

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2025
NAME OF PROVIDER OR SUPPLIER  Benedictine Manor of Wausau		STREET ADDRESS, CITY, STATE, ZIP CODE  1821 N 4th Ave 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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>30570</p> <p>Based on interview and policy review, the facility did not ensure allegations of mistreatment were thoroughly investigated for 1 of 1 (R3) resident reviewed.</p> <p>Certified Nursing Assistant (CNA) C made a comment about the way R3 smelled, allegedly stating R3 needed a bath because he smells like he came out of a barn. The facility investigation did not include all nursing staff working R3's rehabilitation unit during the time of the reported incident.</p> <p>This is evidenced by:</p> <p>The facility policy, Resident Rights-Abuse Prevention, which was not dated, included in part:</p> <p>Policy: It is the policy of this facility that each resident has the right to be free from abuse .Residents must not be subjected to abuse by anyone .</p> <p>Procedures:</p> <p>Investigation-All identified events are reported to the Administrator/Designee immediately and will be thoroughly investigated.</p> <p>The investigation shall consist of:</p> <p>5. An interview with staff members (on all shifts) having contact with the resident during the period of the alleged incident.</p> <p>7. An interview with staff members (on all shifts) having contact with the accused employee .</p> <p>R3's most recent Minimum Data Set (MDS) Brief Interview for Mental Status (BIMS), completed 3/05/25, indicated a score of 15/15, meaning R3 is alert and oriented and able to answer questions correctly.</p> <p>Surveyor reviewed the Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report submitted to the State of Wisconsin by the facility. Surveyor noted the following:</p> <p>(continued on next page)</p>

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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Briefly Describe the Incident: On 1/05/25 [R3] refused a bath and an agency CNA made a comment to the effect of 'you should (have a bath) because you smell like you just came out a barn.' The Resident [R3], a former Social Services Director, took offense and assumed the comment made was with hurtful intent.</p> <p>Resident Specifics: 69 y/o (year old) male who is his own self.</p> <p>Resident Statement: I felt degraded when during my initial contact with [CNA C]. R3 stated he was told, He smelled like I came out of a barn. He never came back to state that was a joke or jest at any point in time. It was degrading. He then stated that I need to soak my fingers and said I am going to soak your hands today. I have sores on both my hands and my orthopedic surgeon said I should not get them wet. He said I am still going to and made derogatory remarks about the ortho surgeon. He did not soak my hands. As he got ready to go leave the room I felt he was overall disrespectful and degrading. At one point he said 'I've never worked someplace where so many people were rude to me.' I said, Did you consider it is your behavior eliciting that treatment. He said nothing and left the room. Ultimately, I felt like I was being bullied.</p> <p>Surveyor noted the facility investigation included interviews conducted with 12 residents who reported no concerns of staff treatment.</p> <p>Surveyor also noted two staff interviews that had been conducted as follows:</p> <p>1/07/25 at 4:15 via phone: CNA C who stated, The resident [R3] had been refusing care since his return from the hospital. [CNA C] acknowledged he told [R3] his room had odor but respected [R3's] wishes to refuse care.</p> <p>1/08/25 (no noted time): CNA D who indicated she went with CNA C to give R3 a bed bath. R3 refused a bath stating he had a bath in the hospital. [CNA C] told him he had to take a one in a very blunt manner which made the resident agitated.</p> <p>Facility did not provide any evidence of other staff interviews being conducted.</p> <p>Surveyor reviewed the nursing staff schedules for 1/04/25 and 1/05/25 and noted 9 other nursing staff working R3's rehabilitation unit.</p> <p>On 3/26/25 at 10:12 AM, Surveyor spoke with Nursing Home Administrator (NHA) A about the facility investigation. NHA A indicated he was the individual who conducted and submitted the facility report. NHA A explained he began an investigation immediately upon learning of the report of mistreatment, which was submitted to the State of Wisconsin. NHA A expressed he immediately placed CNA C on suspension, NHA A expressed residents on the rehabilitation wings were interviewed as well as CNA C and D. The facility concluded the incident occurred, and CNA C will not be returning to the facility. NHA A stated he believed he talked with other staff but has no proof of who he spoke with. NHA A further expressed he should have spoken with all staff working the rehabilitation on all shifts per the facility policy to ensure no other staff had seen any other potential mistreatment of residents.</p>