

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2026
NAME OF PROVIDER OR SUPPLIER Wausau Manor Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials in accordance with State law through established procedures. The facility did not report a potential incident of neglect to the State Agency (SA) for 1 of 1 resident (R47) reviewed for reporting requirements. R47 requires 2 staff assistance with bed mobility and transfers. Staff did not follow R47's plan of care for bed mobility. R47 fell which result in R47 sustaining significant bruising to their face. The facility did not report this incident of potential neglect to the state agency. The facility's policy titled Abuse, Neglect and Exploitation read in part, Neglect means the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, mental anguish, or emotional distress. Possible indicators of abuse include. 8. Failure to provide care needs such as feeding, bathing, dressing, turning & positioning. The facility will have written procedures that include 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes. R47 was admitted to the facility on [DATE], and diagnoses included mild intellectual disability. On 07/17/26, R47 scored 12/15 during Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. R47's care plan included: -At risk for falls due to history of falls. Intervention, provide assistance to transfer and ambulate as needed, initiated 09/04/26. -ADL self-care deficit. Interventions, bed mobility assist of 2, revised 10/10/24. Transfer with EZ stand assist of 2, revised 11/22/24. On 07/20/26 at 12:43 PM, Surveyor observed R47 in the dining room with significant bruising to their face, forehead, around both eyes, and down into both cheeks. Bruising was both dark and light shades of blue, with green and yellow coloring on the outside of the bruise. Surveyor asked R47 if they experienced pain from the bruising, and R47 stated yes. On 07/20/26, Surveyor reviewed R47's fall investigation that occurred on 07/08/26, which included the following: Description: Called into resident's room. It was observed that resident was lying on the floor on left side. CNA x 2 witnessed fall and resident hit left side of head hard on the floor. Instant large hematoma 5.6 cm by 8 cm. Ice applies to hematoma. Area not open. Resident is on Eliquis 50 mg (milligrams) twice daily. Skin shearing to left knee 1.7 cm by 3.2 cm. Skin tear to right index finger 1.7 cm by 0.1 cm. Area cleansed and band aid applied. Resident description: Resident unable to give description. Immediate Action: Resident was taken to ER for eval (evaluation) and dx (diagnosis). (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notes: 07/13/26, IDT (Interdisciplinary Team) reviewed fall. Due to the impact of the resident's head and current anticoagulation therapy, 911 was called and resident was transported to the ER. All scans were within normal limits. The resident returned to the facility with no new orders. On 07/21/26 at 6:55 AM, Surveyor interviewed Certified Nursing Assistant (CNA) D. CNA D confirmed he was present when R47 fell from their bed. CNA D stated R47 is a sit to stand transfer, and all mechanical transfers require two staff. CNA D reported another CNA was present in the room and assisting R47's roommate. CNA D stated he assisted R47 to sit on edge of bed and added R47 can sit on the edge of the bed. CNA D stated he turned to grab the sling for the mechanical lift, and as he turned around R47 was already falling to the floor. CNA D confirmed Director of Nursing (DON) B interviewed him yesterday. On 07/21/26 at 8:42 AM, Surveyor interviewed DON B. DON B stated an investigation of R47's fall was completed, but maybe it was not very thorough. DON B confirmed she did not interview CNA D until 07/20/26. DON B did not indicate why. Surveyor asked DON B if this incident should have been reported to the SA (State Agency) for potential neglect, and DON B nodded her head yes. On 07/21/26 at 12:26 PM, Surveyor interviewed Nursing Home Administrator (NHA) A. NHA A expressed confusion about R47's fall meeting the requirements for a reportable incident. Surveyor asked NHA A to provide any additional documentation to support the facility's claim R47's fall was not reportable. Surveyor did not receive any additional information. On 07/21/26 at 1:24 PM, survey team was exiting with facility leadership staff. A regional corporate staff person was present during exit but was not introduced to the survey team. During the exit conference, the regional corporate staff asked Surveyor why R47's fall should have been reported. Surveyor replied R47's care plan indicated R47 required two staff to assist with bed mobility and transfers, and CNA D's failure to do this resulted in R47's fall causing an injury. Surveyor determined that CNA D did not provide needed services to R47 per R47's plan of care resulting in R47 falling and sustaining an injury. The facility failed to report this incident to the SA.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure a thorough investigation was conducted for a potential incident of caregiver misconduct for 1 of 1 resident (R47) reviewed for investigating an alleged violation. The facility did not conduct a thorough investigation following R47's fall with injury. CNA D did not follow R47's plan of care, R47 fell and sustained an injury. The facility did not complete a thorough investigation into the incident and did not protect residents during the investigation. Findings include: The facility's policy titled Abuse, Neglect and Exploitation read in part, Neglect means the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, mental anguish, or emotional distress. Possible indicators of abuse include: 8. Failure to provide care needs such as feeding, bathing, dressing, turning & positioning. An immediate investigation is warranted when allegations or suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Identifying and interviewing all involved persons, including alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation(s). Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and Providing complete and thorough documentation of the investigation. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during the investigation. Examples include but are not limited to: D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator. R47 was admitted to the facility on [DATE], and diagnoses included mild intellectual disability. On 07/17/26, R47 scored 12/15 during Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. R47's care plan included: -At risk for falls due to history of falls. Intervention, provide assistance to transfer and ambulate as needed, initiated 09/04/26. -ADL (Activities of Daily Living) self-care deficit. Interventions, bed mobility assist of 2, revised 10/10/24. Transfer with EZ stand assist of 2, revised 11/22/24. On 07/20/26 at 12:43 PM, Surveyor observed R47 in the dining room with significant bruising to their face, forehead, around both eyes, and down into both cheeks. Bruising was both dark and light shades of blue, with green and yellow coloring on the outside of the bruise. Surveyor asked R47 if they experienced pain from the bruising, and R47 stated yes. On 07/20/26, Surveyor reviewed R47's fall investigation that occurred on 07/08/26, which included the following: Description: Called into resident's room. It was observed that resident was lying on the floor on left side. CNA x 2 witnessed fall and resident hit left side of head hard on the floor. Instant large hematoma 5.6 cm by 8 cm. Ice applies to hematoma. Area not open. Resident is on Eliquis 50 mg (milligrams) twice daily. Skin shearing to left knee 1.7 cm by 3.2 cm. Skin tear to right index finger 1.7 cm by 0.1 cm. Area cleansed and band aid applied. Resident description: Resident unable to give description. Immediate Action: Resident was taken to ER for eval (evaluation) and dx (diagnosis). Notes: 07/13/26, IDT (Intradisciplinary Team) reviewed fall. Due to the impact to the resident's head and current anticoagulation therapy, 911 was called and resident was transported to the ER. All scans were within normal limits. The resident returned to the facility with no new orders. On 07/21/26 at 6:55 AM, Surveyor interviewed Certified Nursing Assistant (CNA) D. CNA D confirmed he was present when R47 fell from their bed. CNA D stated R47 is a sit to stand transfer, and all mechanical transfers require two staff. CNA D reported another CNA was present in the room and assisting R47's roommate. CNA D stated he assisted R47 to sit on edge of bed and added R47 can sit on the edge of the bed. CNA D stated he turned to grab the sling for the mechanical lift, and as he turned around R47 was already falling to the floor. CNA D confirmed Director of Nursing (DON) B (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interviewed him yesterday. On 07/21/26 at 8:42 AM, Surveyor interviewed DON B. DON B stated an investigation of R47's fall was completed, but maybe it was not very thorough. DON B reported a thorough investigation would include talking to staff, talking with the person who reported the incident, and trying to find out what happened. Talk with staff, provide staff with training. Talk with residents and provide resident education if appropriate. DON B confirmed she did not interview CNA D until 07/20/26, DON B did not indicate why. Surveyor asked DON B if this incident should have been reported to the SA for potential caregiver misconduct, and DON B nodded her head yes. On 07/21/26 at 12:26 PM, Surveyor interviewed Nursing Home Administrator (NHA) A. Surveyor explained the facility's investigation was not thorough, as interviews were not conducted, specifically CNA D was not interviewed until 07/20/26. NHA A did not comment. CNA D did not follow R47's plan of care. CNA D continued working at the facility and did not receive training until seven days after the incident. CNA D was not interviewed until 07/20/26, 12 days after the incident. The facility did not complete a thorough investigation into the incident have evidence of the investigation and prevent further potential neglect during the investigation.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not accurately code the Minimum Data Set (MDS) assessments for 1 of 6 residents (R) reviewed. (R2)R2 had a Preadmission Screening and Resident Review (PASARR) 1 and 2 completed, which the MDS assessment did not reflect. This is evidenced by: R2 was admitted to the facility on [DATE]. R2's current diagnoses include dementia, post-traumatic stress disorder, anxiety disorder, and major depressive disorder. Review of R2's medical record found a PASARR level 2 screen was completed, dated 10/22/25.R2's annual MDS (Minimum Data Set) assessment, dated 11/10/25, documented Section A1500: Preadmission screening and resident review (PASRR) question Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? The response selected was No.R2's significant change MDS assessment, dated 04/16/26, documented Section A1500 Preadmission screening and resident review (PASRR) question Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? The response selected was No.On 07/20/26 at 3:19 PM, Surveyor interviewed Registered Nurse (RN) C the Minimum Data Set Coordinator about the 11/10/25 and 04/16/26 MDS section 1500 of the PASRR being coded as no mental illness. RN C stated they were in training in November. There would have been MDS floats doing the MDS at that time. RN C stated they would have to look to see why section 1500 was coded as no. Surveyor asked if the system would auto fill sections from the previous MDS. RN C stated that the system will auto fill certain sections and don't know which sections. RN C would compare MDS's to catch and verify the correct information. On 07/20/26 at 3:43 PM, Surveyor interviewed RN C asking if R2's MDS was coded correctly. RN C stated they talked with their regional manager and identified RN C had coded the 04/16/26 MDS incorrectly. RN C stated they can't speak to why the other MDS was incorrectly coded. RN C stated they put in a correction for the MDS. On 07/20/26 at 4:04 PM, Surveyor interviewed Nursing Home Administrator (NHA) A about MDS for R2 incorrectly coded for PASSR. NHA A stated understanding, and a correction was made to the MDS.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide adequate supervision to prevent accidents for 1 of 3 residents (R47) reviewed for accidents. R47 requires assistance from two staff with bed mobility and transfers, per the plan of care. One certified nursing assistant (CNA) sat R47 on the edge of the bed and turned to retrieve the mechanical lift sling; during this time R47 fell from the bed landing on their face. R47 sustained significant bruising to their face. Findings include: The facility's policy titled Abuse Neglect and Exploitation states in part, Neglect means the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, mental anguish, or emotional distress. Possible indicators of abuse include. 8. Failure to provide care needs such as feeding, bathing, dressing, turning & positioning. The facility's policy titled Fall Prevention and Management Guidelines read in part, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized plan of care to minimize the likelihood of falls or reduce the possibility/severity of injury. R47 was admitted to the facility on [DATE], and diagnoses included mild intellectual disability. On 07/17/26, R47 scored 12/15 during Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. R47's care plan included: -At risk for falls due to history of falls. Intervention, provide assistance to transfer and ambulate as needed, initiated 09/04/26. -ADL (Activities of Daily Living) self-care deficit. Interventions, bed mobility assist of 2, revised 10/10/24. Transfer with EZ stand assist of 2, revised 11/22/24. On 07/20/26 at 12:43 PM, Surveyor observed R47 in the dining room with significant bruising to their face, forehead, around both eyes, and down into both cheeks. Bruising was both dark and light shades of blue, with green and yellow coloring on the outside of the bruise. Surveyor asked R47 if they experienced pain from the bruising, and R47 stated yes. On 07/20/26, Surveyor reviewed R47's fall investigation that occurred on 07/08/26, which included the following: Description: Called into resident's room. It was observed that resident was lying on the floor on left side. CNA x 2 witnessed fall and resident hit left side of head hard on the floor. Instant large hematoma 5.6 cm by 8 cm. Ice applies to hematoma. Area not open. Resident is on Eliquis 50 mg (milligrams) twice daily. Skin shearing to left knee 1.7 cm by 3.2 cm. Skin tear to right index finger 1.7 cm by 0.1 cm. Area cleansed and band aid applied. Resident description: Resident unable to give description. Immediate Action: Resident was taken to ER for eval (evaluation) and dx (diagnosis). Notes: 07/13/26, IDT (Interdisciplinary Team) reviewed fall. Due to the impact to the resident's head and current anticoagulation therapy, 911 was called and resident was transported to the ER. All scans were within normal limits. The resident returned to the facility with no new orders. On 07/21/26 at 6:55 AM, Surveyor interviewed Certified Nursing Assistant (CNA) D. CNA D confirmed he was present when R47 fell from their bed. CNA D stated R47 is a sit to stand transfer, and all mechanical transfers require two staff. CNA D reported another CNA was present in the room and assisting R47's roommate. CNA D stated he assisted R47 to sit on edge of bed and added R47 can sit on the edge of the bed. CNA D stated he turned to grab the sling for the mechanical lift, and as he turned around R47 was already falling to the floor. On 07/21/26 at 8:42 AM, Surveyor interviewed DON B. DON B stated the root cause of R47's fall would have been staff not having items ready prior to sitting R47 on the edge of the bed. Surveyor asked DON B if the fall occurred because CNA D did not provide R47 with adequate supervision, and DON B stated yes. DON B reported staff received training on 07/15/26, which included resident transfers. Upon review of the training sign in document, Surveyor noted CNA (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D's name was not included. R47 required two staff for bed mobility and transfers. CNA D did not follow R47's plan of care which resulted in R47 falling and sustaining an injury.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that a resident who requires dialysis receives such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences for 1 of 1 sampled resident (R6) reviewed for dialysis. The facility failed to provide ongoing assessment of R6's condition and monitoring for complications before and after dialysis treatments. The facility did not have a system in place for accurate and ongoing communication with dialysis facility. The facility's policy titled Hemodialysis read in part, The facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include:-The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility.-Ongoing assessment and oversight of the resident before and after dialysis treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infections control practices: and-Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services.4. The licensed nurse will communicate to the dialysis facility by utilizing the Pre-dialysis Communication UDA.7. The nurse will monitor and document the status of the resident's access site upon return from the dialysis treatment to observe for bleeding or other complications using the Post-dialysis UDA.12. The facility will ensure that the plan of care for dialysis includes:a. The type of access for dialysis (e.g., arteriovenous shunt, external dialysis catheter) and location;b. The dialysis schedule;c. The dialysis facility name and phone number;d. Transportation arrangements to and from the dialysis facility;e. Any medication administration or withholding of specific medications prior to dialysis treatments;f. Any fluid restriction if ordered by the physician.13. The nurse will ensure that the dialysis access site is checked before and after dialysis treatments and every shift for patency by auscultating for a bruit and palpating for a thrill.R6 admitted to the facility on [DATE], and diagnoses included dependence on renal dialysis. R6's primary language is not English. R6 scored 00/15 during Brief Interview for Mental Status (BIMS).R6's care plan included: -Difficulty communicating as evidenced by trouble being understood even by interpreter. Resident is usually understood but only understands some of the time. R6 rarely/never has the ability to express wants and needs. Revised 05/14/26.-Renal insufficiency related to end stage renal disease, dependence on renal dialysis. Interventions: Check access site for lack of bruit/thrill, evidence of infection, swelling, or excessive bleeding. Initiated 01/16/26.-Record dry weights and report significant changes as ordered. Initiated 02/05/26.Note, according to the National Institute of Health (NIH) dry weight in dialysis is the target post-dialysis weight after all excess fluid is removed.Note, email communication on 06/17/26 from the dialysis facility's Registered Dietician confirmed R6's estimated dry weight to be #135.R6's orders included:-Weight monitoring prior to dialysis, in the morning every Monday, Wednesday, and Friday related to end stage renal disease, start date 05/04/26.-Fluid restriction: 2000mL. Dietary: 1440mL. Nursing 560mL, AM 240, PM 240, NOC 80, every shift for fluid restriction, start date 03/09/26.On 07/21/26 at 7:01 AM, Survey requested R6's dialysis communication book. Licensed Practical Nurse (LPN) E went to the nurses' station to find this and stated it was not at the nurses' station. LPN E and Surveyor went to R6's room, and Surveyor observed LPN E looking for R6's dialysis communication book. LPN E stated she was unable to find the communication book and did not know where it was. Surveyor asked LPN E how the facility communicates with dialysis facility, and LPN E stated usually via phone.Surveyor asked LPN E to describe how staff monitor R6 for dialysis (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	complications. LPN E stated staff obtain R6's weight and vital signs before and after dialysis treatments, and upon R6's return from dialysis, staff check R6's access site for bleeding and infection. On 07/21/26 at 8:36 AM, LPN E brought Surveyor R6's dialysis communication book, stating it was in R6's wheelchair. Surveyor reviewed the book and noted it contained pre and post-dialysis communication forms from 07/20/26, and there was no other communication contained in the book. Surveyor asked LPN E how facility staff know if dialysis facility changes or adds orders for R6. LPN E stated the dialysis facility will either call or send a paper copy. LPN E stated the dialysis center does not send communication for every session R6 attends. Surveyor reviewed R6's pre and post dialysis communication forms in the electronic record for previous four months, under assessments tab. This included the following information not consistent with the facility's policy and standards of practice, (note, the information documented is the most recent, however inconsistencies existed over the four months reviewed): -07/20/26, Post-dialysis communication-vital signs and weights not checked and documented from the pre-dialysis communication. -07/17/26, Pre-dialysis communication-weight obtained on 07/13/26. Post-dialysis communication-weight not obtained and documented from pre-dialysis communication. -07/15/26, Pre-dialysis communication-bruit/thrill present? No. Vital signs and weight obtained on 07/13/26. Post-dialysis communication-weight not obtained and documented from pre-dialysis communication. 07/13/26, Pre-dialysis communication-weight obtained on 07/10/26. Post-dialysis communication-vital signs not checked and documented from pre-dialysis communication. Weight not obtained and documented from pre-dialysis communication. 07/10/26, Post-dialysis communication-weight not obtained and documented from pre-dialysis communication. -07/08/26, Pre-dialysis communication-vital signs and weight obtained on 07/06/26. Post-dialysis communication-weight not obtained and documented from pre-dialysis communication. -07/06/26, Post-dialysis communication-weight not obtained and documented from pre-dialysis communication. -07/03/26, Post-dialysis communication-weight and vital signs not obtained and documented from pre-dialysis communication. -07/01/26, Pre-dialysis communication-Vital signs obtained on 06/29/26. Post-dialysis communication-weight not obtained and taken from pre-dialysis communication. On 07/21/26 at 8:42 AM, Surveyor interviewed Director of Nursing (DON) B. Surveyor asked DON B how the facility and the dialysis facility communicate, and how nursing staff know about changes, vital signs, and weights assessed by the dialysis facility. DON B stated she would need to look into this. DON B provided Surveyor with progress notes and stated this was the communication between the facility and the dialysis facility. The progress notes included the following: -05/06/26, Resident has an appointment for left fistulogram. -05/11/26, Registered Dietician nutritional note. -05/13/25, Email communication with dialysis facility Registered Dietician.		