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	08/29/2024

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46693 Based on observation, interview and record review, the facility did not ensure residents (R) were treated with respect and dignity and cared for in a manner to enhance their quality of life. Facility staff stood over R34 while assisting to eat. This affected 1 of 3 residents observed. Findings include: Facility policy entitled, RESIDENT RIGHTS, last revised January 2024, stated in part, It is the policy of this facility to ensure residents have the right to a dignified existence, self-determination, and communications with and access to persons and services inside and outside of this facility . R34 was admitted to the facility on [DATE] with diagnoses that include weakness, cognitive communication deficit, and diabetes. R34's Minimum Data Set (MDS), dated [DATE], stated that R34 required substantial/maximum assist with eating. On 08/26/24 at 12:57 PM, Surveyor observed Certified Nursing Assistant (CNA) N assisting R34 to eat their noon meal. CNA N stood on the left side of R34 during the entire time R34 was being assisted to eat. R34 did not attempt to feed self at any time during the observed meal. On 08/27/24 at 9:54 AM, Surveyor interviewed Nursing Home Administrator (NHA) A and explained the observations of staff standing over R34 while assisting them to eat. NHA A stated their expectation was for staff to sit beside residents while assisting them to eat. NHA A stated she noticed that yesterday too and spoke with CNA N right after lunch.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47657 Based on observation, interview and record review, the facility did not ensure 4 of 4 residents (R48, R16, R5 and R2) who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal hygiene. The facility did not assure R48, R5, and R16 were provided routine weekly minimum showers as part of their activities of daily living (ADL). The facility staff did not provide assistance with nutrition for R2 who is dependent on staff. This is evidenced by: The facility policy, entitled Activities of Daily Living (ADLs)/Maintain Abilities reviewed on 01/2024, states in part, 3. The facility will provide care and services for the following activities of daily living: a. Hygiene - bathing . Example 1 R48 was admitted to the facility on [DATE]. R48's Minimum Data Set (MDS) with a target date of 06/28/24, indicated that R48 has a Brief Interview for Mental Status (BIMS) of 4 (severe cognitive impairment), requires substantial/maximal assistance with bathing, and dependent on staff to get in/out of tub/shower. On 08/27/24 at 10:48 AM, Surveyor reviewed documentation received from Regional Care Director (RCD) C of R48's routine weekly showers since admission. RCD C provided Skin Monitoring - CNA/STNA Shower Review sheets that stated, Perform a visual assessment of the resident's skin when giving the resident a shower, that were dated 07/18/24, 07/29/24, and 08/22/24. RCD C was unable to provide documentation to support R48 missing 6 shower review sheets for the weeks of 06/23/24, 06/30/24, 07/07/24, 07/21/24, 08/04/24, and 08/11/24 of receiving or refusing a shower. On 08/28/24 at 11:39 AM, Surveyor interviewed R48 regarding receiving showers on a routine basis. R48 stated not recalling if a routine shower was provided. Example 2 R16 was admitted to the facility on [DATE]. R16's Quarterly MDS indicated that R16 has a BIMS of 12 (moderately impaired cognition) requires substantial/maximal assistance for bathing and partial/moderate assistance to get in/out of shower/tub. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/27/24 at 10:48 AM, Surveyor reviewed documentation received from RCD C of R16's routine weekly showers for weeks beginning 06/02/24 to current date. RCD C provided Skin Monitoring - CNA/STNA Shower Review sheets that stated, Perform a visual assessment of the resident's skin when giving the resident a shower, that were dated 07/18/24, 07/29/24, and 08/22/24. RCD C was unable to provide documentation to support R16 missing 7 shower review sheets for the weeks of 06/23/24, 06/30/24, 07/14/24, 7/17/24, 7/21/24, 08/04/24, and 08/18/24 of receiving or refusing a shower. On 08/28/24 at 2:40 PM, Surveyor interviewed R16 regarding receiving showers on a routine basis. R16 stated has not been receiving a shower every week and was not sure what day of the week shower is scheduled, but believes it is on Sundays. Example 3 R5 was admitted on [DATE]. R5's Quarterly MDS with a target day of 04/24/24, indicated that R5 has a BIMS of 11 (moderately impaired cognition), requires substantial/maximal assistance for shower/bathing and requires substantial/maximal assistance for get in and out of shower/tub. On 08/27/24 at 10:48 AM, Surveyor reviewed documentation received from RCD C of R5's routine weekly showers for weeks beginning 06/02/24 to current date. RCD C provided Skin Monitoring - CNA/STNA Shower Review sheets that stated, Perform a visual assessment of the resident's skin when giving the resident a shower, that were dated 06/04/24, 06/07/24, 06/11/24, 07/13/24, 07/20/24, 07/27/24, 07/30/24, 08/08/24, 08/17/24, and 08/24/24. RCD C was unable to provide documentation to support R5's missing 4 shower review sheets for the weeks of 06/16/24, 06/23/24, 06/30/24, and 07/28/24 of receiving or refusing a shower. On 08/28/24 at 11:37 AM, Surveyor interviewed R5 regarding not receiving showers on a routine basis. R5 stated no awareness of missing showers. On 08/27/24 at 10:48 AM, Surveyor interviewed RCD C, regarding expectation from staff if a resident refused a shower. RCD C stated staff should either write resident refused shower on the CNA/STNA Shower Review sheet or the nurse would enter a progress note in chart indicating resident refused. On 08/28/24 at 11:48 AM, Surveyor interviewed Certified Nursing Assistant (CNA) E who cares for R5, R16, and R48 on a routine basis regarding process of documentation when a resident receives or refuses a shower. CNA E stated a skin monitoring shower sheet is filled out for each resident when they receive a shower to indicate any skin concerns while bathing, handed in to the nurse for follow up, and then paper goes to medical records. CNA E stated if a resident refused their bath, they would have resident sign the refusal or write refused on bottom of the form if the resident is unable to sign and hand into the nurse. 46693 Example 4 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2 was admitted to the facility on [DATE]. Diagnoses include, dementia, weakness, multiple sites of contractures, and cognitive impairment. R2's MDS, dated [DATE], indicated that R2 has a BIMS of 4 (severely impaired cognition) and requires supervision and some hands-on assistance by staff for eating. R2's care plan dated 07/29/24 states, .assist with meals as needed and offer substitutes if consumes <50% of meals . On 08/27/24, Surveyor observed the following: At 9:02 AM, R2 was still in their room. R2 had been up since 7 AM. R2's tray was on cart in dining room untouched. Continuous observation of R2's tray was completed. Staff did not take R2's breakfast to R2's room and R2 did not eat in the dining room. There were 4 staff in dining room with 3 staff cleaning up tables and 1 assisting a resident to eat. At 9:11 AM, [NAME] H approached the cart where there were 2 trays left untouched, looked at tickets, then went back into the kitchen. At 9:23 AM, all residents in the dining room were finished eating. A CNA in training, went to cart and checked tickets and walked away. Surveyor observed staff bring R2 to therapy while the tray was still on cart. Therapist asked if R2 liked his breakfast this morning and R2 yelled, No! On 08/27/24 at 9:43 AM, Surveyor interviewed CNA O and Registered Nurse (RN) M about the 2 untouched trays. CNA O stated the one resident always sleeps in and CNA O was not sure of R2. RN M asked where R2 was, and R2 was then found in the hallway. RN M offered the meal and R2 yelled out, No. RN M stated R2 has been here almost a month and does not come right out and say but you can tell he does not want to eat in the dining room. RN M believe it's because R2 is on thickened liquids and R2 needs supervision. RN M will ask the Assistant Director of Nursing (ADON) D what we can do about this. On 08/27/24 at 9:54 AM, Surveyor interviewed Nursing Home Administrator (NHA) A about R2 needing assistance with meals. NHA A stated she would expect a resident with dementia be encouraged to go to the dining room especially if they have modified diets. Residents have the right to eat in their rooms if they prefer. If they refuse, we would try later. Surveyor explained that R2 was up since before 7 AM in wheelchair. Surveyor did not observe anyone offer to bring R2 to the dining room, offer the tray in his room, or offer substitutes. NHA A said this may be because there are 2 people passing trays in the dining room and both are not certified. If tickets have a blue dot on them, it means a nurse or CNA has to pass that tray. On 08/27/24 at 10:16 AM, Director of Nursing (DON) B approached Surveyor and stated, I personally just went down by R2 and asked if he wanted breakfast and he said no, so I told him that if he gets hungry before lunch, let someone know and we can bring you something to eat.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47657 Based on observations, interviews and record reviews, the facility did not ensure 1 of 5 residents (R48) reviewed for high risk of pressure injury development, received the necessary treatment and services to promote healing of existing skin impairments. The facility did not ensure appropriate hand hygiene during wound care was conducted. This is evidenced by: The facility policy entitled Handwashing/Hand Hygiene last reviewed by facility on 01/2024 states in part: Practicing hand hygiene is a simple way to prevent infections by preventing the spread of germs. Wash hands and other skin surfaces when: 1. After immediate contamination with blood, other body fluids or potentially contaminated articles. 2. After removing gloves or other personal protective equipment. 4. Before and after nursing treatments or procedures (dressing changes). R48 was admitted to the facility on [DATE] and has diagnoses that include neutropenia (low white blood cell counts, which are a type of infection-fighting blood cell), type 2 diabetes mellitus with diabetic neuropathy, peripheral vascular disease, and cognitive impairment of uncertain or unknown etiology. R48's care plan, dated 07/22/24, states, Problem: Resident has pressure injury to left heel with potential for infection and discomfort to the area. Interventions include: -Pressure reducing boots on at all times. -Observe and report signs of osteomyelitis (ie; pain, redness or swelling in affected joint, chills, fever (rapid elevation), diaphoresis, tachycardia, restlessness, irritability) -Observe and report signs of sepsis (ie; fever, malaise, mental status changes, tachycardia, hypotension, anorexia, nausea, vomiting, diarrhea, headache, lymph node tenderness/enlargement -Observe and report signs of cellulitis (ie; localized pain, redness, swelling, tenderness, drainage, fever, chills, malaise, tachycardia, hypotension) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/27/24 at 2:09 PM, Surveyor observed Assistant Director of Nursing (ADON) D, enter R48's room to conduct wound care of R48's left heel pressure ulcer. ADON D donned personal protective equipment (PPE) which included gloves, gowns, and goggles. ADON D removed R48's left heel float boot. ADON D pushed call light for transfer assistance then removed gown and gloves to get assistance for the transfer. ADON D returned to room, without conducting hand hygiene, applied clean PPE to transfer R48 to bed. ADON D proceeded to remove soiled dressing with serous sanguineous drainage, cleansed the wound and removed soiled gloves. ADON D, without conducting hand hygiene, proceeded to open clean packages of dressing supplies, donned a clean pair of gloves, and proceed to cleanse left heel again. ADON D with contaminated gloved hands picked up clean skin prep pad and applied on peri wound, placed calcium alginate into the wound and foam border dressing, then wrapped foot with kerlix. On 08/27/24 at 2:44 PM, Surveyor interviewed ADON D regarding facility expectation of completing hand hygiene during dressing changes. ADON D stated expectation would be to conduct hand hygiene between glove changes and when going from clean to dirty. Surveyor shared observation of no hand hygiene between glove changes and after removing soiled dressing and redressing wound. ADON D confirmed not conducting hand hygiene. On 08/28/24 at 2:55 PM, Surveyor shared observation of lack of hand hygiene during dressing change with Regional Care Director (RCD) C, who confirmed expectation would be to conduct hand hygiene after removing soiled gloves and dressings and before donning clean gloves. On 08/28/24 at 8:38 AM, Surveyor interviewed Director of Nursing (DON) B regarding concerns with potential of infecting an open wound if proper hand hygiene is not followed. DON B stated that appropriate hand hygiene is expected during dressing changes to prevent potential wound infections.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40590 Based on observation, interview and record review, the facility did not ensure residents receive adequate supervision and assistive devices to prevent accidents for 5 of 5 residents reviewed (R22, R43, R39, R32, R1). R22 and R43 maintained their own smoking materials which is not consistent with the facility policy for smoking. Staff did not ensure R39 and R32 were smoking safely in designated areas. R39 maintained their own smoking materials. R43's Feeding Precautions were not implemented and placed R43 at risk for aspiration. Staff did not provide R1 with meal assistance for safety as directed in the plan of care. This is evidenced by: The facility policy entitled, Smoking Policy, dated 01/2024, states: -Supervised smoking times will be designated by the facility and posted. -Residents will be alerted at the scheduled smoke time and assisted to designated location. -All cigarettes, and e-cigarettes that are unsmoked will be returned to facility staff for storage. -Smoking material will be labeled and kept in a central location under lock and key and available only to the staff member or family. -Residents that have been assessed as safe smokers will be required to smoke only in designated areas. -Residents are not permitted to have lighters or other smoking paraphernalia on their person during non-smoking times. This includes safe & unsafe smokers. -Smoking aprons will be made available to residents who have been assessed at risk for dropping or mishandling cigarettes and ash. -Smoking is permitted only in properly supervised, designated smoking area. -All smoking materials will be disposed of in the proper designated containers that meet NFPA (National Fire Protection Association) standards. -Residents who knowingly and purposely violate facility smoking policy may have privileges removed and possible subject to involuntary discharge as per State & Federal guidelines. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The Administrator/designee will review the smoking policy with residents who desire to smoke and sign the Smoking Consent Form. Example 1 R22 was admitted to the facility on [DATE] and has diagnoses that include encounter for orthopedic aftercare following surgical amputation, primary, type 2 diabetes mellitus with diabetic neuropathy. R22's Safe Smoking assessment dated [DATE] showed that resident is a safe and independent smoker. R22's care plan, dated 05/24/24, with target date of 07/14/24, states: Problem: Risk for injury related to smoking & drinking. Resident is not always compliant with facility smoking rules & liquor orders. Goal(s): Resident will comply with smoking policies. Resident will safely smoke in designated area with staff supervision. Social services and nursing will discuss the risks and benefits of smoking with resident who will be able to re-state the risks and benefits. Approach: Staff will observe for smoking materials and alcohol that resident may try to keep in room. Approach: Resident will be evaluated upon admission, quarterly and as needed. Approach: Resident will be informed of appropriate areas for smoking. Approach: Resident will obtain own smoking material. Staff will assist upon request and as needed. Approach: Provide verbal cues. Of note, R22's care plan was not updated to reflect that R22 is a safe, independent smoker. List received by the facility of residents who smoke which included R22, states, Resident's Smoking Assessments as of 08/06/24 and All above residents able to smoke independently without supervision. List received by the facility of resident smoking times states, All staff and residents, smoking times are as follows 9:30 AM, 11:00 AM, 3:00 PM, 5:00 PM and 8:30 PM and All residents must be supervised by staff no exceptions. On 08/26/24 at 11:14 AM, Surveyor observed a pack of Marlboro Light 100 cigarettes sitting on R22's bedside table. On 08/27/24 at 8:00 AM, Surveyor observed R22 being pushed down the hallway by a Certified Nursing Assistant (CNA). R22 had a pack of Marlboro light 100 cigarettes sticking out of left shirt pocket. On 08/28/24 at 6:30 AM, Surveyor observed R22 in room. R22 was in bed asleep. R22 had a T-shirt on with a pack of Marlboro Light 100 cigarettes sticking out of the pocket. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/28/24 at 7:59 AM, Surveyor observed Certified Nursing Assistant (CNA) L taking R22 outside to the gazebo to smoke. CNA L left R22 there alone and came back into facility. On 08/28/24 at 8:00 AM, Surveyor interviewed CNA L who stated R22 can smoke independently. CNA L stated R22 keeps lighter and cigarettes within room or on person. 30570 Example 2 Surveyor observed R43's record and noted: R43's Minimum Data Set (MDS) most recently completed 07/02/24 quarterly indicates R43 understands, is understood and is cognitively intact. R43 has no range of motion difficulties. R43's primary diagnosis includes cancer. R43's smoking assessment dated [DATE] indicated R43 is determined to be an independent safe smoker. Surveyor reviewed R43's smoking consent which was completed 08/27/24. The consent notes: ~I have received a copy of the smoking .policies for this facility ~I agree to refrain from smoking in my room or in the building at any time ~I agree to instruct my visitors to adhere to the smoking policy . ~I understand if I violate this agreement, I may lose my smoking privileges . Surveyor reviewed R43's care plan dated 08/27/24. Surveyor reviewed the smoking care plan and noted: Problem: Risk for injury related to smoking. Start date: 08/27/24 Goal: Resident will comply with smoking policies Resident will safely smoke in designated area with staff supervision Social services and nursing will discuss the risks and benefits with resident who will be able to restate the risks and benefits. Approaches all dated as started 08/27/24 Provide redirection as needed (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide verbal cues as needed Resident will be evaluated upon admission, quarterly and as needed Resident will be informed of appropriate smoking areas Resident will be offered alternatives to stop smoking: smoking patch, medication Resident will be provided with a smoking apron if necessary. On 08/26/24 at 3:46 pm, Surveyor observed R43 outside under gazebo smoking a cigarette; no staff were present while R43 smoked. List received by the facility of residents who smoke which included R43 states, Resident's Smoking Assessments as of 08/06/24 and All above residents able to smoke independently without supervision. On 08/27/24 at 7:40 am, Surveyor interviewed CNA J, who is familiar with R43 and routinely provides R43 care, about R43's smoking. CNA J explained R43 usually smokes before and/or after meals. R43's smoking materials are kept in her room and R43 goes to smoking area on own. R43 is safe to smoke on her own and no supervision or devices are needed or offered. On 08/27/24 at 8:45 am, Surveyor observed R43 propel herself from her room up the hallway and through the dining room with a small purse on her lap. Surveyor observed staff approach and assist R43 outside to the gazebo to smoke. Surveyor observed several staff in the dining room and staff assisted R43 to the smoking area. R43 removed a cigarette and lighter from her purse, lit the cigarette and was smoking without supervision. On 08/27/24 at 10:07 am, Surveyor interviewed Licensed Practical Nurse (LPN) K who works R43's wing and oversees her care about R43's smoking needs. LPN K expressed R43 maintains her own smoking materials and smoking aprons are by the exit to the gazebo for those that need them. The Social Worker does the smoking assessments thus she is unaware if R43 requires supervision and devices to smoke safely and if it is safe for R43 to maintain her smoking materials. On 08/28/24 at 7:44 am, Surveyor spoke with Regional Clinical Director (RCD) C regarding the facility smoking policy and R43's care plan for safe smoking. Surveyor verified the current list of resident smokers including R43. Surveyor asked RCD C where the designated smoking areas are located outside the facility. RCD C expressed smoking area is normally outside in the gazebo in the courtyard. However, residents do smoke out front; this is not a preferred area. Surveyor asked RCD C if the area out front is a designated safe smoking area. RCD C answered she cannot answer that and would have to look. Surveyor asked RCD C if R43 is permitted to maintain smoking materials on her person and shared observation of R43 maintaining her cigarettes in a purse beside her in her wheelchair. RCD C expressed R43 is not permitted to maintain her own materials, along with all smokers. All smoking materials are to be turned in due to the safety risk. Surveyor asked RCD C if staff supervision is required for all smokers. RCD C indicated she would expect the policy to provide all smokers supervision to be followed. Example 3 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R39 was admitted to the facility on [DATE] and has diagnoses that include respiratory failure, major depressive disorder, and post traumatic stress disorder. R39's [NAME] Data Set (MDS) assessment, dated 07/18/24 indicated that R39 was cognitively intact, their own person, and was able to understand and be understood. On 08/27/24, R39 was assessed for smoking safety and was deemed able to be a safe smoker. R39 also signed a smoking consent form stating they understand the policies and procedures for smoking at the facility. List received by the facility of residents who smoke which included R39 states, Resident's Smoking Assessments as of 08/06/24 and All above residents able to smoke independently without supervision. On 08/26/24 at 11:00 AM, Surveyor interviewed R39 and during interview noticed that R39 had a pack of cigarettes tucked into their wheelchair. Surveyor asked if they normally kept their own smoking materials on their person to which R39 said yes, they usually do. On 08/28/24 at 6:10 AM, Surveyor observed R39 at the front of the building sitting outside under a no smoking sign. R39 was able to light their own cigarette and continue to smoke. There were no staff members present to supervise and there was no receptacle in sight to put the used cigarette when smoking was completed. Example 4 R32 was admitted to the facility on [DATE] and has diagnoses that include chronic venous hypertension, atherosclerosis of native arteries, and difficulty walking. R32's MDS assessment, dated 07/20/24, indicated that R32 was cognitively intact, their own person, and was able to understand and be understood. On 08/27/24 and 11/10/23, R32 was assessed for smoking safety and was deemed able to be a safe smoker. On 08/27/24, R32 also signed a smoking consent form stating they understand the policies and procedures for smoking at the facility. List received by the facility of residents who smoke which included R32 states, Resident's Smoking Assessments as of 08/06/24 and All above residents able to smoke independently without supervision. On 08/28/24 at 8:31 AM, Surveyor observed R32 outside the front door of the facility smoking. R32 was located north of the entrance; there were no smoking signs posted within 30 feet of the resident. R32 did not appear to have difficulty smoking, but they had set down the used cigarette butts on the brick ledge attached to the building. There was a pile of black soot next to the used butts and ash was on the ground next to the building. Surveyor interviewed R32 and asked where they disposed of their cigarette butts when they were done smoking. R32 said in the dumpsters. There were no dumpsters located around the resident smoking, but there were three trash cans within 30 and 40 feet of the resident. On 08/28/24 at 8:35 AM, Surveyor observed that all three trash cans were lined with plastic bags and contained cigarette butts and empty cigarette packs as well as other assorted trash. (continued on next page)

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	08/29/2024

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/28/24 at 8:47 AM, Surveyor interviewed Maintenance Supervisor (MS) P regarding designated smoking areas. Surveyor asked if the east main entrance to the building is a designated smoking area. MS P said no it was not, although the residents who are cognitive do not always listen, so they installed a fire blanket and extinguisher just in case. Surveyor then asked if they had a National Fire Protection Agency (NFPA) standardized receptacle for cigarettes and MS P said they do. MS P indicated the receptacle was not out there at this time because it was being painted. The facility did have one out front for guests to put out smoking materials before they entered the building. Surveyor asked where the designated smoking area for residents was. MS P said in the gazebo out in the courtyard located just outside of the dining area. Residents do need assistance to exit into that area and there are designated smoking times and aprons available. On 08/28/24 at 9:12 AM, Surveyor observed the designated smoking area. There was a small red trash can with a foot pedal that did not have a NFPA standard label. The small red trash can did have cigarette butts and cigarette packs as well as other assorted trash in it. There was a NFPA standardized smoking material receptacle in the area as well. On 08/29/24 at 9:22 AM, Surveyor interviewed DON B and RCD C regarding the residents smoking in non-designated areas. RCD C said they have now set back up the cigarette receptacle. DON B and RCD C had concerns about taking residents rights away but understood that their policy stated residents should not have materials on their person and should smoke in the designated areas. They would not expect residents to be smoking where there are signs that state no smoking. Example 5 Surveyor reviewed R43's record and noted: Most recent Minimum Data Set quarterly dated 07/02/24 indicates R43 understands, is understood and is cognitively intact. R43 eats with set up and is on a mechanically altered diet. R43's primary diagnosis included cancer. Hospital Discharge Summary: Date of Admission: 08/10/24 Date of Discharge: 08/15/24 Acute Hospital Problems/Diagnosis included moderate protein calorie malnutrition, [NAME] light chain myeloma (cancer) Patient stated she has been on partial puree diet since gastroparesis (condition that affects stomach muscles and prevents stomach emptying and can affect digestion) episode in March . Speech-Language Pathology Consultation/Swallowing Evaluation: 08/12/24 Primary service is questioning patients' ability to tolerate advanced solids Current Nutrition Plan: Soft low fiber diet (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Evaluation showed no clinical signs of aspiration Impression: Mild oral phase dysphagia (difficulty swallowing) . Diet: General Textures, thin liquids. Feeding Precautions: 1. Patient alert, positioning fully upright for all oral intake 2. Staff to provide tray set up and check in supervision 3. Liquids: sips from edge of cup, straw is ok 4. Food: 1/2 spoon/fork full ok 5. Medications: whole with puree or crushed/mixed with puree 6. Take a drink after approximately 2-3 bites 7. Discontinue oral intake if concern for aspiration arises Speech Pathology will continue to follow along and monitor the patient's appropriateness for further diet advancement. Recommendations/Plan: Patient would benefit from follow up by Speech Pathology for further evaluation and treatment . R43's care plan indicated: Will receive adequate nutrition / hydration. No S/S (sign or symptoms) signif wt (significant weight) loss, no S/S fluid imbalance, labs to show improvement by next review Target Date: 11/30/2024 (Long Term Goal) Start Date 08/27/24: Diet per doctor's order: regular with thin liquids and small portions. 08/27/24: Feeding Precautions: 1. Patient alert, positioning fully upright for all oral intake 2. Staff to provide tray set up and check in supervision 3. Liquids: sips from edge of cup, straw is ok 4. Food: 1/2 spoon/fork full ok (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Medications: whole with puree or crushed/mixed with puree 6. Take a drink after approximately 2-3 bites 7. Discontinue oral intake if concern for aspiration arises She does continue to feed herself. 04/01/24: Therapy/Restorative screen and treat prn (as needed) 04/01/24: Assist with meals as needed. 04/01/2024 Monitor tolerance to diet texture, make adjustments as needed. Physician Orders: ~08/26/24 Diet: Regular, thin liquids, small portions ~08/27/24 ST eval and provide treatment if indicated Of note, R43's care plan was not updated to include R43's feeding precautions and physician orders were not obtained for Speech Pathology/Therapy until 08/27/24 even though she discharged from the hospital with recommendations for both. On 08/26/24 at 12:49 pm, Surveyor observed R43 being served lunch in her room consisting of regular meatloaf, au gratin potatoes, beans and a brownie along with a supplement drink and juice. Surveyor observed no staff checking in with R43 until her tray was cleared from her room. On 08/27/24 at 8:25 am, R43 was served regular french toast, bacon and scrambled eggs along with milk and juice in her room. Surveyor noted no staff checking in with R43 until her tray was cleared from her room. On 08/27/24 at 1:07 pm, Surveyor interviewed RCD C about R43's diet, feeding precautions and Speech Therapy recommendations. RCD C expressed when R43 went to the hospital in August she was on a pureed diet due to her gastroparesis episode in March. RCD C expressed there were no issues with swallowing in the hospital records. R43 was seen in the hospital by Speech who conducted a swallowing evaluation on 08/12/24. The Speech recommendations included medications crushed in puree, a soft, low fiber diet and feeding precautions with step-by-step instructions. The instructions from Speech evaluation in hospital were not carried forward to resident plan of care. Instructions are now in the care plan. The care plan was updated today with the feeding instructions. MD orders now include general diet with thin liquids and Speech Therapy evaluation and treat as indicated. RCD C expressed she completed a risk vs benefit with R43 if she continues to eat in her room. Prior to today the facility did not educate R43 on the risk and benefits associated with eating in her room, her care plan did not include her feeding precautions and her tray ticket did not include her feeding precautions and they all should have. 47807 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 6 R1 was admitted to the facility on [DATE] with diagnoses of multiple sclerosis, dysphagia, oropharyngeal phase, and a cerebral infraction. Recently R1 had an anterior displaced type II dens fracture and was fitted with a neck brace at the time of the survey. R1's most recent MDS on 08/01/24 indicated that R1 was not their own person and was not cognitively intact. R1's care plan indicated on 01/26/15 that R1 was to be provided assistance with all meals for safety. On 08/27/24, R1's care plan was updated to include that R1 requires assistance during meals with someone sitting next to her to cue for each additional swallow. Progress note dated 07/30/24 reads: Resident requires assist with ADL's, personal hygiene and grooming. Is transferred with EZ stand to and from w/c. Requires assist with meals, eats a pureed diet with thickened liquids, is fed due to resident having poor vision and will occasionally begin to eat rapidly and is a choking/aspiration risk. On 08/27/24 at 12:42 PM, Surveyor observed lunch for R1 and noted that R1 was not assisted during the meal. R1 was served puree foods and thickened liquids. There were other staff members in the room, but they were assisting other residents with their backs facing R1. The other staff were at the other end of the dining area approximately 75 feet from the resident. R1 finished their whole meal without assistance or prompting or cueing for each additional swallow. On 08/29/24 at 9:22 AM, Surveyor interviewed DON B and RCD C regarding R1 being assisted with meals. DON B and RCD C would expect that R1 be monitored as they can eat fast, but that monitoring can mean a CNA watching closely. Surveyor reviewed with DON B and RCD C that during the observation there was not a staff member watching closely and staff members were on the other side of the dining area.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30570 Based on observation, record review and interview, the facility did not prepare, store or distribute foods in a safe and sanitary manner. The facility practices had the potential to affect all 49 residents. Facility kitchen staff did not maintain proper personal hygiene to prevent contamination. Facility kitchen staff did not store food and equipment properly and did not prevent food contamination. This is evidenced by: Surveyor reviewed the facility policy titled Dietary Dress Code which is dated as most recently revised on , d+[DATE]. The policy in part read: Policy: All dietary employees will wear clean and safe apparel. Beard covers must be worn by staff presenting with facial hair. Surveyor reviewed the facility policy titled Storage Procedures which is dated as most recently revised on , d+[DATE]. The policy in part read: Policy: Food shall be properly stored to preserve flavor, nutritive value and appearance. Dry bulk foods are to be stored in plastic containers with tight covers, or bins which are easily sanitized. The container should be clearly labeled. Open packages are to be stored in closed containers, labeled and dated. Surveyor reviewed the facility policy titled Storage Procedures which is dated as most recently revised on , d+[DATE]. The policy does not address proper storage of equipment. Surveyor reviewed the facility policy titled Machine Dishwashing Racking Procedure which is dated as most recently revised on ,d+[DATE]. The policy in part read: Policy: Dishes will be properly handled and stored. Procedure: To prevent cross-contamination when one employee is operating the dish machine, strict hand washing procedures must be adhered to between soiled dishes and clean dish handling. (continued on next page)

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	525442	A. Building B. Wing	08/29/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor reviewed the facility policy titled Food Procedure Guideline dated as most recently revised on , d+[DATE]. The policy does not address allowing the thermometer to air dry the alcohol from the thermometer before inserting into foods/beverages. The facility policy, entitled Resident Dining Services, dated [DATE], states: 12. All food, desserts, salads, and beverages will be covered before transported through the hallways and flatware will be wrapped unless delivered in a closed cart. Example 1 On [DATE] at 12:32 pm, Surveyor observed [NAME] F in and out of the kitchen serving residents their lunch. [NAME] F had a full beard that was not restrained. On [DATE] at 9:21 am, Surveyor observed [NAME] H washing and putting away clean dishes in the kitchen. [NAME] H had a hair net that was covering his beard and hooked around his ears. Surveyor interviewed [NAME] H about the expectation of beard covering in the kitchen where foods are being prepared and served. [NAME] H indicated he had been on staff for about a year and a half and had not worn beard restraint until today when Dietary Supervisor (DS) I told him it was required. DS I was present during the interview and expressed she was not aware beard restraint was required in the kitchen until today. Example 2 On [DATE] at 9:21 am, Surveyor observed [NAME] H washing dishes in the dish room. Surveyor observed [NAME] H unloading clean dishes on a rack from the dish machine. [NAME] H proceeded to load the dirty dishes to trays for washing. [NAME] H was observed going back and forth between clean and dirty dishes several times. [NAME] H's uniform type shirt was in contact with the dirty dishes and was sprayed with visible food debris when he sprayed the dirty dishes before placing them on the dish rack for washing. [NAME] H removed his gloves and donned clean gloves when going from dirty dishes to clean dishes but did not perform hand hygiene. [NAME] H's dirty shirt was observed in contact with clean dishes as he leaned over the counter to remove dish racks from the dish machine and put the clean dishes away. [NAME] H expressed he does dishes daily and normally does not wear an apron. [NAME] H expressed aprons are worn by preference and are in the apron drawer. Surveyor interviewed [NAME] H about hand hygiene when removing gloves after handling dirty dishes and before donning gloves to handle clean dishes. [NAME] H responded he did not wash hands and should have to prevent contamination. Surveyor asked about potential of dirty uniform top coming into contact with clean dishes and shared observation with [NAME] H and DS I who was present. [NAME] H responded, I see what you mean for potential of contamination. DS I indicated she agrees there is a potential for contamination of clean dishes with [NAME] H's visibly soiled uniform top. On [DATE] at 9:54 am, Surveyor interviewed DS I about the observation. DS I indicated [NAME] H should have washed his hands when removing his gloves after handling dirty dishes and before donning gloves to handle the clean dishes. The facility policy does not address wearing an apron when handling the dirty dishes and removing it before handling clean dishes. Dietary staff will be expected to don an apron when handling dirty dishes and removing it before handling clean dishes to prevent contamination of the clean dishes. (continued on next page)

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	525442	A. Building B. Wing	08/29/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Example 3 On [DATE] at 10:33 am, Surveyor and [NAME] G conducted an initial tour of the kitchen including the dry storage area. Surveyor observed oatmeal in bin with a scoop in the bin. The handle of the scoop was submerged in the oatmeal. The oatmeal was dated as opened [DATE]. [NAME] G expressed the oatmeal comes in bulk and is placed in the bin. Surveyor asked about storing the scoop in container. [NAME] G responded, Always have. Surveyor observed corn flakes, raisin bran, rice crispies, and cheerios in same type of bin with small cups buried in the cereals in the containers. The cheerios were dated as expiring [DATE]. Surveyor asked [NAME] G when the cheerios were last used. [NAME] G responded the cheerios were used this morning ([DATE]). The other bins of cereals were not dated. Surveyor asked [NAME] G how staff know when the cereals are expired. [NAME] G responded, Don't know, you would think they should be dated. On [DATE] at 6:51 am, Surveyor spoke with DS I about the observation. DS I expressed scoops should not be stored in bins of cereals as there is the potential for contaminating the cereal that is served to residents. The bins of cereal should have labels with an open by date. The facility uses a chart that indicates various dry goods, including cereals, with how long the dry goods are good for. Without the open by dates it is not possible to determine the expiration dates of the cereals. DS I expressed she thinks the labels may have fallen off the bins and will be discarding the cereals as expiration dates cannot be determined. Example 4 On [DATE] at 10:33 am, Surveyor observed during the initial tour of the kitchen a meat slicer on the food preparation counters. The slicer was not in use or covered. [NAME] G expressed this is normal storage area for the equipment and staff do not cover the equipment. The slicer is used every once in a while to slice bologna or ham. Surveyor asked if the storing of the equipment has the potential for contamination, and [NAME] G responded, Yes, I see what you mean. On [DATE] at 6:51 am, Surveyor interviewed DS I about the observation. DS I expressed the meat slicer has been stored on the counter and hasn't been covered when not in use. The slicer has the potential to accumulate dust or food particles from foods that are being prepared on the counter. The slicer has the potential to become contaminated and if not washed before use. Example 5 On [DATE], Surveyor observed [NAME] G preparing beverages for tray line that had been removed from refrigeration. [NAME] G wiped the thermometer probe with an alcohol pad and immediately inserted the thermometer into juice. [NAME] G repeated this when checking the temperature of glasses of milk. [NAME] G did not allow the thermometer to air dry thus potentially contaminating the beverages with the alcohol from the wipe. Surveyor interviewed [NAME] G if she is aware of a need to air dry the thermometer before inserting into foods/fluids after wiping with the alcohol pad. [NAME] G responded she was not aware she needed to air dry the thermometer. On [DATE] at 1:04 pm, Surveyor interviewed DS I about the observation. DS I expressed the facility policy does not address air drying of the thermometer before inserting into foods and beverages. The expectation is to allow the thermometer to air dry at least 15 seconds before inserting into foods or beverages to prevent chemical contamination of foods/beverages. (continued on next page)

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	525442	A. Building B. Wing	08/29/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	47807 Example 6 On [DATE] at 12:08 PM, Surveyor observed Certified Nursing Assistant (CNA) E walking a tray of food down the hallways after taking it out of the food cart. CNA E did walk past other resident rooms with the tray, and it had peaches that were uncovered and had no plastic wrap. The tray was delivered to R46. On [DATE] at 12:08 PM, Surveyor observed CNA E walking a tray of food down the hallways after taking it out of the food cart. CNA E did walk past other resident rooms with the tray, and it had peaches that were uncovered and had no plastic wrap. The tray was delivered to R39. On [DATE] at 12:09 PM, Surveyor observed CNA E walking a tray of food down the hallways after taking it out of the food cart. CNA E did walk past other resident rooms with the tray, and it had peaches that were uncovered and had no plastic wrap. The tray was delivered to R11. On [DATE] at 12:11 PM, Surveyor observed CNA E walking a tray of food down the hallways after taking it out of the food cart. CNA E did walk past other resident rooms with the tray, and it had peaches that were uncovered and had no plastic wrap. The tray was delivered to R37. On [DATE] at 12:14 PM, Surveyor interviewed CNA E regarding the process of passing trays. CNA E said they normally would have all the fruits covered on the trays, but today they were not. CNA E also added that taking them out of the food cart after pushing the food cart to each door would also be hard as the trays do not always go in order and shuffling is needed. On [DATE] at 8:35 AM, Surveyor interviewed DS I regarding the covering of trays. DS I said they would expect all trays to be covered when they leave the kitchen, and it must have just been missed.

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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** 46693 Based on observation, interview and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and help to prevent the development and transmission of communicable diseases, and infections for 1 of 4 residents (R) observed. (R202) Facility staff did not wear a gown during high-contact care for a resident on enhanced barrier precautions (EBP). Facility staff did not sanitize lift after use on a resident with EBP. Findings include: Facility policy entitled, Enhanced Barrier Precautions, last revised April 2024, stated in part, .Personal protective equipment (PPE) for EBP is only necessary when performing high-contact care activities .includes, dressing, transferring, changing briefs, toileting . Facility policy entitled, CLEANING/DISINFECTING RESIDENT-CARE ITEMS AND EQUIPMENT, last revised January 2024, stated in part, .Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident . R202 was admitted to the facility on [DATE] with diagnoses that include sepsis, dependent on dialysis, diabetes, left below the knee amputation, right calf wound and pressure ulcer on left buttock. The signage on R202's door states, Enhanced Barrier Precautions. Everyone must sanitize hands, providers and staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities. -Dressing -Bathing/Showering -Transferring -Changing linens -Providing hygiene -Changing briefs or assisting with toileting . -Wound care: any skin opening requiring a dressing change. (continued on next page)

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	525442	A. Building B. Wing	08/29/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/27/24 at 6:56 AM, Surveyor observed Registered Nurse (RN) M and Licensed Practical Nurse (LPN) K transfer R202 via Hoyer lift. Before the transfer, R202 requested to use the bed pan. RN M and LPN K both sanitized hands and donned gloves. RN M applied sock over dressing to right leg wound. LPN K placed bed pan under R202. On 08/27/24 at 7:09 AM, R202 used call light and stated he was finished on the bed pan. RN M and LPN K again both sanitized hands and donned gloves. LPN K wet a washcloth and rolled R202 to left side. LPN K removed bed pan, provided peri care, barrier cream, brief and shorts. RN M and LPN K used the Hoyer lift to transfer R202 into wheelchair and RN M placed the Hoyer lift in hallway. The Hoyer lift was not sanitized nor were there sanitizing wipes on Hoyer lift readily available. Surveyor provided continuous observation of lift. Surveyor interviewed RN M and asked why gowns were not used during toileting and transfer for R202 who is on EBP. RN M stated, They are kept under sinks in a pull-out drawer. I thought of that just after we left the room. On 08/27/24 at 8:00 AM, Surveyor observed Certified Nursing Assistant (CNA) J take the contaminated Hoyer lift to use on a different resident. Surveyor stopped CNA J prior to going into another residents' room, and informed CNA J and RN M that the Hoyer lift was not sanitized. At that time, RN M retrieved wipes from down the hall and gave them to CNA J who then wiped the Hoyer lift down. On 08/27/24 at 9:54 AM, Surveyor interviewed Nursing Home Administrator (NHA) A and asked what the expectation would be for staff regarding lift care between residents and what PPE is expected for staff to wear for a resident on EBP during toileting and transfers. NHA stated that lift should be sanitized between residents and staff should be sanitizing hands, wearing gloves and gowns for high contact care.