STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525503	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wood Aven Health and Rehabilitation	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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents were free from unnecessary medications for 1 of 3 residents (R) reviewed for medication errors (R2). R2 received Metformin (a medication to treat diabetes) for 8 days. R2 does not have a diagnosis of diabetes.Findings: R2 was admitted to the facility on [DATE] with diagnoses which included paranoid schizophrenia and chronic kidney disease. R2 has a Brief Interview for Mental Status (BIMS) score of 7/15 which means severe cognitive impairment. R2 has a legal representative for health care decision making. R2's care plan, last revised 01/26/2025, with a target date of 01/27/2026, states: At risk for impaired cognitive function/dementia or impaired thought process. Interventions include.review medications and record causes of cognitive deficit: new medications. R2's record review indicated the following:- Physician order dated 10/29/2024 to check R2's HgbA1c level (a blood test that measures an average blood sugar level over the past 2-3 months) annually for Zyprexa use (antipsychotic medication used to treat schizophrenia which has a side effect of elevated blood sugar levels). -Nurse Practitioner (NP) H progress note dated 04/28/2026 at 10:45 AM, stated.Assessment and Plan.E11.65 - Type 2 diabetes mellitus [DM].HgbA1c 12.1% on 04/13/2026. Metformin ER 1000mg by mouth daily started. Follow-up HgbA1c ordered. Encounter type: Add on visit.-04/29/2026 at 5:24 PM, nursing note by licensed practical nurse (LPN) G stated R2 received new order from NP H on 04/28/2026: Metformin 1000mg ER (extended release).-R2's Medication Administration Record (MAR) indicated R2 received Metformin daily from 04/30/2026 to 05/07/2026 - a total of 8 doses.-05/06/2026 at 11:08 AM, nursing note by Registered Nurse (RN) F stated RN F spoke with R2's guardian at 11:00 AM and updated him on R2's recent diagnosis of diabetes mellitus (DM) and initiation of Metformin. R2's guardian agreed with new diagnosis and medication.-On 05/07/2026 at 10:22 AM, nursing note by Licensed Practical Nurse (LPN) D informed NP I, R2 received new orders on 04/28/2026 for scheduled Metformin with new diagnosis of type 2 diabetes. LPN D was unable to find any recent HgbA1c results to support this order and diagnosis. R2's guardian was questioning orders for Metformin and new diagnosis of DM. NP I's stated NP H must have dictated wrong. NP I stated R2 did not have a diagnosis of DM and discontinued Metformin orders. LPN D updated R2's guardian and facility management of medication error and misdiagnosis.-05/20/2026 at 1:05 PM, NP H appended the 04/28/2026 progress note for R2 and removed diagnosis of DM and the order for Metformin. -R2's most recent HgbA1c prior to ordered Metformin, was drawn on 09/25/2025 with a value of 5.5, which is within normal range. A follow up HgbA1c was drawn on 05/08/2025 with a value of 5.6, which is within normal range.-05/07/2026 an investigation by facility administration was initiated including chart audits to ensure accurate diagnosis and treatments on all residents, provider education regarding laboratory value interpretation and reinforcement of processes requiring verification of laboratory results prior to initiation of treatment. Facility's medical director was informed and an ongoing investigation by provider's health clinic was in effect. On 05/27/2026 at 9:57 AM, Surveyor interviewed R2's legal guardian. R2's guardian acknowledged the facility's investigation and was satisfied with the follow up care R2 received. R2's guardian voiced concern to Surveyor that the provider did not look at lab [HgbA1c] trending, and facility staff did not question new diagnosis and medication order. On 05/27/2026 at (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:12 AM, Surveyor interviewed R2 regarding the medication error incident that occurred on 04/28/2026. R2 could not recall the incident. R2 could not recall medications currently or previously prescribed and administered. Surveyor asked R2 if he had any concerns regarding his safety at facility and R2 shook head no. Surveyor asked R2 what his overall health was while at facility and R2 stated good. RN F and LPN G were not available for interview on 05/27/2026. On 05/27/2026 between 1:08 PM and 1:15 PM, Surveyors interviewed LPN C, LPN D and Certified Medication Assistant (CMA) E on what type of education the facility provided following the specific medication error incident on R2. LPN C, LPN D and CMA E had no recollection of staff education being provided by the facility specific to that incident. On 05/27/2026 at 12:30 PM, Surveyor interviewed NHA A and DON B about what education was provided to direct staff involved with R2's medication error, as well as facility staff receiving providers' medication orders, lab value monitoring, and recognition of residents with new diagnosis. NHA A and DON B could not provide evidence staff received education and did confirm the facility should have provided immediate education to nursing staff.