STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525369	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wausau Manor Health Services	3107 Westhill Dr Wausau, WI 54401

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to provide privacy during wound care for one of three residents (R) 3, reviewed for wound care out of a total sample of 6 residents. This failure had the potential for R3 to experience embarrassment or feeling exposed during treatment. Findings include: Review of R3's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R3 was admitted to the facility on [DATE]. Review of R3's admission Evaluation - V3, located under the Assessments tab in the EMR and dated 08/14/25 at 6:44 PM, indicated R3 was alert and oriented to person, place, time, and situation. Review of R3's Physician Orders, located under the Orders tab in the EMR, indicated an order dated 08/19/25 for Left Buttock wound, Sacral redness, and Bilateral Buttock redness: Cleanse with NS [Normal Saline], pat dry, and apply Periguard Ointment every day and evening shift for wound healing and as needed for wound healing. During the wound care observation on 08/21/25 at 11:22 AM, R3 stood using a walker for wound care to be provided to R3's buttocks and sacral area. R3 unbuttoned his pants and underwear and lowered both articles of clothing to mid-thigh level. R3's blinds, covering the window, were left open while the wound care was being performed by Registered Nurse (RN) 1. RN1 did not ask R3 if he wanted the blinds to be shut prior to the start of the wound care. Anyone that would walk by the window would be able to see that R3 was having wound care performed to his buttocks. During an interview on 08/21/25 at 11:35 AM, RN1 confirmed she should have closed the blinds before performing wound care to R3's sacral area. During an interview on 08/21/25 at 11:37 AM, R3 was asked about the window blinds that were left open during wound care. R3 stated, Sure, it would bother me if someone saw me. I would prefer them [staff] to close the blinds. During an interview on 08/21/25 at 2:00 PM, the Interim Director of Nursing (IDON) stated, I expect the nurses to provide dignity and respect when performing wound care to a resident by closing the blinds prior to wound care.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525369	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wausau Manor Health Services	3107 Westhill Dr Wausau, WI 54401

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525369	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wausau Manor Health Services	3107 Westhill Dr Wausau, WI 54401

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and Centers for Disease Control and Prevention (CDC) guidance, the facility failed to follow infection control guidelines during a wound care observation for two of two residents resident (R), R2 and R3, observed for wound care and failed to follow Enhanced Barrier Precautions during a dressing change for R3. This failure had the potential for R2 and R3 to be exposed to infections. Findings include:Review of the CDC webpage titled, Clinical Safety: Hand Hygiene for Healthcare Workers, updated 02/27/24, revealed to change gloves and clean hands when moving from work on a soiled body site to a clean body site. Review of the CDC webpage titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), updated 04/02/24 revealed EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities and apply to residents with wounds.1. Review of R2's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R2 was admitted to the facility on [DATE] with the diagnosis of peripheral vascular disease and type two diabetes mellitus. Review of R2's admission Minimum Data Set (MDS), located under the MDS tab in the EMR, with an Assessment Reference Date (ARD) of 06/29/25 indicated R2 had been coded as having a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R2 was cognitively intact. Review of R2's Care Plan, located under the Care Plan tab in the EMR and dated 08/13/25, had a Focus which indicated, Actual ABRASION TO RIGHT KNEE, RIGHT LOWER LATERAL CALF PROXIMAL TO ANKLE, AND TIGHT ANTERIOR SHIN [sic]. Interventions indicated, Administer treatment per MD [Medical Doctor] orders, Report evidence of infection such as purulent drainage, swelling, localized heat, increased pain, etc. Notify MD [Medical Doctor] PRN [as needed]. Review of R2's Physician's Orders located under the Orders tab in the EMR indicated an order dated 08/20/25 Right lower calf/proximal to ankle, right knee and right anterior shin: Cleanse sites with NS [normal saline], pat dry. Apply skin prep peri wound cut Dermaginate AG [silver] to size and apply. Cover with bordered foam dressing. During a wound care observation on 08/21/25 at 10:20 AM, Licensed Practical Nurse (LPN) 1 placed a towel down on the top of the bed, and then proceeded to place clean dressing supplies on the towel. LPN1 removed the old dressing to the right knee and cleaned the wound bed with normal saline. Then LPN1 using the same gloves that the old dressing was removed with, applied skin prep to the peri wound and then discarded the gloves, sanitized her hands, and then donned a new pair of gloves on. LPN1 proceeded to perform the dressing change as documented above for each of the other wounds. LPN1 finished the wound care and stepped outside the resident's door in the hallway and removed her personal protective equipment (PPE) which consisted of a gown and gloves. During an interview on 08/21/25 at 11:40 AM, LPN1 stated, I thought placing skin prep around the wound was part of the cleaning the wound. That was why I did not change my gloves. LPN1 was asked about the towel placed on the bed that the clean supplies we placed on. LPN1 stated, I put a barrier down, so I feel it was okay to do. LPN1 stated she should have removed the gown prior to exiting the room and placed it in the bin in the room. 2. Review of R3's undated Face Sheet located under the Profile tab in the EMR indicated R3 was admitted to the facility on [DATE] with a diagnosis of type two diabetes mellitus. Review of R3's admission Evaluation - V3, located under the Assessments tab in the EMR and dated 08/14/25 at 6:44 PM, indicated R3 was alert and oriented to person, place, time, and situation. Review of R3's Physician Orders, located under the Orders tab in the EMR, indicated an order dated 08/19/25 for Left Buttock wound, Sacral redness, and Bilateral Buttock redness: Cleanse with NS [Normal Saline], pat dry, and apply Periguard Ointment every day and evening shift for wound healing and as needed for wound healing. During the wound care observation on 08/21/25 at 11:22 AM, Registered Nurse (RN) 1 placed a barrier on the overbed table without cleaning it first. RN1 then proceeded to clean the left buttock wound, bilateral buttocks, and sacral areas with NS. RN1 patted these areas dry with a 4x4. RN1 applied Periguard Ointment to these areas using a tongue blade. RN1 wore gloves but did not wear a gown while performing this wound care. During an interview on 08/21/25 at 1:35 PM, RN1 stated, I didn't wear a gown because [R3] wasn't in Enhanced Barrier Precautions. When asked if R3 should be in EBP, RN1 stated, Yes, because [R3] has an open wound. When asked if a tongue blade should have used to apply the ointment to R3's buttocks RN1 stated, That's what I was told to apply it with. During an interview on 08/21/25 at 11:50 AM, the Infection Preventionist (IP) stated, I expect them [nurses]