STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525442	A. Building B. Wing	01/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tomah Nursing and Rehab	1505 Butts Ave 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to thoroughly investigate an allegation of misappropriation for 1 of 2 abuse allegations (R1). On 1/16/26 R1 reported to CNA C (Certified Nursing Assistant) that she was having pain after CNA C assisted her with cares. CNA C reported R1's concern to RN D (Registered Nurse). R1 told RN D, That CNA was rough and She didn't mean to hurt me. R1 was sent to the ED (emergency department). The ED physician indicated, I suspect that R1 likely has a right elbow sprain. The facility failed to interview other residents to determine the scope of the concern. Therefore, this incident has not been thoroughly investigated. This is evidenced by:Facility policy, titled Abuse Prevention Program Policy and Procedure, includes: Each resident has the right to be free from abuse, neglect, and corporal punishment of any type by staff or anyone. The facility will provide a safe resident environment and protect residents from abuse. Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Abuse also includes the deprivation of an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well being. Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, or others but has not yet been investigated and if verified could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. Investigation: Identify alleged perpetrator, remove from resident care area immediately, suspending investigation conclusion, obtain statement. Identify and interview all involved-witness statements- including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. Interview coworkers or other supervisors in regards to the alleged perpetrator's work performance. Review alleged perpetrator's employee file to confirm background checks, reference checks, and to review any possible past performance issues. Determine if abuse, neglect, . occurred, the extent, and the cause. Providing complete/thorough documentation of the investigation findings. time line of events. summary or conclusion. Follow-up actions to correct and prevent potential recurrence. All information must be gathered and reviewed with a final summary analysis with an action plan to prevent reoccurrence. R1 was admitted to the facility on [DATE] with diagnoses including: dementia with behavioral disturbance (memory impairment with a variety of behaviors), cerebral infarction-multiple (strokes), and weakness. R1's Comprehensive Care Plan, initiated 8/31/25, indicates R1 requires 1 staff for bed mobility. Toileting: R1 can be incontinent and does need assist of 1. The facility's Self-ReportOn 1/16/26 CNA C (Certified Nursing Assistant) reported to the RN D (Registered Nurse) that R1 was complaining of pain after performing care. When RN D went to assess R1, R1 stated that CNA C was rough. CNA C was suspended pending investigation, R1 sent to ED (emergency department) for evaluation and law enforcement has been notified. R1's statement: CNA C pulled resident to left with her arm. R1 (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	heard a snap and it hurt. RN D came in and moved R1's arm and it hurt real bad. 10/10 pain CNA C's statement: CNA C documents, I went to clean R1 up and she was complaining of her legs that was hurting. I ask if she was having cramps but she said no. I then proceed to clean her up. At some point, I needed her to roll so I could get the other side of the brief to tape. R1 gave me her hand so I hold [sic] her hand and her hip to roll her. That is when she said I hurt her arm, because I pull it. [sic] I try [sic] to look at her arm but I was surprise [sic] she was hurt. RN D's statement: CNA C came to get me to let me know that R1 was complaining of pain in her right arm after she had turned her to provide cares. RN D assessed R1's pain and she was tearful when RN D tried to touch her elbow. CNA C said that she used R1's right arm to pull her towards the window to complete cares. R1 said that she heard a pop when she was being turned and that was when the pain started. R1 said that aide and was crying. R1 stated, I don't want her to lose her job. RN D tried to do range of motion as part of her assessment but R1 was still sobbing. LPN E (Licensed Practical Nurse) went into [sic] talk to R1 to get more information about what exactly happened. R1 is confused and can be hard to understand. The other nurse confirmed to RN D that R1 said CNA C was rough. CNA C was suspended and did not additional cares. Management was notified. LPN E's statement: R1 said that CNA C went to roll her to the left by pulling her arm. R1 heard a snap, she felt pain. RN D came in to check on R1 and R1 tried to lift her arm and it hurt really bad. 10/10 pain. CNA C came to RN D and myself, LPN E, and reported that when she went to roll R1, R1 started screaming at her that her arm hurt. CNA C asked what was wrong, R1 replied that CNA C hurt her. When EMS (Emergency Medical Services) arrived, R1 wasn't sure what happened. R1's pain was 3/10. The ED report documents as follows: R1 presenting to the emergency department by ambulance from nursing facility due to concern for right elbow pain after being repositioned in bed. Upon evaluation, patient is clinically well appearing, vital signs are stable. Physical exam reveals tenderness to palpation of the radial head of the right arm. Radiograph obtained and negative for acute fracture. The physician further documents, I suspect that patient likely has a right elbow sprain. Recommend she use a sling as needed for comfort, take OTC (over the counter) pain meds (medications) as needed. No further documentation was provided related to this incident On 1/26/26 at 3:15 PM, Surveyor spoke with NHA A (Nursing Home Administrator). Surveyor asked NHA A if the facility interviewed other staff regarding this incident. NHA A stated, no. Surveyor asked NHA A if the facility should have interviewed other residents during their investigation. NHA A stated, yes. The facility failed to interview other residents to determine the scope of R1's concern. This is not a thorough investigation.