hand. [NAME] K separated buns with both gloved hands and used a spoon to place sloppy joe mix on the bottom side of the bun, then grabbed the top bun and placed it on the sandwich with both gloved hands. [NAME] K handed the tray to the staff who delivered the lunch tray to R2. On 03/12/24 at 12:05 PM, Surveyor observed [NAME] K grab a plate with [NAME] K's left gloved hand, and then [NAME] K grabbed buns with [NAME] K's left gloved hand. [NAME] K separated buns with both gloved hands and used a spoon to place sloppy joe mix on the bottom side of the bun, then grabbed the top bun and placed it on the sandwich with both gloved hands. [NAME] K handed the tray to the staff who delivered the lunch tray to R245. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/12/24 at 12:07 PM, Surveyor observed [NAME] K grab a plate with [NAME] K's left gloved hand, and then [NAME] K grabbed buns with [NAME] K's left gloved hand. [NAME] K separated buns with both gloved hands and used a spoon to place sloppy joe mix on the bottom side of the bun, then grabbed the top bun and placed it on the sandwich with both gloved hands. [NAME] K handed the tray to the staff who delivered the lunch tray to R18. On 03/12/24 at 12:09 PM, Surveyor observed [NAME] K grab a plate with [NAME] K's left gloved hand, and then [NAME] K grabbed buns with [NAME] K's left gloved hand. [NAME] K separated buns with both gloved hands and used a spoon to place sloppy joe mix on the bottom side of the bun, then grabbed the top bun and placed it on the sandwich with both gloved hands. [NAME] K handed the tray to the staff who delivered the lunch tray to R5. On 03/13/24 at 1:33 PM, Surveyor interviewed Dietary Manager (DM) H and asked about hand hygiene with serving food to residents such as touching buns with the same gloved hands that have touched utensils, plates, and other equipment. DM H indicated that staff are to change gloves in between touching utensils, plates, or any surfaces before touching buns or ready-to-eat foods.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47807 Based on observation, interview and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility did not properly wipe down lifts after use (R35, R13), did not perform proper hand hygiene (R35, R95) when performing wound care, and did not ensure proper infection control techniques during medication pass (R6). This has the potential to affect 4 residents. Findings include: Example 1 The facility policy, entitled, Durable Medical Equipment Cleaning Procedure dated March 2021, states: 2. Device parts that come in contact with resident's intact skin should be cleaned after contact made/or prior to use with the next resident. a. This equipment may include but not limited to . lift equipment, slings and other items identified as common use equipment On 03/13/24 at 8:50 AM, Surveyor observed Certified Nursing Assistant (CNA) F complete morning cares for R35 who was on contact precautions for Clostridioides Difficile (C.Diff). After transferring R35 with a Hoyer lift, CNA F pushed the Hoyer lift down the hall to a designated resting spot. CNA F then left the Hoyer lift and did not wipe it down. CNA F moved on to help with the next resident who required help. Surveyor did stop CNA F and ask what they were planning to do after not wiping down the Hoyer lift. CNA F said they were going to help with the next resident. Surveyor asked CNA F when would they wipe down lifts. CNA F said after each use especially when leaving a room where someone is on contact precautions. CNA F said they had just forgotten to wipe down the lift in their rush to get to the next resident in need. On 03/13/24 at 9:27 AM, Surveyor observed CNA E transfer R13 into their wheelchair before heading to an appointment. During the transfer, R13 did place their hands on the sit-to-stand lift. CNA E had touched other items in the room and did have contaminated hands. After the transfer, CNA E pushed the lift down the hallway and placed it in the designed lift area. CNA E left the lift and walked down the hallway to help the next resident. Surveyor did stop CNA E and ask if they had sanitized the lift after use. CNA E said they did not because they did not do anything with R13 that was dirty like incontinence care, they were simply moving R13 into their wheelchair. On 03/13/24 at 12:02 PM, Surveyor interviewed Director of Nursing (DON) B regarding expectations of sanitizing lifts after use. DON B would expect that lifts be sanitized after each use. 40181 Example 2 Findings include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility policy entitled, Dressing Change Procedure, last reviewed 09/23, stated in part: .13. Remove gloves. 14. Sanitize hands and put on a new pair of gloves . On 03/13/24 at 8:03 AM, Surveyor observed wound care performed for R35 by Licensed Practical Nurse (LPN) C. Surveyor observed a sign outside R35's door stating contact precautions. LPN C stated R35 had wound cultures in the past showing Methicillin-Resistant Staphylococcus aureus (MRSA), so R35 was on contact precautions for cares. LPN C used alcohol-based hand rub (ABHR) and donned a gown and gloves prior to entering R35's room. Certified Nursing Assistant (CNA) F was already in the room with gown and gloves on when Surveyor entered the room. CNA F assisted R35 to turn on left side toward the wall. LPN C pulled down R35's pajama bottoms and unfastened brief. LPN C removed the old wound dressing and incontinent brief and threw in the trash. LPN C removed gloves, used ABHR and went to bathroom to obtain saline out of a bin in the bathroom. LPN C placed the saline container on the over bed table and put on clean gloves. LPN C did not use ABHR after touching multiple surfaces in the bathroom before putting on clean gloves. LPN C cleansed wounds and packed left wound with gauze per orders. LPN C removed gloves and put on clean gloves. LPN C did not sanitize hands before putting on clean gloves. LPN C cut a piece of calcium alginate with scissors and dabbed santyl ointment on right buttocks wound with the finger of one glove and then covered with the calcium alginate. LPN C removed gloves and applied clean gloves. LPN did not sanitize hands after removing old gloves and putting on clean gloves. LPN C completed the cares without further concern for infection control and washed hands with soap and water after the procedure. Surveyor interviewed LPN C immediately after the procedure. LPN C stated they should have washed hands or used ABHR between each glove change but did not do that with each glove change during this procedure. On 03/13/24 at 8:22 AM, Surveyor observed CNA E and LPN C enter R95's room to transfer R95 to the recliner to perform wound care. Surveyor observed a sign outside R95's room that stated contact precautions. Both CNA E and LPN C had put on proper PPE for contact precautions prior to entering R95's room. After LPN C had removed the gripper sock, ace wrap, tubigrip and old gauze dressing from R95's right leg, LPN C removed gloves, used ABHR and called on walkie talkie for pain medication. LPN C put on clean gloves after touching the walkie talkie without sanitizing hands. LPN C removed sock, ace wrap, tubigrip and old gauze dressing from R95's left leg. LPN C removed gloves, used ABHR, and called on walkie talkie again for pain medication and supplies. LPN C put clean gloves on without sanitizing hands after touching walkie talkie. LPN C continued wound care to legs with proper infection control procedures. LPN C was working on the back of R95's left leg, LPN C placed R95's bare left heel on LPN C's knee. R95's heel was directly on LPN C's uniform, as the isolation gown was hanging between LPN C's knees. LPN C continued wound care to legs with proper infection control procedures. LPN C removed gloves, used ABHR, cut tubigrip for left leg, and called on walkie talkie again. LPN C did not use ABHR after touching walkie talkie. LPN C got more roll gauze from a drawer in the bathroom, and put on clean gloves without sanitizing hands prior to putting on clean gloves. LPN C placed xeroform dressings on R95's left leg and removed gloves. LPN C did not use ABHR and opened more xeroform dressing packages. LPN C put on clean gloves without sanitizing hands and completed wound care procedure without further infection control concerns. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/13/24 at 2:14 PM, Surveyor interviewed DON B and Infection Preventionist (IP) D. Surveyor informed DON B and IP D of observations of no hand hygiene between glove changes during wound care observation for R35 and R95. They stated all staff should perform hand hygiene every time they change their gloves during wound care. 48793 Example 3 On 03/13/24 at 8:27 AM, Surveyor observed Medication Aide (MA) G prep R6's medications. MA G primed the Novolog pen and then drew a total of 8 units. MA G primed the Glargine pen and then drew a total of 10 units. MA G set insulin pens on top of medication cart. On 03/13/24 at 8:37 AM, Surveyor observed MA G grab R6's two insulin pens off the medication cart and place them in MA G's scrub pockets on MA G's shirt. On 03/13/24 at 8:58 AM, Surveyor observed MA G enter R6's room, grab R6's Novolog insulin pen out of MA G's scrub pocket, and administer 8 units in the upper left quadrant of R6's abdomen. MA G placed R6's Novolog insulin pen on R6's bedside table. MA G grabbed R6's Glargine insulin pen out of MA G's scrub pocket and administered 10 units in the lower left quadrant of R6's abdomen. MA G placed R6's Glargine insulin pen on R6's bedside table. MA G recapped both insulin pens and placed insulin pens in MA G's scrub pocket. On 03/13/24 at 9:01 AM, Surveyor interviewed MA G and asked if it was a normal process to place resident medications in personal pockets when walking into residents' rooms to administer medications. MA G indicated that MA G shouldn't have placed R6's insulin pens in pockets and this is not the best practice. On 03/13/24 at 11:55 AM, Surveyor interviewed IP D and asked about expectations for infection control practices during medication administration such as insulin pens and how staff carry insulin pens to and from resident rooms. IP D indicated the expectation is that all nursing staff use standards of practice for hand hygiene and glove use. IP D indicated that most staff utilize pushing medication carts close to where their medications are being dispersed. IP D indicated that MA G should not have placed R6's insulin pens in MA G's scrub pocket.