

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 12/23/2025
NAME OF PROVIDER OR SUPPLIER Wood Aven Health and Rehabilitation		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)
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. (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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and policy review, the facility failed to administer medications as scheduled for one of two residents (Resident (R) 1) reviewed for pharmacy services out of a total sample of six residents. The failure to acquire and administer routine medications to R1 had the potential for unrelieved pain and adverse consequences. Findings include: Review of R1's undated admission Record located under the Profile tab in the electronic medical record (EMR) revealed R1 was admitted to the facility on [DATE] with diagnoses of radiculopathy (a pinched nerve) and spinal stenosis (narrowing) in the cervical region (relating to the neck). Review of R1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/01/25, located under the MDS tab in the EMR revealed R1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R1 was cognitively intact. Record review of R1's undated Order Summary Report located under the Orders tab in the EMR revealed Licensed Practical Nurse (LPN) 1 entered an order on 08/29/25 at 5:46 PM, to administer Lyrica Capsule 25 mg [milligram] [Pregabalin] [a prescription medication used to treat certain types of nerve pain] Give 2 capsules by mouth two times a day for pain related to radiculopathy, cervical region. The medication was scheduled to start on 08/30/25 to be administered at 6:00 AM and 4:00 PM. Record review of R1's August 2025 Medication Administration Report (MAR) located under the Orders tab in the EMR, reflected Lyrica Capsule 25 mg (Pregabalin) was not administered two times a day on 08/30/25 and 08/31/25. Registered Nurse (RN) 1 entered a chart code, 7=Other/See Nurse Notes in the row labeled AM 06 (6:00 AM) and LPN2 entered a chart code, 7=Other/See Nurse Notes in the row labeled PM 16 (4:00 PM) under the column 08/30/25. The nurse notes reflected medication unavailable. Medication Aide (MA) 1 entered a chart code, 7=Other/See Nurse Notes in the row labeled AM 06 (6:00 AM) and MA2 entered a chart code, 7=Other/See Nurse Notes in the row labeled PM 16 (4:00 PM) under the column 08/31/25. MA1's comment reflected pending pharm (pharmacy) and MA2 entered medication unavailable. Record review of R1's October 2025 Medication Administration Report located under the Orders tab in the EMR, reflected A chart code, 7=Other/See Nurse Notes in the rows labeled AM 06 (6:00 AM) and PM 16 (4:00 PM) under the column 10/26/25 for Lyrica Capsule 25 mg (Pregabalin). The nurse's notes entered by MA2, for 6:00 AM time and MA3 for 4:00 PM time, reflected the medication was not available. During an interview on 12/22/25 at 11:51 AM, R1 said that she did not receive her Lyrica after she admitted to the facility and called a Family Member (FM) 1 to inform him of increased pain related to not receiving medication (Lyrica). R1 said that she received Tylenol, as needed (PRN) medication to manage pain when requested. R1 denied not receiving other medications or other doses once Lyrica was available. FM1 was present during the interview and stated that he inquired why R1 did not receive Lyrica and an unknown staff member said that the facility did not receive an order from the transferring facility on the day R1 was admitted. FM1 said that R1 did not receive the Lyrica for three days. During an interview and record review on 12/22/25 at 3:35 PM, MA3 said that she administered medications as reflected on the administration records. MA3 said that she would notify the charge nurse if a medication was not available on the medication cart to administer at the time the medication was scheduled. MA3 reviewed the MAR and progress note, dated 10/26/25, and stated that she entered the comment not available because the medication was not in the medication cart. MA3 said that she notified the nurse in charge, the nurse acknowledged and said that she would notify the pharmacy. MA3 said that she did not have access to medications that were not over-the-counter medications available in the medication room. During an interview and record review on 12/23/25 at 9:25 AM, RN2 said that nurses could access essential first-dose or emergency medications from an automated system in the medication room. RN2 reviewed a progress note she entered on 08/30/25 at 8:48 AM. RN2 acknowledged the note that reflected RN2's attempt to contact the pharmacy about the inability to retrieve R1's routine medications from the automated system due to R1 not registered in the system. RN2 said that the call went straight to voicemail, she left a message and did not receive a call back from the pharmacy before the end of her shift. RN2 said that she placed two outbound calls to the pharmacy and informed the oncoming nurse (RN1) that R1 did not receive her morning medications and to follow up with the pharmacy. RN2 said that she followed up with the pharmacy on 09/01/25 to inform them that there was one dose of Lyrica in the automated system to retrieve and administer to R1 for the morning dose and would not have a dose available for the evening dose if not received by the pharmacy in time. RN2 said that the physician was contacted and a prescription was called</p>		