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	10/02/2025

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 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. Based on observation, interview and record review, the facility did not maintain a safe and sanitary environment in which food is prepared and distributed. This has the potential to affect all 56 residents who reside in the facility.Facility staff did not conduct appropriate hand hygiene during food preparation and were observed touching ready to eat foods with contaminated gloved hands.This is evidenced by:The facility policy, titled Food Preparation, revised last 9/2017, states: All Foods are prepared in accordance with the FDA Food Code.1. All staff will practice proper hand washing techniques and glove use.The facility policy, titled Hand Washing- Food and Nutrition Services, revised last 8/16/22, states: Employees will wash hands as frequently as needed throughout the day using proper hand washing procedures1. When to wash:a. When entering the kitchen.g. During food preparation, as often as necessary to remove soil or contamination and to prevent cross contamination when changing task.i. Before donning disposable gloves for working with food and after gloves are removed.On 9/30/25 at 11:21 AM, Surveyor started the observation of the kitchen preparing and serving foods. Surveyor observed [NAME] (CK) I miss opportunities for washing hands. At 11:25 AM, CK I took off CK I's gloves after serving food to be taken to unit; CK I did not wash CK I's hands after taking off gloves and left the kitchen. At 11:32 AM, CK I came back into kitchen, did not wash CK I's hands, put on gloves and adjusted food pans in warming table with contaminated hands and prepared to serve food. At 11:38 AM, CK I took the bread bag, jelly, and peanut butter out, with contaminated hands. CK I made a sandwich. CK I took off gloves and left the kitchen, no hand washing or hygiene. At 11:53 AM, CK I came back into the kitchen with lunch tickets. CK I did not wash CK I's hands after entering the kitchen. With contaminated hands adjusted position of plate warming cart, removed tinfoil off food items in steamer table and served food onto plates. At 11:55 AM, CK I washed her hands, but using bare fingertips, opened the lid of garbage can at corner and threw paper towel away. CK I then put on gloves on her contaminated hands and went back to serving food. At 12:33 PM, CK I turned heat on steamer table off, took off CK I's gloves, washed CK I's hands but using CK I's bare fingertips to open garbage lid to throw away. Other staff observed using the foot pedal on garbage; foot pedal was in working order. At 12:35PM, CK I put new gloves on CK I's contaminated hands and made a second peanut butter sandwich. On 9/30/25 at 11:21 AM, Surveyor was stationed in a position to observe both CK I and Dietary Aide (DA) J. Surveyor observed DA J miss opportunities for hand washing. At 11:26 AM, Surveyor observed DA J make chef salads. DA J finished putting lettuce in bowls with gloved hands, took off gloves, without washing her hands, started spooning tomatoes on salad. Once done putting tomatoes on salad, DA J put new gloves on her contaminated hands and put cheese with her hands on the salads. At 11:34 AM, DA J took off gloves, without washing her hands, put on new gloves, got a new sheet pan, bowls, and brought over to the salad making station. DA J with same contaminated gloves, reached into lettuce bag and started filling the bowls on the pan. DA J took off DA J's gloves and did not wash DA J's hands. DA J retrieved a cutting board and knife, put gloves on DA J's contaminated hands and started cutting more tomatoes. At 11:51 AM, DA J put gloves on still unwashed hands and started adding tomatoes to salads with spoon. DA J took gloves off, put new gloves on contaminated hands, and again used contaminated (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	hands to put cheese on salads. No hand washing between gloves. On 9/30/25 at 3:03 PM, Surveyor interviewed Dietary Manager (DM) K who stated, you should never use hands to touch food. DM K expects dietary staff to wash hands before coming into the kitchen or before leaving the kitchen. DM K stated staff wear gloves when dealing with raw meat and ready to eat foods. Staff should change gloves after touching meat or when they are soiled. DM K expects dietary staff to wash hands in between using gloves. DM K stated hands should be washed when taking gloves off your hands, before putting them on, all the time. DM K stated gloves never replace the need of washing hands.On 10/1/25 at 11:21 AM, Surveyor interviewed DA J who stated you wash your hands when you come in, leave the kitchen and if you start a new task. DA J stated DA J should wash hands between gloves.On 10/1/25 at 12:18 PM, Surveyor interviewed CK I who stated CKI washes CK I's hands when CK I enters the kitchen. CK I stated wash hands whenever they are dirty. Surveyor asked when gloves are worn in the kitchen. CK I stated when working with food; never touch ready to eat foods with bare hands. CK I stated you should change your gloves between tasks and if they get dirty. Surveyor asked do you have to wash hands if you wear gloves. CK I stated yes you should wash hands before you put on gloves and when you take them off.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and interview, the facility did not ensure garbage and refuse were properly disposed in the outside garbage storage receptacles. This has the potential to affect all 33 residents residing in the facility.This is evidenced by:The facility policy titled, Environment, last revised 9/2017, states: .All trash will be contained in covered, leak-proof containers that prevent cross contamination.According to State Operations Manual, Appendix PP: Guidance to Surveyors for Long Term Care Facilities, revised last 4-25-25, garbage receptacles should be covered to prevent the harborage and feeding of pests.On 9/29/25 at 11:30 AM, Surveyor observed garbage dumpster uncovered, right side lid was open. On 9/29/25 at 2:30 PM, Surveyor observed garbage dumpster uncovered, right side lid was open. Surveyor observed for 15 minutes to make sure it wasn't being used.On 09/30/25 at 9:30 AM, Surveyor interviewed the Environment Services Manager (ESM) O who stated, Waste Management come early on Monday, Wednesday, and Friday to take garbage.On 9/30/25 at 2:54 PM, Surveyor and Dietary Manager (DM) K observed garbage dumpster uncovered, right side lid open.On 9/30/25 at 2:54 PM, DM K stated that should be closed; they should never be left open.

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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. Based on observation, interview and record review, the facility did not maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections.Staff did not perform hand hygiene when changing gloves during resident cares and procedures for 4 of 12 residents (R). R31, R9, R5, R56Staff did not clean the mechanical lift in between patient use.Findings include:Facility policy and procedure titled, Hand Hygiene, dated 11/02/22, states in part: Hand Hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of antiseptic hand rub, also known as alcohol-based hand rub (ABHR).2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table.6. a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves .The attached Hand Hygiene Table, dated 11/2/2022, states in part: Alcohol Based Hand Rub or Soap and waterBetween resident contacts Before applying and after removing personal protective equipment, including gloves During resident care, moving from a contaminated body site to a clean body site After assistance wither personal body functions On 9/29/25 at 10:34 AM, Surveyor observed Certified Nursing Assistant (CNA) L approached R31's room and put on gloves, gown and mask without hand hygiene first. CNA L went into the room of R31 and applied the mechanical lift sling to R31. CNA H came into room to help, all PPE in place. CNA L and CNA H moved R31 to the bathroom, assisted R31 by pulling down the soiled brief and clothing, lift sling also removed while R31 was on toilet. With same contaminated gloves, CNA L assisted with clean brief and pants, while CNA H assisted with clean shirt for R31. Both CNAs stepped out of bathroom to allow privacy, took off gown and gloves and left room. CNA L walked down to R9's room. CNA H went back into R31's room and grabbed the mechanical stander. CNA H did not wipe down the mechanical lift prior to taking it out of the room and down the hall to R9's room. CNA H left the lift outside of R9's room and walked away. CNA H did not complete hand hygiene after leaving room and pushing lift down hall or walking away to the next task. On 9/29/25 at 10:52 AM, Surveyor observed CNA L push dirty mechanical lift into R9's room. Surveyor continuously observed the lift; it was not wiped down. CNA L did not complete hand hygiene before entering R9's room with contaminated lift. CNA L put mechanical lift sling on R9 and put on gloves on unwashed hands while waiting for assistance. With the assistance of CNA H, R9 was maneuvered to bathroom and lowered to toilet using the contaminated lift. CNA H left the room once R9 was on the toilet; no concerns with hygiene. CNA L stayed with R9 and burped R9's colostomy. CNA L removed CNA L's soiled gloves, and put on new gloves, with no hand hygiene. CNA L assisted R9 into wheelchair and touched clean items in R9's room with contaminated gloved hands. CNA L did not wash hands, complete hand hygiene, or change gloves until CNA L left the room at end of cares. CNA H came into R9's room to assist CNA L finish R9's cares. CNA H entered R9's bathroom and put on gloves. CNA H provided peri-care, pulled up R9's brief. With same contaminated gloves, CNA H pulled up R9's pants. Using the contaminated lift, CNA L and CNA H assisted R9 into R9's wheelchair. CNA L took lift out of room and pushed it back down to R31's room. CNA H took off CNA H gloves; no hand hygiene was conducted. CNA H started picking up R9's room and putting things in place, placing dirty into a garbage bag and took out of room. Surveyor followed CNA H to dirty utility; CNA H did not complete hand hygiene after R9's care, or when leaving R9's room and walking through facility to dirty utility. On 9/29/25 at 11:09 AM, Surveyor observed CNA L push mechanical lift to R31's room. CNA L maneuvered lift into bathroom, applied same sling from earlier, and with assist from CNA H, stood R31 up. CNA L completed peri-care, took off CNA L's right glove, put a new glove on CNA L's right hand, did not conduct hand hygiene and left glove remained in place. CNA L pulled up R31's brief and pants. With contaminated gloved hands, CNA L assisted with getting R31 into R31's wheelchair, removed lift sling from R31, positioned R31's glasses on R31's face, took R31's glasses off and cleaned them with a tissue, put R31's glasses back on and made sure R31 did not need anything else. CNA L disposed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gloves and left room, took dirty and garbage with him. CNA L opened dirty utility door, tossed away garbage, and came right back out. Observation was continuous; door did not get a chance to close. No hand hygiene observed between taking off gloves in R31's room, discarding things in dirty utility and going to the computer to chart. Example 2On 9/30/25 at 7:55 AM, Surveyor observed CNA M and Assistant Director of Nursing (ADON) G provide cares to R5. CNA M told ADON G that R5's groin was pink, and he needed to get a new draw sheet under R5. Both caregivers completed hand hygiene and put on appropriate PPE before entering R5's room. Both CNA and ADON G opened the brief on their respective sides. Both CNA M and ADON G gently touched and pulled apart R5's thighs so ADON G could assess redness. After, CNA M pulled tube from stand and applied cream to groin. ADON G reminded CNA M to put on fresh gloves. CNA M took off CNA M's gloves and put on new gloves, with no hand hygiene. CNA M asked if ADON G needed new gloves. ADON G stated ADON G did not need new gloves. Surveyor observed ADON G touch R5's brief and upper thigh to assess reported redness in the groin. With contaminated gloved hands, both reattached R5's used brief, rolled resident to get draw sheet under R5, straightened R5's gown, rolled R5 to R5's right and put a sheep skin roll under her right shoulder. Sheep skin roll was placed on other side of R5, but R5 remained basically on her back and on bony prominences of her buttocks. On 10/1/25 at 11:21 AM, Surveyor observed CNA M complete hand hygiene and put on gloves and gowns and enter R5's room. CNA M uncovered R5 and removed sheep skin pillows from right shoulder and touched R5's legs and brief. CNA M realized there were no wipes and took off CNA M's gloves and gown and left room. CNA M came back with wipes and put on new gown and gloves; no hand hygiene prior. CNA M provided peri care R5, applied barrier cream applied to bottom, took off dirty gloves, no hand hygiene before putting on clean gloves. CNA M, with contaminated gloved hand, secured brief tabs, straightened R5's clothing and bedding, put pillows on right side again, left sheep skin on foot of bed, and left the room. Example 3On 9/30/25 at 9:15 AM, Surveyor observed CNA M and assistant approach R56's room. No concerns with assistant. CNA M put on gloves and gowns, no hand hygiene first. CNA M, with contaminated gloved hands, checked R56's brief with a quick look, and stated R56 was fine. Both CNAs repositioned R56 and put bed in low position. With same contaminated gloved hands, CNA M adjusted R56's head to a more comfortable position and covered R56 up. CNA M removed gloves and left room. Hand hygiene was completed in hallway before entering next room.On 0929/25 at 11:14 AM, Surveyor interviewed CNA H who stated I don't remember if I wiped off the lift before it was taken to R9's room. It should have been. The slings are left in the resident's room.On 9/30/25 at 4:05 PM, Surveyor interviewed CNA H who stated hand hygiene is done before you go into a room to deal with patients, whenever your hands are dirty. CNA H stated it's a lot. When Surveyor asked about glove use, CNA H stated yes, hand hygiene should happen between gloves. CNA H stated, Oh, I missed that (hand hygiene between gloves). I should have done that.On 9/30/25, at 7:55 AM, Surveyor interviewed ADON G and CNA M. ADON G stated she had not touched the groin; she did not need to change her gloves. Surveyor asked ADON G and CNA M if the groin is a clean area. ADON G walked out. CNA M stated yes and walked out. CNA M came back when Surveyor was standing outside room. CNA M stated I meant, CNA M cleaned R5's groin before asking someone to help get the draw sheet under R5. CNA M stated no, the groin is never considered a clean area. Once a brief is on it is considered dirty.On 10/1/2025 at 11:37 AM, Surveyor interviewed CNA M who stated hand hygiene should be done whenever you are going in a resident's room, before putting stuff on, you should sanitize between cares. CNA stated if you get BM on your hands you should wash them. CNA M stated CNA M should have changed gloves and did hand hygiene every time CNA M changed them (gloves).On 10/2/25 at 9:20 AM. Surveyor interviewed ADON G who stated hand hygiene should happen before all contact with residents and food, in between glove changes, after restroom use. ADON G stated ADON G tells staff you really can't go overboard. Hand hygiene should certainly be before a resident's room or touching their belongings, after resident care and food, and in between glove changes. ADON G stated the facility does ongoing hand washing audits, also there is a checklist with new hires. ADON G stated audits are definitely ongoing routinely, even the best forgets.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not develop a comprehensive person-centered care plan for the diagnosis of Congestive Heart Failure (CHF) with the use of a diuretic for 1 of 16 residents (R) R9 reviewed for care plans.This is evidenced by: The facility's policy, Comprehensive Care Plan read in part, The comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. R9 was admitted to the facility on [DATE], with diagnoses including chronic diastolic congestive heart failure, hypertensive heart disease, and edema. R9's Minimum Data Set (MDS) assessment, confirmed a Brief Interview for Mental Status (BIMS) could not be completed. Staff assessment of R9's cognition showed R9 to have moderately impaired cognition. Review of R9's medical record identified orders for the following diagnosis of CHF:-Metolazone 5 mg tablet, give one tablet by mouth every other day for possible heart failure exacerbation.-Lasix 40 mg tablet, give one tablet daily for diuresis. Review of R9's care plan identified no problems or interventions related to R9's diagnosis of CHF and use of diuretics. On 10/01/25 at 1:48 PM, Surveyor interviewed Licensed Practical Nurse (LPN) C. Surveyor asked LPN C when assessments are completed on residents with a diagnosis of CHF. LPN C reported assessments for increased weight, increased edema, and lung sounds would be completed when a resident has symptoms related to fluid overload. On 10/02/25 at 8:49 AM, Surveyor interviewed Director of Nursing (DON) B. DON B stated a resident with a diagnosis of CHF should have an individualized care plan. DON B stated R9 did have a CHF care plan, but it was resolved. DON B stated she ?unresolved' the CHF care plan and it was present in R9's record at this time. Surveyor reviewed R9's care plan and noted the CHF care plan was resolved 03/2025, and unresolved 10/02/25.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility did not include the participation of a resident or family representative at care planning conferences. This occurred for 3 of 4 residents, (R) R2, R9, and R48, reviewed for care conferences. The facility did not conduct and document care planning conferences for R2, R9, and R48. Findings: The facility policy, Comprehensive Care Plan read in part, The comprehensive care plan will be reviewed and revised as appropriate by the interdisciplinary team after each comprehensive and quarterly MDS assessment, and as needed with changes in condition. The physician, other practitioner, or nurse designee will inform the resident and/or resident representative of the risks and benefits of proposed care, of treatment, and treatment alternatives/options. On 09/29/25 at 1:17 PM, Surveyor interviewed R9's activated Power of Attorney (POA). During the interview R9's POA reported concerns about R9 discharging to a different facility. R9's POA reported being unsure of what was going on or if R9 would be able to remain at the facility. On 09/30/25, Surveyor reviewed R9's record and was unable to find documented evidence of quarterly care conferences. Surveyor reviewed sampled residents R2, R6, and R48 for evidence of quarterly care conferences, and was unable to find related documentation. Surveyor requested documentation from facility. On 10/01/25, Surveyor was given the following: R2: -10/10/24, care conference summary. -03/14/25, a progress note indicating a care conference letter was sent to POA. -08/13/25, a document titled Care Plan Areas with no evidence of a care conference being held with R2 or R2's representative. R6: No concerns. R9:-03/25/24, care conference summary. -07/23/24, a progress note indicating a care conference letter was sent to POA. -10/29/24, a progress note stating a meeting was held to discuss neurology appointment and other placement, without evidence this was a care conference. -10/31/24, a progress note indicating a care conference letter was sent to POA. -03/13/25, a progress not indicating a care conference letter was sent to POA. -04/18/25, a progress note stating a care conference was discussed with POA, she will call next week to set up a meeting. -04/24/25, a progress note stating a care conference would be scheduled for 05/03/25. Note, there was no evidence of a care conference on 05/03/25. -07/07/25, a progress note stating a meeting was held to discuss placement options, with no evidence of a care conference being held with R9 or POA. -07/23/25, a document titled Care Plan Areas with no evidence of a care conference being held with R9 or his POA. -09/30/25, a progress note indicating a care conference letter was sent to POA. R48:-04/24/24, Care conference summary. -11/14/24, progress note indicating a care conference letter was sent to POA. -04/21/25, progress note indicating a care conference letter was sent to POA. -07/23/24, progress note indicting a care conference letter was sent to POA. -08/27/25, a document titled Care Plan Areas, with no evidence of a care conference being held with R48 or her POA. On 10/01/25 at 9:33 AM, Surveyor interviewed Social Services Director (SSD) E. SSD E stated care conferences are held within 48-72 hours of a resident's admission and then offered every three months or with quarterly Minimum Data Set (MDS) assessments. SSD E stated the facility has not been tracking care conferences. SSD E stated the document titled Care Plan Areas was being used by nursing staff for MDS reviews, and recently SSD E has been using the document. SSD E stated residents and/or representatives should have been offered quarterly care conferences. On 10/01/25 at 1:48 PM, Surveyor interviewed Licensed Practical Nurse (LPN) C and Certified Nursing Assistant (CNA) D. LPN C and CNA D stated they are not invited to care conferences, and sometimes supervisory staff will ask about a resident prior to a care conference being held, but not very often. On 10/01/25 at 3:50 PM, Surveyor interviewed Nursing Home Administrator (NHA) A. NHA A reported she spoke with SSD E and was aware care conferences were not consistently being held with the resident or representative, or documentation did not support the requirements of a care conference.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interview, the facility did not ensure a resident who was dependent for repositioning, personal cares, and hydration receive timely assistance for 1 out of 4 residents (R) (R5) reviewed for Activities of Daily Living. R5 who is dependent for hydration was not offered hydration during cares. R5 who is dependent for repositioning and turning was not repositioned for over 3 hours.This is evidenced by:The facility policy, titled Hydration, last revised 9/19/2024, states: The facility offers each resident sufficient fluid, including water and other liquids, consistent with resident needs and preferences to maintain proper hydration and health. The facility policy, titled Turning and Repositioning, last revised 12/6/22, states: It is our policy to implement turning and repositioning as part of our systematic approach to pressure injury prevention and management. This policy establishes responsibilities and protocols for turning and repositioning. 2. Turning and repositioning is a primary responsibility of nursing assistants. However, facility nursing staff are expected to assist with turning and repositioning. 3. The frequency of turning and repositioning will be documented in the resident's care plan of care and will be determined by the resident's assessments including but not limited to:a. Level of activity, moisture, and mobility/Braden Scale. R5 was admitted to the facility on [DATE], with the diagnoses of malignant neoplasm of brain, partial removal of right skull, left side paralysis, difficulty swallowing, and severe protein calorie malnutrition.R5's Minimum Data Set (MDS) assessment, dated 9/2/2025, indicates that R5 is severely cognitively impaired and dependent for all hygiene, dressing, eating, movement and positioning. R5 has difficulty swallowing and a tube feeding. R5 is also always incontinent of bowel and bladder and needs assistance with peri-care and skin maintenance.R5's care plan states ADL selfcare deficit. Up in Wheelchair no longer than 2 hours at a time then in bed 1-2 hours and then may get up again. Bowel and Bladder incontinence. check and change every 2-3 hours and as needed. Completed Gentle Range of Motion (ROM) to bilateral lower legs . Daily Complete Passive (with assistance) ROM to left arm daily and active ROM to Right arm Daily. The resident has risk for impaired skin integrity related to history of Left ischium pressure injury and left buttock pressure injury (stage 3) Turn and reposition every 2-3 hours and as needed.Record review indicates R5 has a continuous Tube Feeding at 50ml/hr/24hrs. Dietician reviewed resident's labs and weight 9/15/25. Resident is to have 1200 ml of formula via tube feeding, 967ml free water and 360ml flush volume in 24 hours for an additional 1327ml. Resident has had significant weight loss and change in condition noted 9/15/25. Tube feeding was increased to 55ml/hr/24hr or 1320ml/24 hrs. R5 should be getting 967ml free water above and beyond what is provided in the tube feeding.On 9/30/25 at 7:51 AM, Surveyor observed R5 lying in bed. R5 opened her eyes and whispered hello when Surveyor entered room. R5 was weak and provided head shakes and quiet no's and yes to questions. Surveyor observed R5's lips were chapped and dry. R5 was licking her lips. There was a full water pitcher and full glass of what appeared to be apple juice on her tray table. Tray table was pushed away from bed slightly. Surveyor asked R5 if she could reach her water. R5 stated yes, but then turned her head towards tray table, stretched her neck and opened her mouth. Surveyor asked R5 if she could hold her glass. R5 said no.On 9/30/25 at 7:55 AM, Surveyor observed Certified Nursing Assistant (CNA) M and Assistant Director of Nursing (ADON) G reposition R5. R5's brief was opened. ADON G observed red area, CNA M applied barrier cream, and brief was reattached. Brief was not changed. ADON G and CNA M left the room without offering R5 a drink and R5's tray table was not moved closer to R5. Tray table remained where it had been pushed further away from R5's bed against the curtain dividing the room during cares. On 9/30/25 at 9:15 AM, Surveyor had been standing observing R5's hallway and door continuously since 7:55 AM. No one had entered R5's room.On 9/30/25 at 11:08 AM, Surveyor observed R5's room continuously for approximately 3 hours and 15 minutes. Tray table remained against the curtain dividing the room out of reach from the bed, with a water pitcher and the glass or possible juice. Levels were the same. No one had entered R5's (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	10/02/2025

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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room.On 9/30/25 at 3:55 PM, Surveyor observed R5 appearing in the same position. Tray table remained pushed off to the side with water pitcher and juice glass at the same level.On 9/30/25 at 4:30 PM, Surveyor stopped in R5's room and observed that she was holding a plastic green cup with straw. R5 attempted to lift it and bring to mouth but was unable. R5 tried to bend down and bring mouth closer but still was unable to get straw to mouth. Surveyor asked if she could lift her cup and R5 whispered no. On 10/1/25 at 7:28 AM, Surveyor observed R5 lying in bed on her back with a full water pitcher, glass of what appeared to be juice and the green cup on her tray table pushed up against curtain dividing room, out of reach from the bed. LPN C was followed into room. Surveyor observed LPN C's interaction with R5. When LPN C was done, she left room, and no drink was offered to R5. Tray table remained out of reach of the bed. On 10/1/25 at 10:00 AM, Surveyor had consistently observed R5's room. No one had entered R5's room since LPN C did this morning at 7:28 AM.On 10/1/25 at 11:21 AM, Surveyor observed CNA M provide cares to R5. CNA M uncovered R5 and removed the sheep skin pillow under R5's left side back and the pillow between R5's legs. CNA M removed brief, provided peri care to R5, applied barrier cream to bottom, reattached new brief, adjusted resident and made comfortable. R5 was not offered a drink, tray table remained pushed against curtain, and out of reach from the bed. Interviews:On 9/30/25 at 8:05 AM, Surveyor interviewed ADON G who stated R5 was repositioned when rolled to provide cares. ADON G stated the goal is to get R5 off R5's hip bones, and moved sheet to show hip was off the bed. When asked what about the bony prominences of the butt, ADON G stated the air mattress takes care of that. On 10/1/2025 at 9:03 AM, Surveyor interviewed LPN C who stated that R5 is dependent for cares. R5 has declined in the last month due to her brain tumor. R5 was admitted to hospice last week (9/24/25). R5 is repositioned every 2 hours and encouraged to take a drink when staff are in there. R5 does not eat much but is encouraged to eat and drink still; staff must stay with her.On 10/1/25 at 11:37 AM, Surveyor interviewed CNA M who stated he is a caregiver. CNA M stated CNA M tries to get dependent residents up every 2 hours but sometimes that is hard. CNA M stated this wing has a lot more residents needing Hoyer lifts (mechanical lift) so sometimes CNA M needs to wait for help. CNA M stated CNA M tries to do cares and repositioning both at once. CNA M stated we continue to provide cares to residents on hospice. CNA M stated we still help with positioning, swabbing the mouth, stuff like that. CNA M stated CNAs are on the comfort side; if residents need to be rotated, we do that. CNA M stated R5 has a plan to be repositioned. When asked directly, CNA M said most residents are independent except for R5. CNA M stated he tries to provide fluids when he is in with R5. Surveyor asked if he did that just now. CNA M stated, No I did not. Yes, I should have, and I'll go give it to her now.On 10/1/2025 at 12:50 PM, Surveyor interviewed Director of Nursing (DON) B, who stated DON B's expectation is that staff follow the care plan for repositioning. DON B stated that care plans are often every 2-3 hours. This gives staff 2 hours to get back in there; if they can't be back in time in 2 hours it gives staff leeway to position and change at same time. Surveyor told DON B about observation of R5 receiving cares at 7:58 AM and no one going into her room again until 11:21 AM. DON B stated, No that is not ok. They should have been in there between 9-10. DON B stated her expectation is that everyone is encouraged to drink every time staff are in resident's room. DON B stated R5 needs assistance with feeding self, difficulty with swallowing and is weak. R5 needs help to drink, help holding glass.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, facility did not implement professional standards of practice to ensure that a resident does not develop pressure injuries (PIs), receives necessary treatment and services to promote healing and prevent new PIs from developing for 1 of 2 residents (R) reviewed. (R21) This is evidenced by:National Pressure Injury Advisory Panel (NPIAP) guidance recommends repositioning all individuals with or at risk of pressure injuries on an individualized schedule, unless contraindicated. Determine repositioning frequency with consideration to the individual's level of activity and ability to independently reposition. Reposition the individual in such a way that optimal offloading of all bony prominences and maximum redistribution of pressure is achieved.R21 was admitted to the facility on [DATE]. Current diagnoses include hypertensive heart and chronic kidney disease, weakness, cognitive communication deficit, type 1 diabetes mellitus, asthma, heart failure, chronic kidney disease stage 3, and fibromyalgia.Minimum Data Set (MDS), dated [DATE], an admission/5 day assessment documented R21 having a Brief Interview for Mental Status (BIMS) score of 14, meaning no cognitive impairment. R21 needs maximum assistance from staff for dressing and personal hygiene. R21 needs moderate assistance from staff for toileting, transfers, and bed mobility. R21 is at risk for PI and had 1 stage 2 PI that was present on admission. R21's physician orders include:09/17/25 Border foam dressing to left elbow. every day shift every 3 day(s) for Left elbow open area AND as needed.R21's care plan, dated 09/17/25, .Actual Stage 2 pressure injury to left elbow R/T (related to) resident using elbows to keep self propped up, as this is a preference for her while resting in bed. Interventions dated 09/22/25 Elbow protectors to be worn daily, check skin for redness on elbows.Braden scoring assessments for risk of skin breakdown:09/12/25 score 18 risk breakdown mild risk 15-18.On 09/17/25, a skin assessment of left elbow documented site remains and measures at 2 cm X 1.2 cm X 0.1 cm, has defined edges with a wound bed that is comprised of approximately 100% moist, light red tissue. Moderate amounts of serous drainage present. Scant amounts of sang., drainage present from site. No s/s of infection noted.On 09/29/25 at 11:30 AM, Surveyor interviewed R21 about open areas to skin. R21 stated having chronic areas on legs. Surveyor observed R21 resting in bed with head of bed elevated with elbows resting on bed. No elbow protectors noted. R21 had an alternating air mattress. On 09/30/25 at 10:48 AM, Surveyor interviewed Certified Nursing Assistant (CNA) H about R21 having worn any elbow protectors. CNA H stated not sure R21 usually has a sweatshirt on and not sure if there is anything under. Surveyor asked how would you know what is needed and is there a care plan to follow. CNA H stated there is a care plan in the closet. On 09/30/25 at 10:48 AM, Surveyor observed CNA H assist R21 to the bathroom. Surveyor observed R21 to not be wearing elbow protectors and did not observe elbow protectors in room. Surveyor observed R21's care plan posted in closet door documenting elbow protectors to be worn. CNA H did not check or place elbow protectors on R21.On 09/30/25 at 11:24 AM, Surveyor interviewed Registered Nurse (RN) F about R21 wearing elbow protectors. RN F stated the border foam is the protectors, and R21 will take off the dressing. RN F went to check on R21 and reposition R21 off coccyx. RN F stated R21 does have the dressing on elbow. R21 is able to reposition self in bed and will position self back onto her back after staff reposition. On 09/30/25 at 12:43 PM, Surveyor interviewed Director of Nursing (DON) B about R21's elbow protectors. DON B stated the elbow protectors are a foam that goes over the elbow to protect from pressure. Surveyor asked if the border foam dressing a pressure relieving elbow protector. DON B state the elbow protector is more than the dressing. The elbow protector is to prevent pressure on the elbow and cradles the elbow. Surveyor reviewed with DON B the interviews with staff and Surveyor's observation. DON B stated will check to see if the elbow protectors are in R21's room. DON B returned, stating the elbow protectors were not on R21 and are now, and staff had been educated.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility did not ensure pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) to meet the needs of each resident, for 1 of 1 resident (R9). R9 had an order to check systolic blood pressure prior to administering medication, with parameters to hold the medication if systolic blood pressure was less that 110. The facility did not complete blood pressure checks as ordered. Findings include: The facility policy titled Medication Errors, read in part. Staff will follow best practices to prevent medication errors: a. Clarify an order that is incomplete. b. Ensure that orders are fully understood before administering medications.On 10/01/25, Surveyor reviewed R9's record and noted an order for: 01/02/25, metolazone 5 mg tablet every other day for possible heart failure exacerbation, hold for systolic blood pressure (SBP) <110. Surveyor was unable to find evidence of BPs prior to medication administration. Surveyor requested this from Director of Nursing (DON) B. On 10/01/25 at 9:21 AM, Surveyor interviewed Licensed Practical Nurse (LPN) C. LPN C was not aware of checking R9's BP prior to receiving metolazone. LPN C stated, The med techs might do that. I am not sure. If we are supposed to, I don't think it has been done. On 10/01/25 at 1:26 PM, DON B reported R9's BPs were not being completed prior to receiving metolazone, as ordered. DON B stated she would correct this in the medication record.