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	01/13/2026

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 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. Based on observation, interview, and record review, the facility did not maintain a safe and sanitary environment in which food is prepared, stored, and distributed. This has the potential to affect all 48 residents who reside in the facility.Surveyor observed dishwashing process. Dietary Aide failed to ensure proper hand washing was complete before going from dirty items to clean items in the kitchen.Evidence by:The facility policy, Machine Dishwashing Racking Procedure, Reviewed 1/25, states, in part;.To prevent cross-contamination when one employee is operating the dish machine, strict hand washing procedures must be adhered to between the soiled dish and clean dish handling.The facility policy, Hand washing/Hand Hygiene, Reviewed 1/25, states, in part;.Procedure:.3. Scrub your hands for at least 20 seconds. Need a timer? Hum the Happy Birthday song from beginning to end twice.On 1/12/26 at 8:54 AM, Surveyor observed dishwashing. Surveyor observed two staff assisting with dishwashing, one was assigned to the dirty dishes and the other staff assigned to clean dishes. Dietary Aide M (DA) indicated he was assigned to the dirty dishes and began cleaning off plates. [NAME] L indicated since he was the cook he was assigned putting away the clean dishes. DA M did not have on gloves and was directly touching the left-over food and dirty napkins. DA M went from the dirty area to other areas of the kitchen without washing hands. DA M was observed to go from dirty dishes to emptying the garbage can and then touching two clean coffee pots and multiple clean cups. Multiple times DA M would go from dirty dishes and wash hands for less than 20 seconds and then touch clean dishes. Surveyor met with DA M and [NAME] L and both indicated understanding of the above concern.On 1/12/26 at 5:00 PM, Dietary Manager K (DM) indicated staff should always wash their hands when going from dirty dishes to clean. DM K indicated staff should wash their hands at least 20 seconds. DM K indicated understanding of the above concern.The facility did not maintain a safe and sanitary environment in which food is prepared, stored, and distributed. This has the potential to affect all 48 residents who reside in the facility.

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
	525442	A. Building B. Wing	01/13/2026

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility did not ensure that garbage and refuse was disposed of properly. This has the potential to affect all 48 residents who reside at the facility.Surveyor observed the facility's main dumpster lid open and garbage outside of the dumpster. Surveyor observed a garbage bag, multiple disposable gloves, a hairnet, food wrappers, and cardboard outside of the dumpster.Evidenced by:The facility policy, Sanitizing Garbage Cans and Dumpsters, Revised 1/25, states, in part;.8. Dumpsters provided by the local refuge vender will be maintained by the facility and kept covered at all times. 9. Area around the dumpster will be kept clean, free of debris, foul odors, and free of harboring/feeding of pests.On 1/7/26 at 10:06 AM, During the initial walk through of the kitchen, Surveyor observed the facility dumpsters. Surveyor and Dietary Manager K (DM) observed the dumpster lid open and a garbage bag, multiple disposable gloves, a hairnet, food wrappers, and cardboard outside of the dumpster. DM K indicated it is everyone's responsibility to keep the area around the dumpster clean, and all garbage should be inside the dumpster with the lid down. DM K indicated they would clean up the area.The facility did not ensure that garbage and refuse was disposed of properly. This has the potential to affect all 48 residents who reside at the facility.

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	01/13/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse, to the administrator of the facility and to other officials including the State Survey Agency for 2 of 2 incidents (R10 & R5) reviewed. R10 voiced an allegation of neglect to CNA O (Certified Nursing Assistant) of being left in her wheelchair for around 6 hours, left in a wet brief, left without colostomy care, and left without a call light or a way to summons assistance. The facility failed to follow the facility's abuse policy and failed to report allegation to NHA A and to state agency. R5 reported an allegation of abuse via a grievance form. The facility failed to report the allegation of abuse to the State Agency. 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. Willful is defined as used in the definition of abuse means the individual acted deliberately, not that the individual must have intended to inflict injury or harm. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. 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. Immediately means as soon as possible, in the absence of a shorter state time frame requirement, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. Reporting/Response: All alleged or suspected violations are to be reported immediately to NHA A (Nursing Home Administrator) or DON B (Director of Nursing), which are responsible to notify required officials, including the State Survey Agency, Adult Protective Services, Local Public Safety, Licensure Boards, Regional Director of Operations or Regional Clinical Directors, and any other agencies in accordance with State law through established procedures. All alleged violations involving abuse, neglect, . are reported immediately, but not later than 2 hours after allegation is made if the events that cause the allegation involve abuse. Not later than 24 hours after the allegation is made if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Example 1 R10 admitted to the facility on [DATE] with diagnoses including: weakness, diabetes mellitus with (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	01/13/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diabetic neuropathy (never damage) R10's Comprehensive Care Plan, initiated 4/11/25, indicates R10 requires 2 staff and a hoyer lift (full body) for transfers. On 1/7/26 at 11:06 AM, during the screening process, Surveyor introduced self and asked R10 to complete a short interview. R10 stated, It won't do a damn bit of good to talk to you. Surveyor observed R10 use her hands to shield her face. R10 indicated staff leave her in her wheelchair for long periods of time even when she is asking them to lay down in her bed. R10 indicated staff tell her there is only one staff working and they are too busy to assist her. R10 indicated one time she was left in her chair for 12 hours. R10 indicated she has reported this event and others to staff and has asked to file a report, but nothing ever happens about it. Surveyor observed R10 to have tears rolling down her face as she spoke. R10's Grievance Form, dated 12/24/25, includes: Summary of Grievance- at 12:00 AM when I did my rounds R10 was still in her chair in her day clothes. She needed her colostomy bag changed due to leaking. I feel like the PM aide/Activity Director/CNA P (certified nursing assistant) who was assigned did not take care of her. Receipt of grievance: 12/25/25 at 12:30 AM. Who received: DON B (Director of Nursing) via phone. Summary of Findings: grievance confirmed. R10 was still in her wheelchair at 12:00 AM. CNA that was assigned stated that R10 refused to go to bed or allow cares. R10 agrees that she may have told CNA she did not want to lay down when approached. R10 feels as though they should have come back again later to put her to bed. Corrective action: Education with CNA to reapproach resident after refusal of cares. R10's Nurse Notes, dated 12/25/25 at 2:24 AM, includes: . R10 is alert and cooperative. R10 was found awake, still in her wheelchair during rounds at midnight. R10 was very tearful and upset with the evening staff, whom she stated left her alone, in her wheelchair, since supper. R10 requested a report to be filed, which was documented with DON B. R10 was toileted, changed and helped into her bed. (It is important to note the facility's supper meal is served between 5:00 PM and 6:00 PM). On 1/12/26 at 4:15 PM, DON B (Director of Nursing) indicated CNA O called her in the middle of the night around 12:30 AM on 12/25/25 to inform her of R10's concern that CNA P did not provide care and that R10 was left in her chair since before supper, was not assisted into her night clothes, and was assisted into bed. DON B indicated she talked to R10 the next day and she also talked to some of the staff that worked on the PM shift of 12/24/25 and the night shift of 12/24/25 to 12/25/25. DON B indicated she did not document the interviews, she did not interview other residents, and she did not interview all staff that were working during this period of time. DON B indicated a concern of a staff member not taking care of a resident or a resident being left in her wheelchair for 6 hours could be an allegation of neglect. DON B indicated the facility policy is that the facility reports all allegations of abuse/neglect to the state agency within 2 hours. DON B indicated she did not report this allegation to the state agency. On 1/13/26 at 7:20 AM, LPN Q(Licensed Practical Nurse) indicated during the night shift of 12/24/25 to 12/25/25, CNA O reported to her around 12:00 AM that R10 was never put to bed. LPN Q indicated R10 was found in her wheelchair wearing her day clothes, her call light was not in reach, and R10 could not get to her call light. LPN Q indicated R10 is very soft spoken and she doesn't know if R10 tried to yell for help. LPN Q indicated she went to talk to R10 and R10 was sad, tearful, mad, and at (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	01/13/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	first did not want to talk. LPN Q indicated R10 requires a hoyer lift for transfer assistance. LPN Q indicated a concern of a staff member not providing cares and/or leaving a resident without a call light for 6 hours could be an allegation of abuse/neglect and that is why she told CNA O to call DON B right away to report it. LPN Q indicated she is not aware of R10 having a behavior of crying or being tearful. On 1/13/26 at 7:44 AM, during an interview CNA O (Certified Nursing Assistant) indicated on the night shift between 12/24/25-12/25/25 she found R10 in her wheelchair at around midnight. CNA O indicated R10 was crying and really upset, she was incontinent and had soaked through her clothing , her colostomy bag had exploded and was on her clothing, and she did not have her call light nearby nor was she able to get to it. CNA O indicated R10's supper tray was still in her room and she removed it at midnight rounds. CNA O indicated R10 likes to go to bed early and she would stay in bed all of the time if she could. CNA O indicated R10 wanted to file a report that CNA P neglected to provide cares for her. CNA O indicated she filled out the grievance form for R10, reported the allegation of neglect to LPN Q and DON B right away. CNA O stated, I told DON B that this was an allegation of neglect against CNA P. On 1/13/26 at 7:55 AM, Activity Director/CNA P indicated she works as a CNA on the floor every once in awhile when the facility needs her to. CNA P indicated she worked on 12/24/25 from 6PM to 10PM. CNA P indicated her and 2 other CNAs covered the hallway sharing the workload. CNA P indicated at around 8:00 PM she went in and asked R10 if she wanted to go to bed and R10 indicated she was fine. CNA P indicated she was unsure if R10 had her call light in reach at this time. CNA P indicated R10 is soft spoken and she has never heard her call out or yell. CNA P indicated DON B never interviewed her about R10 or asked her to fill out a statement regarding 12/24/25 PM shift until Surveyor brought it to her attention. On 1/13/26 at 8:26 AM NHA A (Nursing Home Administrator) indicated the facility needs to work on reporting allegations of abuse timely and investigating them thoroughly. NHA A indicated DON B told her the following day that there was a concern, but that the concern was a concern that third shift had issues with second shift. NHA A indicated DON B should have interviewed residents and all staff who worked that shift, should have documented her interviews, should have told NHA A the concern from the resident's perspective as it was reported initially, and should have informed NHA A immediately so that she could report to the state agency timely. NHA A indicated R10's allegation was not reported to the state agency. Example 2 R5 was admitted to the facility on [DATE] with diagnoses that include PTSD (Post -traumatic stress disorder), borderline personality disorder, chronic kidney disease stage 5 (kidney failure), and dependence on dialysis (a life sustaining treatment that filters waste, toxins, and extra fluid from the blood when the kidneys fail). R5's most recent MDS (Minimum Data Set) dated 1/12/26 states that R5 has a BIMS (Brief Interview of Mental Status of 14/15, indicating that R5 is cognitively intact. Nurse's note on 1/11/26 states in part, the following: Resident talked to the Aide about her treatment the day she didn't go to dialysis. Aide gave resident the grievance form to fill out. R5's grievance form dated 1/12/26 states in part .Date received 1/12 Time: 9AM Who Received: SW C (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	01/13/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Social Worker) .Findings of Investigation (R5 inadvertently wrote their grievance in this section): on 1-6-26 I woke up with severe pain in my right leg. Couldn't lift it, etc. I had PT (Physical Therapy) from [PTA (physical Therapy Aide) name] the day B4 (before). When trying into[sic] get into medical van for dialysis, I couldn't lift my right leg. [PTA Name, RN (Registered Nurse name)] and blonde CNA (Certified Nursing Assistant)- came out and try to shove me in and I was in more pain. I screamed in pain and cried. I didn't make it to dialysis that day. On 1/13/26 at 8:28 AM, Surveyor interviewed R5. Surveyor asked R5 to explain the events of 1/6/26, R5 stated that the 3 staff were trying to shove her into the van to go to dialysis. R5 reported that their actions caused increased pain and was upset. Surveyor asked R5 if anyone from the facility discussed the grievance with her, R5 stated not really. On 1/13/26 at 11:02 AM, Surveyor interviewed DON B (Director of Nursing) and SW C. Surveyor asked DON B when they were made aware of R5's grievance, DON B stated yesterday afternoon (1/12/26). Surveyor asked DON B if R5's report of staff members tried to shove me in and I was in more pain be considered an allegation of abuse, DON B stated yes. Surveyor asked DON B and SW C when an allegation of abuse should be reported to the State Agency, SW C stated within 2 hours. Surveyor asked if the allegation was reported to the State Agency, DON B stated no. On 1/13/26 at 12:21 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor reviewed R5's grievance form with NHA A. Surveyor asked NHA A if R5's allegation of abuse should have been reported to the State Agency, NHA A stated yes and reported that since she became aware, they have submitted the allegation.

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	01/13/2026

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 did not ensure that in response to allegations of abuse, neglect, exploitation or mistreatment, that all alleged violations are thoroughly investigated for 1 of 2 sampled Residents (R10). R10 voiced an allegation of neglect to CNA O (Certified Nursing Assistant). The facility failed to investigate the allegation thoroughly, including gathering staff interviews, gathering resident interviews, and recording an interview with R10. 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. R10 admitted to the facility on [DATE] with diagnoses including: weakness, and diabetes mellitus with diabetic neuropathy (nerve damage)R10's Comprehensive Care Plan, initiated 4/11/25, indicates R10 requires 2 staff and a Hoyer lift (full body lift) for transfers.On 1/7/26 at 11:06 AM, during the screening process, Surveyor introduced self and asked R10 to complete a short interview. R10 stated, It won't do a damn bit of good to talk to you. Surveyor observed R10 use her hands to shield her face. R10 indicated staff leave her in her wheelchair for long periods of time even when she is asking them to lay down in her bed. R10 indicated staff tell her there is only one staff working and they are too busy to assist her. R10 indicated one time she was left in her chair for 12 hours. R10 indicated she has reported this event and others to staff and has asked to file a report, but nothing ever happens about it. Surveyor observed R10 to have tears rolling down her face as she spoke.R10's Grievance Form, dated 12/24/25, includes: Summary of Grievance- at 12:00 AM when I did my rounds R10 was still in her chair in her day clothes. She needed her colostomy bag changed due to leaking. I feel like the PM aide/Activity Director/ CNA P who was assigned did not take care of her. Receipt of grievance: 12/25/25 at 12:30 AM. Who received: DON B (Director of Nursing) via phone. Summary of Findings: grievance confirmed. R10 was still in her wheelchair at 12:00 AM. CNA that was assigned stated that R10 refused to go to bed or allow cares. R10 agrees that she may have told CNA she did not want to lay down when approached. R10 feels as though they should have come back again later to put her to bed. Corrective action: Education with CNA to reapproach resident after refusal of cares.R10's Nurse Notes, dated 12/25/25 at 2:24 AM, includes: . R10 is alert and cooperative. R10 was found awake, still in her wheelchair during rounds at midnight. R10 was very tearful and upset with the evening staff, whom she stated left her alone, in her wheelchair, since supper. R10 requested a report to be filed, (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	01/13/2026

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	which was documented with DON B (Director of Nursing). R10 was toileted, changed and helped into her bed.(It is important to note the facility's supper meal is served between 5:00 PM and 6:00 PM).On 1/12/26 at 4:15 PM, DON B (Director of Nursing) indicated CNA O called her in the middle of the night around 12:30 AM on 12/25/25 to inform her of R10's concern that CNA P did not provide care and that R10 was left in her chair since before supper, was not assisted into her night clothes, and was assisted into bed. DON B indicated she talked to R10 the next day and she also talked to some of the staff that worked on the PM shift of 12/24/25 and the night shift of 12/24/25 to 12/25/25. DON B indicated she did not document the interviews, she did not interview other residents, and she did not interview all staff that were working during this period of time. DON B indicated a concern of a staff member not taking care of a resident or a resident being left in her wheelchair for 6 hours could be an allegation of neglect.On 1/13/26 at 7:20 AM, LPN Q (Licensed Practical Nurse) indicated during the night shift of 12/24/25 to 12/25/25, CNA O reported to her around 12:00 AM that R10 was never put to bed. LPN Q indicated R10 was found in her wheelchair wearing her day clothes, her call light was not in reach, and R10 could not get to her call light. LPN Q indicated R10 is very soft spoken and she doesn't know if R10 tried to yell for help. LPN Q indicated she went to talk to R10 and R10 was sad, tearful, mad, and at first did not want to talk. LPN Q indicated R10 requires a hoyer lift for transfer assistance. LPN Q indicated a concern of a staff member not providing cares and/or leaving a resident without a call light for 6 hours could be an allegation of abuse/neglect and that is why she told CNA O to call DON B right away to report it. LPN Q indicated she is not aware of R10 having a behavior of crying or being tearful.On 1/13/26 at 7:44 AM, during an interview CNA O (Certified Nursing Assistant) indicated on the night shift between 12/24/25-12/25/25 she found R10 in her wheelchair at around midnight. CNA O indicated R10 was crying and really upset, she was incontinent and had soaked through her clothing, her colostomy bag had exploded and was on her clothing, and she did not have her call light nearby nor was she able to get to it. CNA O indicated R10's supper tray was still in her room and she removed it at midnight rounds. CNA O indicated R10 likes to go to bed early and she would stay in bed all the time if she could. CNA O indicated R10 wanted to file a report that CNA P neglected to provide cares for her. CNA O indicated she filled out the grievance form for R10, reported the allegation of neglect to LPN Q and DON B right away. CNA O stated, I told DON B that this was an allegation of neglect against CNA P.On 1/13/26 at 7:55 AM, Activity Director/CNA P indicated she works as a CNA on the floor every once in a while, when the facility needs her to. CNA P indicated she worked on 12/24/25 from 6PM to 10PM. CNA P indicated her and 2 other CNAs covered the hallway sharing the workload. CNA P indicated at around 8:00 PM she went in and asked R10 if she wanted to go to bed and R10 indicated she was fine. CNA P indicated she was unsure if R10 had her call light in reach at this time. CNA P indicated R10 is soft spoken and she has never heard her call out or yell. CNA P indicated DON B never interviewed her about R10 or asked her to fill out a statement regarding 12/24/25 PM shift until Surveyor brought it to her attention. On 1/13/26 at 8:26 AM, NHA A (Nursing Home Administrator) indicated the facility needs to work on reporting allegations of abuse timely and investigating them thoroughly. NHA A indicated DON B told her the following day that there was a concern, but that the concern was a concern that third shift had issues with second shift. NHA A indicated DON B should have interviewed residents and all staff who worked that shift, should have documented her interviews, should have told NHA A the concern from the resident's perspective as it was reported initially, and should have informed NHA A immediately so that she could report to the state agency timely. NHA A indicated R10's allegation was not investigated thoroughly, and it should have been.

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	01/13/2026

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure that each resident had a baseline care plan developed and implemented, within 48 hours, with needed instructions to provide effective and person-centered care for 1 of 6 residents (R5) reviewed. R5's baseline care plan did not include R5's diagnosis of PTSD (Post- traumatic stress disorder), triggers, or interventions.Evidenced by:The facility's policy titled Resident Baseline Care Plan Development updated on 1/17/18 states in part .Policy: The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person- centered care of the resident that meet professional standards of quality care. The baseline care plan must-.ii. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- .e. Social Services.R5 was admitted to the facility on [DATE] with diagnoses that include PTSD (Post -traumatic stress disorder), borderline personality disorder, chronic kidney disease stage 5 (kidney failure), and dependence on dialysis (a life sustaining treatment that filters waste, toxins, and extra fluid from the blood when the kidneys fail).R5's most recent MDS (Minimum Data Set) dated 1/12/26 states that R5 has a BIMS (Brief Interview of Mental Status) of 14 out of15, indicating that R5 is cognitively intact.R5's baseline care plan dated 12/15/25, signed by R5 on 12/17/25 does not list any pertinent diagnoses, including PTSD, nor does it list triggers or interventions.The portion of the baseline care plan pertaining to Social Services is blank.The portion of the form titled additional comments/Needs/ Preferences is blank.On 1/12/26 at 10:30 AM, Surveyor interviewed SW C (Social Worker). Surveyor asked SW C if R5 should have a care plan for PTSD, SW C stated yes, and that nursing is responsible for the care plans.On 1/12/26 at 10:41 AM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if R5's PTSD, triggers and interventions should be on their baseline care plan, DON B stated yes.

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	01/13/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure that a resident who requires dialysis receives such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 1 of 1 sampled resident (R5) reviewed for dialysis. Facility staff were not fluent in the emergency plan for a resident bleeding from their dialysis access site. This is evidenced by:The facility's policy titled Dialysis Services last reviewed on 1/2025 does not include an emergency plan. According to Clinical Journal of the American Society of Nephrology article titled Diagnosis, Treatment, and Prevention of Hemodialysis Emergencies dated February 2017, .Vascular Access Hemorrhage: Hemorrhage from an AV access is an uncommon but potentially fatal complication if it is not recognized promptly and acted on with an appropriate intervention. Most fatal vascular access hemorrhages occur outside of the dialysis facility, but occasionally, they rupture at the dialysis unit (120). Patients and their families should be educated about the recognition and emergent management of a bleeding AV access. In the event of bleeding from vascular access site, direct continuous pressure with a finger for 15-20 minutes is the most effective method of controlling the bleeding. In the event of rupture of a PSA or aneurysm away from dialysis unit or hospital, direct pressure with a finger at the site of bleeding is the best method of controlling bleeding. Patients should be advised to continue holding direct pressure until emergency medical help arrives and avoid applying a tourniquet, towel, or BP cuff to the extremity. Diagnosis, Treatment, and Prevention of Hemodialysis Emergen . : Clinical Journal of the American Society of Nephrology R5 was admitted to the facility on [DATE] with diagnoses that include PTSD (Post -traumatic stress disorder), borderline personality disorder, chronic kidney disease stage 5 (kidney failure), and dependence on dialysis (a life sustaining treatment that filters waste, toxins, and extra fluid from the blood when the kidneys fail).R5's most recent MDS (Minimum Data Set) dated 1/12/26 states that R5 has a BIMS (Brief Interview of Mental Status) of 14 out of 15, indicating that R5 is cognitively intact. R5's care plan initiated on 12/16/25 does not include steps for staff to take if R5 is bleeding out of their dialysis catheter. R5's CNA (Certified Nursing Assistant) Kardex does not include steps for staff to take if R5 is bleeding out of their dialysis catheter. 01/07/2026 10:48 AM Surveyor observed R5's room. Surveyor noted that there was no signage indicating that R5 has a dialysis catheter or what to do in an emergent situation if R5 starts bleeding from their dialysis catheter. Additionally, Surveyor did not observe any emergency equipment or supplies in R5's room. On 1/8/26 at 10:06 AM, Surveyor interviewed CNA D. Surveyor asked CNA D what steps they would take if they saw R5 bleeding from their dialysis catheter, CNA D stated they would immediately get the nurse, put on their PPE (Personal Protective Equipment), and then follow the nurse's instruction. Surveyor asked CNA D if their care sheet or Kardex had any emergency instructions on it, CNA D stated no. Surveyor asked CNA D if they have received any education from the facility on how to care for a resident on dialysis, CNA D stated no. On 1/8/26 at 10:14 AM, Surveyor interviewed CNA E. Surveyor asked CNA E what steps they would take if they saw R5 bleeding from their dialysis catheter, CNA E stated that they would yell for the nurse, not leave the resident alone, make sure they are in a safe and comfortable position. Surveyor asked CNA E if they have received any education from the facility on how to care for a resident on dialysis, CNA E stated no. On 1/8/26 at 10:23 AM, Surveyor interviewed LPN F (Licensed Practical Nurse). Surveyor asked LPN F what they would do if they saw R5 bleeding from their dialysis catheter, LPN F stated that they would apply pressure, call for help, call they dialysis center, and send the resident to the ER (Emergency Room). Surveyor asked LPN F what steps they would expect the CNAs to take, LPN F stated that they should call for the nurse immediately or call the ADON/DON (Assistant Director of Nursing/ Director of Nursing). On 1/8/26 at 10:27 AM, Surveyor interviewed CNA G. Surveyor asked CNA G what steps they would take if they saw R5 bleeding from their dialysis catheter, CNA G stated that they would get the nurse, hurry back, (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	01/13/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	put on gloves and grab some rags and stuff to apply pressure. Surveyor asked CNA G if they have received any education from the facility on how to care for a resident on dialysis, CNA G stated no. On 1/8/26 at 11:27 AM, Surveyor interviewed DON B and RN H (Regional Nurse). Surveyor asked what steps they would expect staff to take find a dialysis resident is bleeding from their dialysis catheter, DON B stated they would expect staff to make sure the site is bleeding, apply pressure and update the MD (Medical Doctor). Surveyor asked what steps they would expect the CNAs to take, RN H stated they would expect the CNAs to get the nurse. Surveyor asked if they would expect the CNAs to apply pressure, RN H stated they should get nursing assistance. Surveyor asked what steps the facility has in place to ensure that their staff knows what to do in an emergent bleeding situation, RN H stated that there is site monitoring on every shift. Surveyor asked if there was any education provided to staff on what to do if a dialysis resident was bleeding from their access site, RN H stated they would have to look.Of note, no education was provided to Surveyor.

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	01/13/2026

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure 1 of 1 resident (R5) who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. R5 has a diagnosis of PTSD (Post Traumatic Stress Disorder) and does not have a complete trauma assessment or a care plan addressing triggers, resident specific approaches, or interventions.Evidenced by:The facility's policy titled Trauma Informed Care revised 9/2022 states in part, .Policy Explanation and Compliance Guidelines: .2. The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), admission Assessment, the history and physical, the social history/assessment, and others.6. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan.R5 was admitted to the facility on [DATE] with diagnoses that include PTSD (Post -traumatic stress disorder), borderline personality disorder, chronic kidney disease stage 5 (kidney failure), and dependence on dialysis (a life sustaining treatment that filters waste, toxins, and extra fluid from the blood when the kidneys fail).R5's most recent MDS (Minimum Data Set) dated [DATE] states that R5 has a BIMS (Brief Interview of Mental Status) of 14 out of 15, indicating that R5 is cognitively intact.R5's Trauma Informed Care Observation dated [DATE] states in part .Have you ever experienced, witnessed, learned about a natural disaster (e.g. flood, tornado, hurricane, earthquake, etc.)? Answer: Personally witnessed.Have you ever experienced, witnessed, learned about a life-threatening illness or injury (e.g. cancer, heart attack, AIDS, leukemia, multiple sclerosis, etc.)? Answer: Personally experienced. Have you ever experienced, witnessed, learned about a physical assault (e.g. attacked, hit, beaten up, etc.)? Answer: Personally experienced. Have you ever experienced, witnessed, learned about a sexual assault (e.g. rape, attempted rape, made to perform sexual act via force or threat of harm, etc.)? Answer: Personally experienced.R5's care plan dated [DATE] does not have PTSD listed as a problem, and there are no goals, triggers, or interventions.On [DATE] at 10:48 AM, Surveyor interviewed R5. Surveyor asked R5 if they were comfortable talking about their PTSD, R5 stated yes and then proceeded to tell Surveyor that they have had a lot of traumas in their life that included an assault in 1990 that resulted in a broken neck and near-death situation, their brother, mother, father, and cat all died. R5 reported that their brother died from sarcoidosis (an inflammatory disease where immune cells form tiny lumps in organs, potentially disrupting organ function) and had to be med flighted to a hospital. Surveyor asked R5 what their triggers are, R5 stated that loss of special people, their diagnosis of kidney failure, and hearing helicopters.On [DATE] at 10:05 AM, Surveyor interviewed CNA G (Certified Nursing Assistant). Surveyor asked CNA G how they are made aware that a resident has a diagnosis of PTSD, CNA G stated that when the resident is admitted , they get an overview. Surveyor asked CNA G how they know what the triggers and interventions are, CNA G stated they are on the care plan. Surveyor asked CNA G if they were aware of what R5's triggers and interventions are, CNA G stated that they have not had the opportunity to review the care plan. Surveyor and CNA G reviewed R5's care plan. Surveyor asked CNA G if R5's care plan contained any triggers or interventions for PTSD, CNA G stated no.On [DATE] at 10:11 AM, Surveyor interviewed LPN F (Licensed Practical Nurse). Surveyor asked LPN F how they are made aware that a resident has a diagnosis of PTSD, LPN F stated that the information would get passed along during report. Surveyor asked LPN F if they were aware that (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	01/13/2026

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5 has a diagnosis of PTSD, LPN F stated yes. Surveyor asked LPN F what R5's triggers and interventions are, LPN F reviewed R5's care plan and reported to Surveyor that they were unable to find triggers or interventions in R5's care plan.On [DATE] at 10:30 AM, Surveyor interviewed SW C (Social Worker). Surveyor asked SW C what the process is when a resident is admitted with a diagnosis of PTSD, SW C stated they set the resident up with psych services. Surveyor asked SW C if a trauma assessment is completed as part of the admission assessment, SW C stated yes. Surveyor asked SW C if they completed R5's trauma assessment, SW C stated yes. Surveyor asked SW C if they asked R5 about their trauma, triggers, and interventions, SW C stated that for the assessment, the resident answers yes or no to the questions and that she did not ask any additional questions about R5's trauma, triggers, or interventions. Surveyor asked SW C if a resident with PTSD should have a care plan addressing the diagnosis, SW C stated yes and that they believe nursing staff makes the care plans.On [DATE] at 10:41 AM, Surveyor interviewed DON B (Director of Nursing), NHA A (Nursing Home Administrator), and RN H (Regional Nurse). Surveyor asked what the expectation is when a resident is admitted with a diagnosis of PTSD, DON B and RN H stated they should complete a trauma informed care assessment and a PTSD care plan. Surveyor asked if R5 should have a care plan for PTSD, given their diagnosis, DON B stated yes.

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	01/13/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility did not provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 (R13) of 5 residents reviewed for medications.R13 was prescribed Buspirone for anxiety and failed to receive the medication.This is evidenced by:The facility's policy Care Standards, Standards of Nursing Practices, dated 1/25, includes: Responsibility with Medications and Physicians Orders 1. The licensed nurse that receives an order and notes the order is responsible to carry the order through by placing in achieve [Electronic Health Record], on the MAR (Medication Administration Record), TAR (Treatment Administration Record), ordering the medication from pharmacy, communicating order specifics to appropriate departments.R13 admitted to the facility on [DATE] with diagnoses including other symptoms and signs involving cognitive functions and awareness, anxiety disorder and depression.R13's BIMS (Brief Interview for Mental Status) dated 11/6/25 has a score of 11, indicating R13 has moderate cognitive impairment.R13's Psych Initial Evaluation, dated 11/17/25, provided by NP I (Nurse Practitioner) includes: .a past medical history significant for anxiety disorder, cognitive impairment. She reports her current mood has been up-and-down with symptoms of anxiety described as on and off being restless. Medications Buspar (buspirone) 5 mg tablet - NEW Take 1 tablet by mouth three times a day for anxiety. Assessment and Plan F41.9 Anxiety disorder, unspecified: Patient reports anxiety symptoms described as on and off being restless with mood fluctuations. Denies symptoms of depression, hallucinations, delusions, or thoughts of self-harm. Starting buspirone (Buspar) 5 mg three times daily for anxiety management. Follow-up Start buspirone Follow-up in 2 weeks or sooner if changes in mood or behaviors.R13's physician orders for November 2025 do not include Buspar 5 mg three times daily.R13's November 2025 MAR does not include Buspar 5 mg three times daily.On 1/12/26 at 1:50 PM, Surveyor interviewed NP I regarding R13's buspirone order. NP I indicated she is not sure why the faxed order was not processed. NP I indicated if a fax fails she receives a notice and would resend the order. NP I indicated she did not have any fax failed notifications.On 1/12/26 at 1:42 PM, Surveyor interviewed ADON J (Assistant Director of Nursing) regarding R13's buspirone order. ADON J indicated when NP I completes her assessment on a resident, NP I will verbally discuss any changes she recommends with the ADON J or DON B (Director of Nursing). ADON J indicated NP I will fax over the order changes and ADON J will put the order in. ADON J stated NP I will fax the orders over almost instantly. ADON J indicated she is not sure why R13's buspirone order was not entered into R13's physician orders or MAR. ADON J indicated she remembered talking about R13's buspirone order with NP I but the faxed order never came through.R13's Psych Follow Up note, dated 12/1/25, provided by NP I includes: At her last evaluation, the patient reported her mood as up-and-down with symptoms of anxiety. Buspirone was initiated at her last visit to address her anxiety symptoms and racing thoughts. The order was never entered or administered resend buspirone 5 mg 3 times daily for anxiety. Assessment and Plan Start buspirone 5 mg by mouth three times daily.R13's Physician Order Form, dated 12/1/25, signed by NP I, states buspirone 5 mg by mouth three times a day for anxiety. The order has a received faxed date and time stamp of 12/25/25 9:37 AM.R13's physician orders for December 2025 do not include Buspar 5 mg three times daily.R13's December MAR does not include Buspar 5 mg three times daily.R13's Informed Consent for Medication for Buspirone was presented to R13 by ADON J and signed by R13 on 12/2/25.On 1/12/26 at 1:50 PM, Surveyor interviewed NP I regarding R13's buspirone order. NP I indicated she is not clear about what happened with R13's buspirone order. NP I indicated she did not receive a fax failed notification and since she did not hear from the facility she though R13's buspirone order had been entered and R13 was receiving the buspirone. NP I indicated she would expect the facility to call her if the fax was not received since (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	01/13/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they had discussed the change to R13's medication. On 1/12/26 at 1:42 PM, Surveyor interviewed ADON J regarding R13's buspirone order. ADON J indicated she talked with NP I about the buspirone. ADON J indicated she obtained consent for buspirone on 12/2/25 from R13 based on the conversation with NP I. ADON J indicated she never received the faxed order for R13's buspirone so she did not enter it into R13's electronic physician orders or MAR. ADON J indicated she found the faxed order was uploaded into R13's documents but never entered into R13's physician orders or MAR.R13's Progress Note, dated 1/5/26, provided by NP I, includes: Assessment and Plan F41.9 Anxiety disorder, unspecified Buspirone order was never initiated.On 1/12/26 at 1:50 PM, Surveyor interviewed NP I regarding R13's buspirone order. NP I indicated since R13's anxiety had decreased on the 1/5/26 visit, NP I felt the anxiety was situational. NP I indicated R13 did have complaints of feeling more depressed and NP I decided to increase a different medication R13 was already receiving. NP I indicated she put the order through the facility's messaging app to ensure they would receive the order.On 1/12/26 at 3:40 PM, Surveyor interviewed DON B regarding R13's buspirone order. DON B indicated the facility should follow provider orders. DON B indicated the facility should have sent a message to NP I regarding the facility not receiving the faxed order after the verbal conversation of NP I wanting to initiate a new medication. DON B indicated R13 did not receive buspirone NP I had ordered but should have received buspirone as NP I had ordered.

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	01/13/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility did not ensure it was free of medication error rates of 5% or greater. There were 8 errors in 25 opportunities that affected 1 resident (R50) out of a sample of 5 residents observed for medication administration. This results in an error rate of 16%. R50's medications were scheduled for 6:00 PM- 10:00 PM and R50 received their medications at 4:10 PM. Additionally, R50 was administered the wrong dose of hydroxyzine. Evidenced by: The facility's policy titled Medication Administration Procedures dated 4/2020 states in part A. Designated Times: .4. All medications must be passed within one hour on either side of the designated time.B. Dosage: 1. Give the exact number of tablets/ capsuled ordered. On 1/8/26 at 4:10 PM, Surveyor observed RN N (Registered Nurse) administer medications to R50. Surveyor observed RN N administer the following medications: Klor-Con 20 mEq (milliequivalent) 1 tablet, levetiracetam 1000mg (milligrams) 1 tablet, tamsulosin hydrochloride 0.4 mg oral capsule, and hydroxyzine hydrochloride 25 mg tablet- 1/2 (half) tablet.R50's medication orders are as follows:Klor- Con 20 mEq 1 tablet oral twice a day 6:00 AM- 10:00 AM and 6:00 PM- 10:00 PM.Levetiracetam 1000mg 1 tablet oral twice a day 6:00 AM- 10:00 AM and 6:00 PM- 10:00 PM.Tamsulosin hydrochloride 0.4 mg 1 oral capsule at bedtime 6:00 PM- 10:00 PM.hydroxyzine hydrochloride 25 mg tablet 1 tablet oral at bedtime 6:00 PM- 10:00 PM.On 1/12/26 at 10:27 AM, Surveyor interviewed RN H (Regional Nurse). Surveyor asked RN H if administering medications at the wrong time would be considered a medication error, RN H stated yes. Surveyor asked RN H if administering the wrong dose of a medication would be considered a medication error, RN H stated yes. R50 received medication at the wrong time and received an inaccurate dose of hydroxyzine.