STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020064	A. BUILDING: _____ B. WING _____	C 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOVE HEALTHCARE ORCHARD HILLS ASSISTED LIV	1403 TRUAX BLVD EAU CLAIRE, WI 54703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 07/09/2025, Surveyor conducted a probationary survey and complaint investigation at Dove Healthcare Orchard Hills Assisted Living. Data collection continued through 07/11/2025. The complaint was unsubstantiated. Six deficiencies were identified. Census: 36	N 000		
N 200	83.14(2)(e) Notify within 7 days of administrator change The licensee shall notify the department within 7 days after there is a change in the administrator. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not notify the department within 7 days after there was a change in the administrator. Findings include: On 07/09/2025 at approximately 11:00 AM, Surveyor entered the facility and asked to speak to the designated administrator for the facility. Director A introduced him/herself and stated s/he was in charge of the facility. Surveyor asked if Administrator B was still employed as s/he was listed as the administrator per department records. Director A informed Surveyor that Administrator B was no longer with the company, effective 04/01/2025. Campus Administrator (CA) C informed Surveyor that Director A should be the listed administrator for the facility.	N 200		

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

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N 200	Continued From page 1 When asked if the Department was notified of the change, Director A and CA C stated they were not sure. On 07/10/2025, Surveyor reviewed the facility's electronic file for any correspondences related to the administrator change, effective 04/01/2025. No communication had been received regarding the change from Administrator B to Director A.	N 200		
N 284	83.26(2) Orientation, continuing education documented Employee orientation and hours of continuing education shall be documented in the employee ' s file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 employee records had documentation of orientation. Findings include: On 07/09/2025, Surveyor requested to review a sample of 3 employee records for orientation documentation. Caregiver D had a hire date of 04/23/2025. The record for Caregiver D did not have documentation of orientation. On 07/10/2025 at approximately 2:55 PM, Surveyor interviewed Caregiver D via phone and asked if s/he had completed and received orientation training upon hire. Caregiver D stated s/he did receive orientation and recalled signing	N 284		

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N 284	Continued From page 2 off on an orientation checklist but informed Surveyor it had gotten misplaced. Caregiver D stated his/her supervisor was trying to locate it. On 07/10/2025 at 3:47 PM, Surveyor received an email from Director A stating s/he was unable to locate training documentation for Caregiver D.	N 284		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not develop a comprehensive individual service plan (ISP) that identified all of the residents' needs for 2 of 2 residents reviewed. Findings include: On 07/09/2025, Surveyor requested a sample of resident records to review, including the	N 386		

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N 386	Continued From page 3	N 386		

comprehensive ISP and current ISP on file.

Resident 1

Resident 1 had an admission date of 05/07/2025.

On 07/09/2025 at approximately 1:00 PM, Surveyor observed Resident 1 in his/her room. Resident 1 was seated in an electric wheelchair. Resident 1 stated, "Staff help me get dressed because only the right arm works. They do my meds (medications), laundry, make my bed and help me in the shower every Wednesday, or more if I request more showers. They also put a cream on my head for this rash I have."

Surveyor reviewed Resident 1's ISP, received from Nurse H. The ISP did not contain signatures or a date. The ISP documented Resident 1 had "no skin concerns."

Surveyor reviewed Resident 1's medication administration record (MAR). The MAR for July 2025 documented staff administered the following order: "Ammonia Lactate External Lotion 12%- Apply to face topically two times a day."

Resident 3

Resident 3 had an admission date of 05/15/2025.

On 07/09/2025 at approximately 1:20 PM, Surveyor interviewed Resident 3 in his/her room. Resident 3 was seated in the recliner, wearing a call pendant around his/her neck, and was receiving 1 liter of oxygen from the concentrator located next to the recliner. Resident 3 informed Surveyor s/he uses oxygen "all the time," and received 1 liter during the day, and 3 at night. When asked if Resident 3 received other

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N 386	Continued From page 4 treatments, Resident 3 pointed to a nebulizer machine on the nightstand. Resident 3 stated s/he used it periodically, or "at times" daily. There was also a wheelchair parked in the corner of Resident 3's room, and a toilet riser installed on Resident 3's bathroom toilet. Surveyor reviewed Resident 3's ISP, received from Nurse H. The ISP did not contain signatures or a date. The ISP did not identify Resident 3's current needs for continuous oxygen use, nebulizer treatments, use of the call pendant, or the toilet riser installed in the bathroom. On 07/09/2025 at approximately 1:30 PM, Nurse H confirmed the ISPs provided to Surveyor were the current ISPs on file and were the comprehensive 30-day ISPs. On 07/11/2025 at approximately 11:30 AM, Nurse H confirmed via phone that the ISPs did not include the above items for Resident 1 and Resident 3. Nurse K informed Surveyor the provider had recently switched to a new charting system and would remedy the issue immediately to ensure ISPs were comprehensive for each resident.	N 386		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal	N 387		

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N 387	Continued From page 5 illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not involve the resident in developing the individual service plan (ISP). ISPs were not signed by the resident acknowledging their involvement in, understanding of, and agreement with the plan, for 2 of 2 resident ISPs reviewed. Findings include: On 07/09/2025, Surveyor requested to review Resident 1 and Resident 2's signed ISPs on file. Resident 1 Resident 1 had an admission date of 05/07/2025 and was listed as his/her own decision-maker. On 07/09/2025, Surveyor reviewed Resident 1's ISP, received from Nurse H. The ISP did not contain signatures or a date. At approximately 1:05 PM, Surveyor interviewed Resident 1 and asked if s/he had seen his/her written ISP or was involved in a care plan meeting with staff regarding his/her care needs. Resident 1 stated s/he had not seen the ISP document, and did not participate in a care plan meeting with staff.	N 387		

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N 387	Continued From page 6 Resident 3 Resident 3 had an admission date of 05/15/2025 and was listed as his/her own decision-maker. On 07/09/2025, Surveyor reviewed Resident 3's ISP. received from Nurse H. The ISP did not contain signatures or a date. At approximately 1:15 PM, Surveyor interviewed Resident 3 and asked if s/he had seen his/her written ISP or was involved in a care plan meeting with staff regarding his/her care needs. Resident 3 stated s/he could not recall whether or not s/he had seen the ISP document, and stated s/he could not see the small print. Resident 3 could not recall if s/he had met with staff to discuss his/her care needs. On 07/09/2025 at approximately 1:40 PM, Nurse H informed Surveyor s/he was unable to locate signature pages for ISP reviews. Nurse H acknowledged the discrepancy and stated they would ensure ISP reviews are completed with the resident and/or resident's legal representative, as appropriate going forward.	N 387		
N 393	83.35(5)(a) Initial evaluation of evacuation limitations. Initial evaluation. The CBRF shall evaluate each resident within 3 days of the resident ' s admission to determine whether the resident is able to evacuate the CBRF within 2 minutes in an unsprinklered CBRF and 4 minutes in a sprinklered CBRF without any help or verbal or physical prompting, and what type of limitations that resident may have that prevent the resident from evacuating the CBRF within the applicable period of time. A form provided by the	N 393		

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N 393	Continued From page 7 department shall be used for the evaluation. The resident ' s evaluation shall be retained in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 residents were evaluated for evacuation capabilities within 3 days of admission. Findings include: On 07/09/2025, Surveyor reviewed a sample of 3 resident records for documentation of initial evacuation assessments. Resident 1 had an admission date of 05/07/2025. The record did not contain an evacuation assessment. Resident 2 had an admission date of 03/17/2025. The record contained an evacuation assessment, dated 06/03/2025; approximately 2.5 months after admission. On 07/09/2025 at approximately 1:00 PM, Surveyor interviewed Resident 1 and asked if s/he was evaluated upon admission for evacuation capabilities. Resident 1 stated s/he had not participated in a fire drill, and did not recall being assessed for evacuation in the event of an emergency. On 07/09/2025 at approximately 3:15 PM, Surveyor interviewed Nurse H regarding evacuation assessments. Nurse H informed Surveyor the nursing staff was responsible for assessments. Nurse H confirmed Resident 1 did not have an evacuation assessment on file, and	N 393		

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N 393	Continued From page 8 Resident 2's evacuation assessment was late. Nurse H stated the provider would ensure compliance going forward.	N 393		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire drills were conducted with both employees and residents. Documentation did not include record of residents having an evacuation time greater than the time allowed under DHS 83.35(5), and the type of assistance needed for evacuation. Findings include: On 07/09/2025, Surveyor requested quarterly fire	N 525		

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N 525	Continued From page 9 drills for 2025. Two drills were received with the following information: -01/22/2025: date, alarm start time, alarm stop time and employee signatures. -04/28/2025: date, alarm start time, alarm stop time and employee signatures. The above drills did not document residents having an evacuation time greater than the time allowed under DHS 83.35(5), and the type of assistance needed for evacuation. On 07/09/2025 at approximately 11:50 AM, Surveyor discussed the requirement for resident participation in drills and documentation requirements. Campus Administrator (CA) C informed Surveyor the 04/28/2025 drill was a "silent" drill for staff only. CA C confirmed residents did not participate in the drill. On 07/09/2025 at approximately 3:30 PM, Surveyor discussed the requirements with Maintenance Director (MD) G, who requested clarification on fire drill requirements as s/he was new to his/her role. MD G stated s/he would review the requirements to ensure compliance going forward.	N 525		