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	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wood Aven Health and Rehabilitation	1821 N 4th Ave Wausau, WI 54401

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 4 of 5 residents (R1, R8, R19, and R67) or their representatives received the proper notice of transfer, reason for transfer, and ombudsman notification.-Facility did not have a specific reason for the transfer notice for R1, R8, R19, and R67.-Facility did not notify the ombudsman of R8, R19, and R67's transfers to the hospital.Findings include: Surveyor reviewed policy titled, Criteria for Transfer and Discharge, dated 12/25 last reviewed, .Procedure: 5. If the transfer or discharge is necessary for the resident's welfare and the residents' needs cannot be met in the Facility, the resident's physician shall document in the resident's medical record: a. The specific residents need that cannot be met . Surveyor reviewed policy titled, Transfer and Discharge (including AMA), dated 03/26, .3. The facility's transfer/discharge notice will be provided to the residents and residents representative in a language and way they can understand. The notice will include all the following at the time it is provided: a. The specific reason and basis for transfer or discharge. 10. h. The Social Services Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable, such as in a list of residents monthly, if the list meets all requirement for content of such notices. Example 1 R8 was admitted on [DATE], transferred to hospital on [DATE], and re-admitted on [DATE] with diagnosis of sepsis and cellulitis. Surveyor reviewed form titled, Notice of Transfer, dated 10/31/25, which states in part, .The transfer or discharge is/was necessary for the resident's welfare, and the residents' needs cannot/could not be met with the facility. Surveyor did not find a specific reason for the transfer. Surveyor reviewed Social Services Manager F's email notifications to Ombudsman, dated 12/16/25, which states in part, Notified of October 2025 hospitalizations including R8's hospitalization on 10/31/25 on 12/16/25. R8 was transferred to hospital on [DATE] and re-admitted on [DATE] with diagnosis of status post below the knee amputee. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed form titled, Notice of Transfer dated 11/24/25, states in part, .An immediate transfer or discharge is/was required by the residents' urgent medical needs. Surveyor did not find a specific reason for the transfer. On 04/01/26 at 8:29 AM, Surveyor interviewed Social Services Manager F and asked for verification documentation that Ombudsman was notified of hospitalizations. Social Services Manager F reported that they would gather the information. Surveyor asked Social Services Manager F for the process for notifying Ombudsman. Social Services Manager F reported to Surveyor that usually Social Services Manager F will send notifications to Ombudsman around the 10th of each month. Social Services Manager F reported that they like to wait until everything has been cleared up in the medical record so that Social Services Manager F can print the report which is sent to the Ombudsman. On 04/01/26 at 8:45 AM, Surveyor received and reviewed the Ombudsman notification via Social Services Manager F's emails. On 04/01/26 at 9:12 AM, Surveyor interviewed Social Services Manager F and asked why October hospitalizations were not sent to Ombudsman until 12/16/25. Social Services Manager F stated, I cannot recall why it didn't get sent until then. Example 2 R67 was admitted on [DATE], transferred to hospital on [DATE], and re-admitted on [DATE] with diagnosis of Urinary Tract Infection (UTI) and Hyperkalemia. Surveyor reviewed form titled, Notice of Transfer dated 01/13/26, states, .An immediate transfer or discharge is/was required by the residents' urgent medical needs. Surveyor did not find a specific reason for the transfer. Surveyor reviewed Social Services Manager F's email notifications to Ombudsman, dated 03/27/26, which states in part, Notified of January hospitalizations including R67's hospitalization on 01/13/26 on 03/27/26. R67 was transferred to hospital again on 02/27/26 and re-admitted on [DATE] with diagnosis of status post Covid infection. Surveyor reviewed form titled, Notice of Transfer, dated 02/27/26, which states in part, .An immediate transfer or discharge is/was required by the residents' urgent medical needs. Surveyor did not find a specific reason for the transfer. On 04/01/26 at 9:12 AM, Surveyor interviewed Social Services Manager F and asked why January 2026's hospitalizations were not sent to Ombudsman until 03/27/26. Social Services Manager F stated, I cannot recall why it didn't get sent until then. On 04/01/26 at 9:43 AM, Surveyors interviewed Director of Nursing (DON) B about R67's and R8's discharges. DON B stated the expectation is for nursing staff to fill out transfer forms accurately with a specific reason on why residents are being transferred so the resident, representative, and hospital (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	are aware of the medical needs residents will need when transferring to higher level of care. Example 3 R19 was admitted to the facility on [DATE]. On 09/10/25, R19 was transferred to the hospital via ambulance for evaluation of worsening surgical incision wound. R19 was admitted to the hospital for osteomyelitis and discharged back to the facility on [DATE]. The facility's written notice of transfer did not include the specific reason for transfer. The facility did not notify the Ombudsman of the transfer until 03/31/26. On 10/28/25, R19 was transferred to the hospital via ambulance for evaluation after a fall and was admitted to the hospital. There was no written notice of transfer documented. The facility did not notify the Ombudsman of the transfer until 12/16/25. On 12/01/25, R19 was transferred to the hospital via ambulance and was admitted to the hospital. The facility's written notice of transfer did not include the specific reason for transfer. On 04/01/26 at 9:10 AM, Surveyor interviewed Social Services Manager F regarding written notice of transfers and Ombudsman notification. Social Services Manager F stated the transfers/discharges from September 2025 were missed and accidently sent the wrong month. This wasn't recognized until March 2026 and was then sent to the Ombudsman. Surveyor asked Social Services Manager F about the Ombudsman notifications for October 2025 not being completed within 30 days. Social Services Manager F stated she could not recall why this happened. Example 4 R1 was admitted to the facility on [DATE]. On 12/21/25, R1 was transferred via ambulance to the hospital and was admitted for treatment of UTI. The facility's written notice of transfer did not include the specific reason for transfer.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not determine if self-administration of medications was clinically appropriate for 1 resident (R7) out of 3 residents reviewed for self-administration of medications in a sample of 17 residents. The facility did not ensure the interdisciplinary team (IDT) assessed and determined R7 was clinically appropriate to self-administer prescription topical creams and inhalers, located in R7's room and at bedside. This could result in an adverse event happening because of R7 incorrectly self-administering medications. Findings include:The facility policy, titled Self-Administration of Medications, last revised 03/2026, states, . a resident's cognitive, communication, visual, and physical ability to carry out this responsibility will be evaluated quarterly and as needed.if the resident is a candidate for self-administration of medications, this will be indicated in the medical record.resident's care plan will be updated to reflect self-administration.R7 was admitted to the facility on [DATE] and has diagnoses that include chronic obstructive pulmonary disease (COPD), muscle weakness, low back pain and reduced mobility.R7's Minimum Data Set (MDS) assessment, dated 02/09/2026, indicated R7 has a Brief Interview for Mental Status (BIMS) score of 13, which means cognitively intact. R7 makes own health care decisions. R7's care plan, last revised 03/27/2026, does not include any information related to self-administration of medications.R7's physician orders included*Fluticasone-Salmeterol (Advair) inhalation aerosol powder breath activated 250-50 MCG/ACT - 1 inhalation orally two times a day related to COPD*Tiotropium Bromide Monohydrate (Spiriva) inhalation aerosol solution 2.5 MCG/ACT - 2 inhalations orally one time a day related to COPD*Voltaren external gel 1%. Apply to affected areas topically four times a day for painThere is no physician order for R7 to self-administer medications or for medications to be stored at bedside/roomThere is no evidence that a self-administer assessment has been done by IDT to determine if R7 is clinically appropriate to self-administer medications or safely store medications in room.On 03/30/2026 at 12:52 PM, Surveyor observed:*4 partially used tubes of generic Voltaren gel on the windowsill in R7's room.*Advair inhaler also sitting on windowsill of R7's room. There was no pharmacy label attached to these medications identifying who the medication was prescribed for, or instructions for use. *Spiriva inhaler sitting on a tray table next to R7's bed. A pharmacy label was observed with R7's name and instructions for use. Both the Spiriva and Advair inhalers had a written date of 3/6 on them. On 03/30/2026 at 12:52 AM, R7 was lying in bed. Surveyor asked R7 about the medications and if he used the medications independently. R7 indicated he used the Spiriva inhaler when he is having breathing difficulty, Maybe 3 times a day. When asked about the Voltaren gel on the windowsill, R7 indicated he was not aware of them. R7 informed Surveyor the Voltaren gel was for an area on the butt but could not remember if staff applied the gels yet that day. R7 stated certified nursing assistants (CNAs) apply the gels during cares because R7 is unable to reach buttock area. When asked about the Advair inhaler, R7 was not aware of Advair inhaler on windowsill. R7 could not provide Surveyor with instructions for use or if it was administered by staff that day. On 03/31/2026 at 7:33 and 10:19 AM, Surveyor observed the Voltaren gel and Advair inhaler on still on the windowsill in R7's room, along with Spiriva inhaler on the tray table. On 04/01/2026 at 6:40 AM, Surveyor observed the tube of Voltaren gel and Advair inhaler on the windowsill, and the Spiriva inhaler was on tray table next to R7. Surveyor asked R7 if he administered any inhalers that day. R7 could not recall if inhalers were administered by staff or himself stating, I don't think I did yet. Surveyor asked R7 if able to reach the medications sitting on windowsill to self-administer and R7 stated he could not. Surveyor asked R7 if he knew when to administer the Spiriva inhaler. R7 stated, I have a body clock. I know when to use it. On 04/01/2026 at 7:07 AM, Surveyor asked License Practical Nurse (LPN) D if R7 was able to self-administer the inhalers sitting in his room. LPN D stated yes. LPN D was unsure if R7 knew when to take them and stated R7 required cueing from staff. LPN D stated CNAs administer the Voltaren gel as needed during cares for (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's shoulder pain. On 04/01/2026 at 11:30 AM, Surveyor asked Director of Nursing (DON) B how residents are determined to be clinically appropriate to self-administer medications. DON B stated upon admission, a self-administration assessment is done on all residents. DON B stated if a resident is clinically appropriate to self-administer medications, it is documented in the resident's medical record. DON B stated no medications are to be left in a resident's room.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not notify the provider of changes in condition for 1 of 17 residents (R19) reviewed.This is evidenced by:The facility's Standing Orders, most recently reviewed and approved by the Medical Director on 03/05/26, states, Please follow these standing orders unless otherwise indicated by healthcare provider. Provider Notification: Systolic Blood Pressure less than 90 or greater than 200.R19 was admitted to the facility on [DATE] with diagnoses that include cognitive communication deficit, acquired absence of right leg above knee, chronic kidney disease stage 3.R19's most recent quarterly Minimum Data Set (MDS) assessment, dated 03/18/26, noted a Brief Interview for Mental Status (BIMS) score of 15, indicating cognition intact.Surveyor reviewed R19's vital signs:*10/24/25, R19's blood pressure (BP) was documented as 83/50. No provider notification of systolic blood pressure (SBP) less than 90 was noted.*10/25/25, R19's BP was documented as 87/56. No provider notification of SBP less than 90 was noted.*11/07/25, R19's BP was documented as 83/54. No provider notification of SBP less than 90 was noted.*11/17/25, R19's BP was documented as 89/61. No provider notification of SBP less than 90 was noted.*02/25/26, R19's BP was documented as 84/53. No provider notification of SBP less than 90 was noted.Surveyor reviewed R19's progress notes:*10/27/25 at 1:48 PM, Speech Therapy (ST) entered a note stating R19 had reported experiencing recent visual hallucinations of seeing animals and spiders in room. No additional documentation was noted of informing nursing staff of this change in mental status. No documentation was noted of nursing staff informing provider of change in mental status.On 04/01/26 at 8:29 AM, Surveyor interviewed Registered Nurse (RN) E regarding provider notification of changes. Surveyor asked RN E when the facility's standing orders are implemented. RN E stated that she honestly had no idea and that typically the provider will enter orders of when to be notified. Surveyor asked RN E if provider notifications would be documented in the resident's chart. RN E stated yes, in a progress note. Surveyor asked RN E what the facility's procedure was when other staff, such as ST, identify a change in mental status. RN E stated that other staff, like ST, would typically tell the nurse and the nurse would handle notifying the provider of the change and write a progress note in the resident's chart.On 04/01/26 at 8:33 AM, Surveyor interviewed Licensed Practical Nurse (LPN) D regarding provider notifications. Surveyor asked LPN D when nursing would notify the provider of abnormal vital signs, such as a low BP. LPN D stated that they typically follow the provider's orders for when to notify of changes, but typically when an abnormal BP is taken, the nurse would review the resident's chart to see if there was a trend of lower/higher BP. Then the nurse would decide if it is something that should be reported to the provider. Surveyor asked LPN D what an abnormally low BP would be for reporting to the provider. LPN D stated 82/52. Surveyor asked LPN D why this exact reading. LPN D stated he didn't know, but that would be a reading he would report to the provider. LPN D stated after notifying the provider, the nurse would enter a progress note in the resident's chart documenting what was reported to the provider.On 04/01/26 at 9:15 AM, Director of Nursing (DON) B stated nursing staff are expected to follow the standing orders. Surveyor asked DON B what the expectations are when ancillary staff, such as ST, identify a change in a resident. DON B stated she honestly did not know if that staff should report directly to the provider or the nurse. DON B stated the nurse would be expected to write a progress note in the resident's chart of what the notification was regarding and any response by the provider. Surveyor informed DON B of R19's BP findings and no evidence of notifying the provider. DON B stated that those BPs should have been reported to the provider.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review and interview, the facility did not implement policy and procedures related to screening employees for a prior history of abuse, neglect, exploitation of residents, or misappropriation of resident property for 2 of 8 employees reviewed. -The facility did not ensure their abuse policy was implemented when two employees' Background Information Disclosures (BID) did not include results from the Department of Justice (DOJ) and Integrated Background Information System (IBIS) before Certified Nursing Assistant (CNA) P and Facility Driver O started working for the facility. Findings include:The facility's policy titled, Abuse Prevention reads in part, . Employee Screening . 2. All employees will be properly screened for criminal background.On 04/01/26 at 10:14 AM, Surveyor reviewed 8 random staff's BID.1. On 04/01/26 at 10:32 AM, Surveyor interviewed Regional Human Resource K and asked if facility had CNA P's DOJ and IBIS forms completed when facility ran CNA P's background on 11/01/24. Regional Human Resource reported that when the company took over last year, they had a 3rd party company re-run all employees' backgrounds to start fresh. Regional Human Resource Staff K reported to Surveyor that Regional Human Resource will work on finding the information. On 04/01/26 10:47 AM, Regional Human Resource K entered conference room and reported to Surveyor that upon reviewing CNA P's background information, Regional Human Resource K reviewed that facility only has the DOJ and IBIS from prior background ran on 10/07/21. Regional Human Resource K reported that the 3rd party company must have missed CNA P's DOJ and IBIS as there is not an updated one on file. 2. On 04/01/26 at 11:01 AM, Surveyor interviewed Human Resource (HR) Manager L and asked if HR has the DOJ and IBIS for Facility Driver O as Surveyor could not find the reviews. HR L stated they are not able to provide a DOJ or IBIS for Facility Driver O.

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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 observation, interview and record review, the facility did not ensure the resident's environment remains as free of accident hazards as possible for 1 out of 4 residents (R44).Staff transferred R44 with the incorrect mechanical lift resulting in a fall after Occupational Therapy (OT)'s recommendations for transfer were ordered. R44's care plan was not updated with transfer changes in a timely fashion.Findings include: Facility policy titled, Safe Resident Transfer Program, dated reviewed on 03/26, states: .Steps for Program use: #1. All transfers will be indicated in the care plan. 6. Staff always have the option of using higher level of transfer assist, if in their judgement, the residents condition warrants it; for example, a resident normally uses Ez-Stand but suddenly is unable to bear weight, then a full body lift should be used. Facility policy titled, Fall Prevention, dated reviewed on 11/24, states in part: .Procedure: A care plan is formulated based on the fall risk assessment. If a potential for a fall is triggered, a care plan will be formulated pertaining to fall prevention. If a resident sustains a fall, the care plan is updated. R44 was admitted to the facility on [DATE] with diagnoses including, in part, unspecified encephalopathy, urinary tract infection, cellulitis of right upper limb, spontaneous rupture of other tendons in the right upper arm, polymyalgia rheumatica, venous insufficiency peripheral, gastro-esophageal reflux disease, atrial fibrillation, hypertension, and chronic kidney disease. R44's Minimum Data Set (MDS) assessment, dated 01/13/26, identified on admission that R44 had a Brief Interview for Mental Status (BIMS) score of 15/15. This indicated R44 had intact cognition. The MDS assessment also identified R44 has impairment of upper extremity (shoulder, elbow, wrist, and hand) bilaterally requiring partial/moderate assistance with bathing/showering self, and upper body dressing. R44 was dependent on lower body dressing. R44 was substantial/maximal assistance with sit to stand, chair to bed transfer, and toilet transfer.Surveyor reviewed R44's self-care deficit care plan initiated on 11/21/24 and revised on 01/20/26:-Ambulation: I require assistance of one contact guard assist with wheelchair to follow.-Bathing-Max assist.-Bed mobility: I require extensive assist of 1 to assist me with bedmobility.-Dressing: I require max assist of one with upper and lowerbody dressing.-Personal hygiene: I require total assistance with one with toilet.-Transfers: I require extensive assistance x1.Surveyor reviewed R44's fall care plan initiated on 11/21/24 and revised on 01/20/26:-Fall 10/17; maintenance to fix wheelchair brakes, initiated on 10/17/25.-Fall 03/26/26; changed to Hoyer lift, PT/OT eval and treat, initiated on 03/31/26.-Keep personal items in reach as well and call light; proper foot wear when up, initiated on 11/21/24.On 03/19/26 at 8:26 PM, bruising to right lower abdomen, sent on communication to provider: Noted with night cares: Bruise to right abdominal. Staff continue to report resident is having difficulty transferring especially using left leg. Staff reports that when resident gets off the toilet she leans heavily into toilet paper dispenser due to not using left leg. Most probable cause of bruise. Writer has sent a request for therapy to evaluate. Not sure if that has been done yet but will request again. Will monitor bruise until resolved. R44's progress note on 03/20/26 at 9:57 PM, states a note was sent to the provider stating Patient has been having an increased difficulty with transfers; she is not standing well and her positioning on her toilet riser does not seem appropriate. Can we get an order for PT/OT to eval and treat? Thanks. Awaiting response.A progress note on 03/22/2026 at 5:41 AM, states, Nursing: CNA (Certified Nursing Assistant) just reported to this nurse that resident was uncooperative with cares this morning. She has been having more difficulty with transfers and has a PT/OT referral for re-evaluation. For the weekend it is nursing's suggestion from previous shifts to use a Hoyer lift for resident and staff safety.R44's 3/25/2026 progress note at 12:45 PM, states Therapy: Received verbal consent from resident on 3-25-26 @ 11:43am regarding an PT/OT evaluation due to resident having more difficulty with upper body strength and transfers. Reviewed residents' insurance coverage of therapy services.Surveyor (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed OT evaluation progress note dated 03/26/26, states, .Initial evaluation: Upper and lower body dressing max assist x1, toileting hygiene max assist x1, and transfer using sit to stand with min-mod assist.Surveyor reviewed OT evaluation progress note dated 03/27/26, states .Updated: Patient to stand pivot with 1-2 assist using grab bars or walker, condition varies, and if weakness noted use Hoyer lift.On 03/27/26 at 9:31 PM, Nursing: Resident complained of arms hurting with writer receiving report that staff has been using EZ stand to transfer resident. Received scheduled Tylenol as ordered.On 03/28/26 at 5:23 PM, Nursing: Resident has been having an increased difficulty with transfers with an order for PT/OT that was obtained on 03/20. Resident has a dark purple bruise noted to right inner upper arm into her right axilla area. Writer was notified that staff have been using EZ stand to transfer the resident. Resident states she got it from the machine that they use to haul you around. She complained of 5/10 general pain all over, mostly in her arms. Scheduled Tylenol administered and ice to right axilla area. DON notified. Provider notified.On 03/28/26 at 6:16 PM, Nursing Late Entry: Adding to note above: Dark purple bruise noted to residents' inner breast and a smaller bruise to left breast. Resident on Eliquis 5mg twice a day. Provider ordered Hold Eliquis for one dose, continue to monitor.On 03/28/26 at 6:23 PM, SBAR summary: Situation: The Change in Condition/s reported on this CIC (change in condition) Evaluation are/were: BruisingOutcomes of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were:- Functional Status Evaluation: General weakness Decreased mobilityNursing observations, evaluation, and recommendations are Ice, rest, and scheduled Tylenol to be given. PT/OT to evaluatePrimary Care Provider Feedback: Primary Care Provider responded with the following feedback:A. Recommendations: Hold Eliquis and monitor.On 3/29/26 at 12:27, SBAR Situation: The Change in Condition/s reported on this CIC Evaluation are/were: FallsOutcomes of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were:- Functional Status Evaluation: General weakness FallNursing observations, evaluation, and recommendations are:Primary Care Provider Feedback: Primary Care Provider responded with the following feedback:A. Recommendations: follow facility protocolC. New Intervention Orders: - Hoyer for transfers.-On 3/29/26 at 12:56, Nursing: Staff were in bathroom with the resident and was transferring her to the toilet when her knees gave out and she was helped to floor. She did not hit her head. Denies dizziness or new pain. We have started vital/neuro checks per facility protocol and intervention will be to use Hoyer for transfers until re-assessed by therapy.-On 3/30/26 at 1:18 PM, alert charting: Skin Alteration (monitor bruising to right axilla and right/left breasts) Purple bruising remains to right breast and axilla. States are still sore. Does not appear to be increasing in size. Eliquis had been held yesterday.Surveyor reviewed OT evaluation progress note dated 03/30/26, states in part, .Updated: Hoyer lift.03/31/26 at 8:56 AM, IDT (Interdisciplinary Team) Note Text: IDT met to review fall on 3/29. The resident was lowered to the floor with transfer via EZ stand. The resident had been experiencing weakness, seen by PT and OT. Transfer status changed to Hoyer lift. MD and brother updated. Care plan updated to reflect change in transfer status. On 03/31/26 at 9:01 AM, IDT, Note Text: IDT met to review bruising to right arm and bilateral breasts. Resident had been experiencing increased weakness. Resident reports bruising was caused by machine they use to haul me around. Resident's is seen by PT and OT r/t (related to) increased weakness. MD and DON notified, resident is own person. Eliquis was held times one dose. Resident has now been downgraded to Hoyer lift. Resident placed on alert charting to monitor .On 03/30/26 at 12:58 PM, Surveyor interviewed R44 who indicated that R44 has a bruise under right shoulder/armpit because staff keep picking her up by that machine that hauls you around. Surveyor asked R44 to specify what machine R44 is speaking of. R44 reported to Surveyor that R44 is unsure of the name of the machine but that it's the one with the sling that goes under arms to lift to stand. R44 stated to Surveyor, I told those girls I can't lift my arm due to my left shoulder having very limited range of motion. I tell them it hurts so bad and now look at me. On 03/31/26 at 10:24 AM, Surveyor interviewed Registered Nurse (RN) E and RN H and asked about Physical Therapy (PT) updates. RN E reported (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that updates are placed in the 3 binders per hall at the nurse's station as well as updating the medical record for all to see right away. RN H reported there is also a daily update pink binder near the time clock that all CNAs and nurses are to view when clocking into each shift. It is located near the time machine.Surveyor reviewed the pink binder near the time clock and observed R44's care plan was not updated with R44's new transfer changes until 03/31/26 even though PT had recommended using a Hoyer beginning on 3/27/26.On 03/31/26 at 10:35 AM, Surveyor interviewed Therapy Program Manager J and asked about R44's transfer status. Therapy Program Manager J reported that R44 is a Hoyer lift now. Therapy Program Manager J reported that PT received the evaluation order on 03/26/26. PT evaluated and implemented R44's new transfer status on 03/26/26, Transfer using non-mechanical sit to stand with min-mod assist. Therapy Program Manager J reported that an updated evaluation was completed by OT I on 03/27/26, patient to stand pivot with 1-2 using grab bars or walker condition varies, if weakness noticed use Hoyer, and then on 03/30/26, Hoyer lift. Surveyor reviewed the pink binder near the time clock and noted that R44's care plan was updated on 03/30/26 and that R44 was changed to Hoyer lift due to weakness on 03/30/26. On 03/31/26 at 12:18 PM, Surveyor interviewed OT I and asked OT I to walk Surveyor through the process for when R44 was evaluated and what was decided with transfer status due to weakness.OT I reported that R44 was having difficulties transferring. PT was notified and OT I evaluated R44 on 03/26/26 and deemed R44 to transfer using sit to stand with mid-mod assist. OT I reported to Surveyor that at the time the staff on the floor must not have understood the order for R44 to use the sit to stand as staff were noted to be using the EZ-Stand lift. OT I reported to Surveyor that then OT I re-evaluated R44 due to further weakness and complaints of pain. R44 was mad that staff were using the EZ-Stand as it hurts R44's shoulders. OT I reported that R44 is not a candidate for EZ-Stand due to R44's history of shoulder concerns. OT I reported to Surveyor that on 03/27/26, OT I changed status to patient to stand pivot with 1-2 using grab bars or walker, condition varies, if weakness noticed use Hoyer. OT I stated to Surveyor, [R44] was having a very hard time even transferring with stand by assist over the last couple weeks, which is why [OT I] educated [R44] heavily that if [R44] does not show [OT] I that [R44] can stand strong, [R44] will need to be Hoyer.OT reported that two days later, R44 had fallen via EZ-Stand by CNAs transferring R44 and that's when OT I changed R44 to full Hoyer. OT I reported that staff must have been confused about transferring R44 with sit to stand versus EZ-Stand, so on 03/30/26 at the IDT review meeting, OT I brought up concern with needing very detailed language explained to staff on mechanical and non-mechanical lifts so that staff understand the correct transfer means.On 03/31/26 12:33 PM, Surveyor asked CNA G what the difference between an EZ-Stand and Sit-to-Stand were. CNA G reported that every facility is different and thought they were both the same here at this facility. CNA G stated there was confusion over the sit-to-stand being the stand alone which is not mechanical but then the EZ-Stand was used on R44 when staff were not supposed to. On 03/31/26 at 12:45 PM, OT I approached Surveyor and stated, I just looked back at notes and confirmed that if [R44] was feeling weak or having difficulties transferring, staff were to use straight Hoyer for [R44]. [R44] was transferred by staff via mechanical EZ-Stand two days later and fell or lowered while in mechanical lift. On 03/31/26 at 1:35 PM, Surveyor interviewed Director of Nursing (DON) B and reviewed R44's progress notes pertaining to R44's fall and in the improper transfer on 03/29/26. DON B reported that R44 should have went straight to Hoyer until further evaluation for safety. DON B indicated staff did not do that. DON B stated there are standing orders allowing staff to downgrade R44's transfer status from stand pivot to Hoyer. DON B reported that aides did not use a Hoyer for R44's transfers. DON B reported that R44 should have went straight to Hoyer until further evaluation for safety. Surveyor asked DON B about R44's fall on 03/29/26. DON B reported to Surveyor that staff were not supposed to be using EZ-Stand at all, and the EZ-stand is not what was ordered for transfers. DON B acknowledged R44's care plan was not updated until 03/31/26. DON B stated the process is usually done by unit managers but should have been done timely.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure a resident who is continent of bladder on admission receives services and assistance to maintain bladder function as possible for 1 of 5 residents (R54). The facility did not ensure an accurate bowel and bladder assessment completed upon admission to determine an appropriate toileting program or plan in place to manage current urinary status or regain/maintain urinary continence status. The facility policy titled Bowel and Bladder Assessment last revised 03/26 states: It is the policy of this facility to provide the resident who is incontinent of bowel and/or bladder the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Under the section titled Purpose states: The purpose of the bowel and bladder evaluation is to develop an individualized, goal-oriented approach to elimination. Under the section titled Procedures states in part: 1. The Bowel and Bladder Evaluation will be completed on residents upon admission, quarterly and as needed for changes in condition to determine the appropriate level of bowel and bladder program. Bowel and Bladder scoring: 1. 0-4 = Good Candidate for Bowel and Bladder re-training . 2. Residents identified to have the potential to benefit from a bowel and bladder program (residents with the score of 0-12 on the Bowel and Bladder Evaluation form) will be started on a d day Bowel and Bladder diary. 3. Based on the results of the voiding diary, the appropriate toileting program will be established. R54 was admitted to facility on 02/25/26 from hospital after a fall causing a displaced fracture of left humerus, pubis and hip socket, and pelvic hematoma of urinary bladder causing slight displacement to the right. R54's Medicare 5-day Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 11/15 (mildly impaired). R54's Medicare 5-day Minimum Data Set (MDS), dated [DATE], indicated prior to the current injury was: *Independent with activities of daily living including toilet use, dressing, and ambulation without an assistive device. *Independent with toilet use. *Independent with activities of daily living and functional cognition with planning regular tasks, such as shopping or remembering to take medication. R54's admission MDS dated [DATE] indicated: *Dependent for: toileting hygiene, lower body dressing, sitting to stand positioning and transfers. *Impairment on one side of both upper and lower extremity. *Requires use of a wheelchair for mobility. *Frequently urinary incontinence. *Does not have a toileting program for schedule toileting, prompted voiding or bladder retraining attempted. R54's daily skilled nursing notes dated 02/25/26 through 04/01/26 indicated, Genitourinary: Resident continent of bladder. Urine clear yellow. Denies urinary complaints. R54's Bowel and Bladder evaluation completed on 02/28/26 indicates continent or good candidate. R54's Certified Nursing Assistant (CNA) task completed every shift 02/25/26 through 04/01/26 indicates incontinent of bladder every day. R54's care plan does not address bladder concerns, goals or interventions. On 03/30/2026 at 11:16 AM, Surveyor interviewed R54 who stated they had no urinary problems and did not wear any products prior to the fall with fractures. R54 stated now I wear a diaper or at times stated will use urinal or puts on call light, but they are busy, and I don't like to bother them. On 03/31/2026 between 6:03 AM and 8:18 AM, Surveyor completed a continuous observation outside R54's room. The door was shut, and no call light use observed. On 03/31/2026 at 8:18 AM, 2 staff entered R54's room and repositioned R54 for breakfast. Resident did not request to use bathroom, and staff did not offer or assist with toileting. On 04/01/2026 at 5:17 AM, Surveyor interviewed CNA C. CNA C stated R54 will at times attempt to use the urinal independently, or ring for assistance to use urinal, but is sometimes still unaware of incontinence. On 04/01/2026 at 7:10 AM, Surveyor interviewed Director of Nursing (DON) B regarding R54's continence status. DON B stated that R54 was incontinent of urine in hospital prior to admission due to bladder being shifted due to hematoma from fall at home with fractures. DON B stated that based on licensed nursing staff documenting R54 was continent of bladder upon admission. DON B (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated further assessment, monitoring or toileting plan was not developed. On 04/01/2026 at 8:51 AM, DON B indicated they were unable to locate a care plan on R54's bladder incontinence, goals or interventions to manage, maintain or improve incontinence status.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications for 2 of 2 residents (R10 and R55).The facility's policy and procedure included a method that is no longer recognized as a nationally accepted standard of practice. Staff were unable to provide a reference to a nationally recognized standard of practice used to develop their policy and procedure. Facility staff were observed using auscultation as it may not provide accurate results. R55 and R10's tube placement was checked using auscultation. This is evidenced by: Facility's policy titled, Gastrostomy Tube Care and Management, with a reviewed date of 03/2026, states in part: Policy: It is the policy of this facility to provide proper care and maintenance of gastrostomy tubes. Procedure: 4. Before every feeding, verify the tube position.check the position every shift and as needed using aspiration of gastric contents, air auscultation, X-ray examination, or external graduation marks. 9. Verifying Tube Placement: a. Verify gastrostomy tube placement prior to starting the administration of the tube feeding. i. Use of external graduations mark: Most gastrostomy tubes are graduated for easy verification. Note this graduation measure on the resident record as a reference point. ii. Aspiration of stomach contents: The physician may recommend that you draw back on the syringe to check for residual feeing contents in the stomach. If the amount of residual is less than 100 cc, continue feeding. If the amount of residual is greater than 100 cc, return aspirated gastric contents to the stomach and hold the feeding for one hour. After one hour, check the residual again. If the amount is still large, continue to hold the feeding and notify the physician. Follow physician orders. iii. Air auscultation: This method involves listening to the stomach with a stethoscope while injecting air into the tube with a syringe. You should hear a bubbling or gushing sound as the air enters the stomach. Example 1: R10 was admitted to the facility on [DATE] with a diagnosis of dysphagia oropharyngeal phase. On 01/22/26, R10 had a PEG tube inserted after failed swallow study and aspiration pneumonia. R10's physician orders: 01/27/26 Check gastric residual volume Q 8 hours and PRN. 01/27/26 Check tube placement by auscultation before initiating enteral feeding every shift. According to American Society of Parenteral Nutrition, auscultation is no longer a recommended process for checking tube placement. R10's care plan, dated 01/28/26, with a target date of 05/13/26 states: Requires tube feeding related to dysphagia with a goal to remain free of side effects or complications related to tube feeding. Interventions include: Check for tube placement and gastric contents/residual volume and record. On 03/31/26 at 7:06 AM, Surveyor observed Licensed Practical Nurse (LPN) D administer prepared medications via R10's PEG tube. Prior to administering medications, LPN D gathered a stethoscope, (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	graduate container with tap water, and a large syringe with plunger and brought items to R10's bedside. Surveyor asked LPN D to describe what she was going to do. LPN D stated that he was going to verify placement of R10's PEG tube by auscultating air into the tube and listening for a 'whooshing' sound. Surveyor then observed LPN D place the stethoscope on R10's abdomen. LPN D then pulled back the plunger on the syringe, connected it to the PEG tube, and push in approximately 30 ml of air into R10's PEG tube. LPN D stated that he heard the whoosh and disconnected the plunger from the PEG tube. LPN D stated that they also check the gastric residual volume to ensure placement. Surveyor asked LPN D what the nurse would be looking for in gastric volume. LPN D stated he couldn't remember exactly but that if it is under a certain amount then it's fine, but if it's over a certain amount then the nurse is supposed to call the provider. On 03/31/26 at 10:20 AM, Surveyor interviewed Director of Nursing (DON) B regarding enteral feeding tube assessments. Surveyor asked DON B what the current procedure is for nursing to assess placement of PEG tubes. DON B stated by using auscultation to listen for the 'whoosh' sound and residual volume. Surveyor asked DON B what guidance the facility uses to determine their PEG tube placement assessments. DON B stated the Medical Director. DON B did not provide a nationally recognized standard of practice on which the facility's policy and procedure is based on. Example 2 R55 was admitted to the facility on [DATE] with pertinent diagnoses of dysphagia, amyotrophic lateral sclerosis (ALS,) pneumonitis due to inhalation of food and vomit, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. R55's care plan, dated 03/17/26, states: Requires tube feeding related to recent aspiration pneumonia, dysphagia, and progression of ALS. Interventions include in part Monitor/document/report to MD: Tube dysfunction or malfunction, .Self-extubating. R55's physician orders dated 03/17/26 state: Check tube placement by auscultation before initiating enteral feeding. Every shift. Of note: order to check tube placement by auscultation does not follow current practice guidelines. Check for tube placement and gastric contents/residual volume and record. Check gastric residual volume Q 8 hours and PRN. Every shift if there is more than 250ml of GRV, withhold further and recheck in an hour. Notify physician if the GRV is more that 250ml on the second check. If the GRV is greater than 500ml, withhold feeding and notify the physician. On 03/31/26 at 8:41 AM, Surveyor observed LPN D administer prepared medications via R55's PEG tube. Prior to administering medications, LPN D gathered a stethoscope, graduate container with tap water, and a large syringe with plunger and brought items to R55's bedside. Surveyor observed LPN D fill the large syringe with plunger with 30 cc of water and pushed in the 30cc of water into the PEG tube. LPN D then proceeded to place the stethoscope on R55's abdomen. LPN D then pulled back the plunger on the syringe, connected it to the PEG tube, and push in approximately 30 ml of air into R5's PEG tube stating, That sounds good, I heard a swish sound. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted LPN D did not check gastric residual during process. On 04/01/2026 at 6:30 AM, Surveyor interviewed LPN D regarding auscultation and checking gastric residual. LPN D described what surveyor observed of listening for swish per policy and stated did not check residual as ordered.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that residents are free from significant medication errors for 1 of 17 residents (R55) R55 was not administered medication for bowel regimen based on physician orders. R55 was admitted to the facility on [DATE] with diagnoses of dysphagia, amyotrophic lateral sclerosis (ALS,) pneumonitis due to inhalation of food and vomit, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. R55's physician orders dated 03/24/2026 state: Metamucil Oral Powder 48.57 % (Psyllium) Give 1 Tbsp via PEG-Tube one time a day for loose stools mixed in 4-8 ounces free water. R55's record shows last bowel movement was documented on 3/28/26 at 19:45 7:45 PM of incontinent small formed soft/normal stool. On 03/31/2026 at 8:41 AM, Surveyor observed Licensed Practical Nurse (LPN) D set up R55's medications which included order for Metamucil. LPN D measured 1 tablespoon of Metamucil and placed it into a 30cc medication cup and added 5 cc of water without stirring medication.When mixed with water, Metamucil thickens. When only a small amount of water is used, the Metamucil can clump into one solid mass. LPN D then took the plunger out of the 60 cc syringe and connected it to PEG tube and gravity fed 5cc of water alternating each medication followed by 5cc of water. During administration of Metamucil, LPN D stated, I don't feel Metamucil is right choice for resident and gravity feeds and addition 30 cc of water as Metamucil clumps in cup and in tubing.The physician's order was to mix the Metamucil with 4 to 8 ounces, or 120 to 240 ccs of water. LPN D only used 30 ccs or a quarter of the minimum ordered amount. LPN D was unable to administer the full dose of Metamucil and discarded the majority of the clumped medication in the trash. Surveyor reviewed Medication Administration of Metamucil which indicated LPN D had administered R55's medication 4 additional dates of 3/25, 3/28, 3/29 and 3/30/26. On 03/31/2026 at 12:46 PM, Surveyor interviewed LPN D after reviewing R55's physician orders. LPN D stated he was not aware of the order to mix with the 4-8 ounces of water and has not been administering extra water per order since order was entered. On 03/31/2026 at 1:16 PM, nurses notes state: Resident has not had BM for 3 days. ABD soft and non-tender with active bowel sounds in all 4 quadrants, denied any GI discomfort, administered PRN MiraLAX, waiting for results.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not maintain an infection prevention program designed to provide a safe and sanitary environment to prevent the transmission of communicable disease and infection for 3 of 17 sampled residents (R7, R43, and R31). Staff did not implement enhanced barrier precautions for R7 and R43. Staff did not perform hand hygiene during R31's medication administration.The facility policy, titled Enhanced Barrier Precautions, dated 03/24/2026, states, Initiation of Enhanced Barrier Precautions (EBP), the facility will have the discretion in using EBP for residents who do not have a chronic wound.an order for enhanced barrier precautions will be obtained for residents with any of the following: wounds (chronic wounds such as pressure ulcers.) even if a resident is not known to be infected or colonized with a methicillin drug resistant organism (MDRO).make gowns and gloves available immediately near or outside the resident's room. Example 1 R7 was admitted to the facility on [DATE]. R7 was documented to have a stage II pressure injury, facility acquired, to buttock area on 03/18/2026. According to the facility's policy and procedure, EBP should have been initiated for R7. R7's care plan did not have focus or interventions in place for EBP. A review of R7's medical record found no standing orders for EBP were started. On 03/30/2026 at 12:52 PM, Surveyor observed a certified nursing assistant (CNA) assist R7 into bed with a mechanical stand device. The CNA was not wearing personal protective equipment (PPE). After completion of R7's transfer to bed, CNA left room and Surveyor then noticed a red bag garbage container in room. Surveyor did not observe signage for EBP in place outside of R7's room. There was no PPE cart outside of room; however, a container with blue gowns and gloves was hanging on a wall just inside the door. On 03/31/2026, between 6:30 AM and 4:00 PM, Surveyor did not observe signage for EBP outside of R7's room. Example 2 R43 was admitted to the facility on [DATE]. R43 currently has a port-a-cath device (a central venous access to administer chemotherapy through) in place right anterior chest. R43's care plan did not have focus or interventions in place for EBP. On 03/24/2026, nursing documentation for R43 indicated a boil/pustule without drainage on upper right chest was noted by staff. On 03/26/2026, area over port site right chest was cultured and antibiotics started. Culture results on 03/27/26 indicated methicillin susceptible staphylococcus aureus infection. Despite antibiotic therapy, port was visible through open wound. No orders for EBP were in place On 03/30/2026 at 10:39 AM, Surveyor observed a red bag garbage container inside R43's room. No (continued on next page)

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	04/01/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signage for EBP in place outside of room. Shelving on wall inside door of room was empty of gowns and gloves. On 03/31/2026 at 6:45 AM, Surveyor was informed by staff that R43 was admitted to the hospital on [DATE] at 8:19 PM for an infected port-a-cath site. On 03/31/2026 at 6:50 AM, Surveyor interviewed Wound Care Registered Nurse (RN) Q and asked if wound care management was being done for R7 and R43. RN Q confirmed wound cares were being done for both residents, and both residents had open, draining wounds. RN Q stated EBP were taken during wound cares. Physician orders for wound management to sacrum were initiated on 03/11/2026. No standing orders for EBP are in place. On 03/31/2026 at 1:33 PM, Surveyor interviewed infection prevention RN N when EBP precautions would be initiated for a resident. RN N stated for any open wounds with drainage, or when working with closed system devices, such as a urinary catheter. Surveyor asked if R7 and R43 should have EBP in place and RN N stated yes, they both should because both have open wounds. Surveyor asked RN N to indicate if EBP signage was in place for R7 and R43 and RN N confirmed there was no signage in place outside either room. Surveyor asked RN N if PPE was available in R43's room and RN N confirmed no PPE was available inside R43's room. RN N stated it was housekeeping's task to stock PPE in rooms. Example 3 The facility's policy titled, Hand Hygiene reviewed 3/2026, states in part, . 2. Use alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations. c. Before preparing and after handling medications.l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident. On 3/31/2026 11:59 AM, Surveyor observed RN M set up R31's medication. RN M positioned the medication cart in front of R31's doorway. RN M reviewed the medication record on the laptop touching the laptop in the process. RN M then opened various drawers of the medication cart, opened narcotic book, took a pen out and wrote in the book. RN M touched multi-use stock medication bottles and various medication cards of multiple residents. RN M then locked her cart and entered R31's room. RN M gave R31 medications with a spoon. RN M then picked up R31's water cup and assisted R31 to take a drink. RN M then exited the room and returned to her medication cart. Surveyor did not observe RN M using hand hygiene at any time during this observation. Immediately after this observation, Surveyor asked RN M about hand hygiene during medication pass. RN M replied, Oh yeah and then proceeded to use the hand sanitizer which was on the medication cart. On 4/01/2026 at 9:22 AM, Surveyor interviewed Infection Preventionist (IP) N about hand hygiene. IP N stated hand hygiene should be performed before preparing residents' medications and prior to assisting a resident with taking the medications.