| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525442 | A. Building<br>B. Wing | 09/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Tomah Nursing and Rehab | 1505 Butts Ave<br>Tomah, WI 54660 |

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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>(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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of professional standards of practice, the facility did not ensure that the services provided by nursing personnel met the professional standards of quality for 1 of 3 residents (R1). Facility received orders to get a UA (urinalysis) on R1. Facility did not obtain the UA for R1 as ordered by the physician.Evidenced by:Surveyor requested a copy of all policies that reflect following the physicians orders and what to do if unable to complete physicians orders. Facility was unable to provide Surveyor with a policy that addressed following physicians orders or what to do if unable to follow physicians orders.R1 was admitted to the facility on [DATE] and has diagnoses that include Alzheimer's disease, dementia without behavioral disturbance, psychotic disturbance, hypertension, edema, anxiety, major depressive disorder, personality disorder, and chronic pain.Nurses Note from 8/8/25 at 15:03 (3:03 PM) states, Family continues to express concerns about urinary urgency, burning and foul-smelling urine. Message sent to provider to request UA/C (urinalysis and culture) and orders received for UA and CBC (complete blood count). CBC obtained and sent to lab. Nursing staff notified to obtain sample. POA (power of attorney) notified.Nurses Note from 8/8/25 at 17:33 (5:33 PM) states, updated POA that labs were obtained and are being run at lab. Unable to obtain urine specimen. Order entered to push fluids through the weekend and continue to monitor for s/sx (signs and symptoms) of urinary issues. POA was satisfied with this.Of note 8/8/25 was a Friday. The facility sends their lab to the clinic if labs are not obtained before the lab closes the facility has to send the resident to the ER or obtain an order to hold the lab until next clinic/lab day.On 9/23/25 at 5:02 PM, Surveyor interviewed RN (registered nurse)/IC (infection control) C. Surveyor asked RN/IC C to tell me about R1's urine not being collected as ordered on 8/8/25. RN/IC C stated, R1 was unable to void then the lab closed so we had to wait till Monday. Surveyor asked RN/IC C if she updated the MD (medical doctor) or NP that she was not able to obtain the urine sample. RN/IC C stated, I believe so but will look for documentation. I would have talked to the NP. On 9/23/25 at 5:10 PM, Surveyor interviewed RNC D (regional nurse consultant). Surveyor asked RNC D what the expectation would be if staff were not able to obtain an ordered UA. RNC D stated, if there is an order for a UA they should collect it and take it to the lab. If unable to get a UA by the time that the lab closes staff would need to take the resident to the ER (emergency room) if ordered STAT (immediately) or contact the MD on what he/she would like done.On 9/23/25 at 5:15 PM, Surveyor RN/IC C provided Surveyor with an email she had sent to the NP through HUCU. RN IC C stated, see I did update. Surveyor asked RN/IC C where we would be able to see the response from the NP. RN/IC C stated, the NP did not respond or give any orders. Surveyor asked RN/IC C if she followed up with NP on if she was okay with not getting the UA. RN/IC C stated she did not.On 9/23/25 at 5:23 PM, Surveyor interviewed RNC D. Surveyor asked RNC D if staff are unable complete an NP or MD's orders and emailed the provider to report this and do not hear back what would the expectation be. RNC D stated, if they don't hear back from the NP or MD, they should contact the on-call provider to follow up on what is to be done.The facility had an order for a UA and was unable to obtain the UA prior to the lab closing on a Friday PM. The facility did not speak with the provider regarding not obtaining the UA or further instruction if the UA should be obtained in ER or hold lab until next clinic/lab day. |