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 _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMAH NURSING AND REHAB	1505 BUTTS AVE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This was a complaint survey conducted at Tomah Nursing and Rehab from 09/09/2020 - 09/10/2020. Federal citations issued: 3 The most serious citation is F760 cited at a severity/scope level of G (Harm/isolated). Census: 38 Sample size: 10	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility did not ensure that each resident receives adequate supervision and assistance devices to prevent accidents in 2 of 3 residents reviewed for falls (R1 and R2). R2 was assessed to be a fall risk. R2 also was assessed and care planned to need 2 plus staff's extensive physical assistance with transfers, bed mobility, and toilet use, One staff member rolled R2 out of bed onto the floor while changing her brief.	F 689		

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 _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMAH NURSING AND REHAB	1505 BUTTS AVE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 1	F 689		

R1 was assessed to be a fall risk and one of his care planned interventions is to have bed in lowest position while R1 is in it. Surveyor observed R1 lying in his bed while bed was not in lowest position and staff were not with R1.

Evidenced by:
Facility policy, entitled Fall Prevention Program, dated 6/2016, includes, in part: Program must be interdisciplinary in order to be successful ... both clinical and nonclinical, investigations must be conducted thoroughly, accurately, and timely ... all factors that contributed to the event have to be identified ... development, implementation, monitoring for effectiveness of preventive plan of care ...

Example 1
R2 was admitted to the facility on 1/12/11 with diagnoses, including: vascular dementia and dysphagia. Her most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/5/20, indicates R2 is severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 3 out of 15. R2's MDS also indicates she is fully dependent on staff and requires the physical assistance of two or more staff to meet her needs in bed mobility, transfer, dressing, and toilet use.

R2's Comprehensive Care Plan, includes, in part:
Problem: R2 requires assistance for Activities of Daily Living related to immobility, arthritis, cognitive impairments, decreased safety awareness, limitations to range of motion, incontinence, ... Initiated: 8/13/2009
Approach: Requires assist of two for turning and repositioning. Start date: 8/13/2009
Problem: R2 is at risk for falls related to history of

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 _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMAH NURSING AND REHAB	1505 BUTTS AVE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 2	F 689		

falls, limited mobility, pain, psychotropic medication use, anticonvulsant medication use, impaired safety awareness, behaviors, obesity, dementia ... initiated 1/12/11 ...

CNA Care Card, undated, includes, in part: R2 ... hoyer ... Tues/Friday PM ...
(It is important to note: there is no more information regarding R2 on this document.)

R2's Fall Report, dated 8/6/20, includes, in part: On 8/6/20 at 4:50 AM Resident fell out of bed during cares ... Resident was receiving cares and rolled out of bed during brief change ... CNA Q statement, includes in part: 8/6/20 ... I was getting resident washed up so we could get her dressed and put in her chair. I had resident rolled away from me when I went to grab her brief she rolled off her bed and onto the floor. My coworker who was in the room with me ran and got the nurse. Nurse came into room and assisted me in getting resident back in bed...

R2's Hospital Note, dated 8/6/20, includes, in part: patient reportedly fell out of bed ... Patient has laceration to right forehead with controlled bleeding ... Patient presents with a hematoma to the right forhead area. Has a skin tear on the dorsum of her left hand as well as contusion on her left forearm ... Right frontal scalp hematoma with no underlying calvarial fracture ...

On 9/9/20 at 11:33 AM during an interview, EMT P indicated R2 told her staff pushed R2 out of bed and this was not the first time this had happened.

On 9/9/20 at 2:00 PM during an interview, CNA Q indicated on 8/6/20 around 5 AM, she was

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 _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMAH NURSING AND REHAB	1505 BUTTS AVE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 3	F 689		

helping R2 while her partner (CNA R) was assisting R2's roommate with a brief change. CNA Q indicated she had R2's new brief on a table next to the bed. When she reached out for the new brief R2 rolled away from her falling to the floor on the other side of the bed. CNA Q indicated she was not aware R2's care plan or most recent MDS indicated R2 required physical assistance by 2 or more staff for bed mobility, transfer, dressing, and toilet use. CNA Q indicated she does not have access to residents' care plans, only a CNA care card.

On 9/9/20 at 2:30 PM during an interview, CNA R indicated on 8/6/20 when R2 rolled out of bed, she was assisting R2's roommate with cares and her partner, CNA Q, was assisting R2. CNA R indicated she was not aware R2's care plan stated she required physical assist of 2 staff members for bed mobility. Dressing, transfer, and toilet use. CNA R indicated she has never seen a care plan since working in the facility.

On 9/9/20 at 2:45 PM during an interview RN M indicated the root cause of this fall was that CNA Q turned away from R2 to get supplies. Surveyor, RN M and NHA A reviewed R2's most current MDS, R2's care plan, and CNA Care Card regarding R2. Surveyor asked how staff are to access Care Plans. NHA A indicated this is something that needs to be addressed. She suggested printing all resident care plans and placing in a binder at the nurse' station. Surveyor asked if a root cause for this fall could have been there was only one staff assisting R2 with bed mobility and dressing. NHA A and RN M indicated yes it could. RN M indicated she did not put it together that R2 needed 2 staff to assist her. Surveyor asked if CNA Care Card reflects

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 _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMAH NURSING AND REHAB	1505 BUTTS AVE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4	F 689		

R2's care plan. NHA A and RN M indicated it does not. RN M indicated two CNAs should have been assisting R2 and if she would have caught that she would have educated staff on following care plans. NHA A agreed with RN M.

Example 2
R1 was admitted to the facility on 5/20/20 with diagnoses, including: encephalopathy, and post-traumatic stress disorder. R1's most recent MDS, with ARD of 5/26/20, indicates R1 is cognitively intact with a BIMS score of 14.

R1's Care Plan, includes, in part: R1 is at risk for falling related to weakness and impaired cognition. R1 has a history of falls in the facility ... 7/15/20 ... Approach: start date: 7/15/20 keep bed in lowest position with brakes locked ...

On 9/10/20 at 8:00 AM Surveyor observed R1 in bed. His bed was at normal height, not lowered to floor.

At 8:10 AM-8:30 AM Surveyor observed CNA R in room with R1. CNA R assisted R1 with his meal. CNA R left R1's room. R1 was still in bed and R1's bed was still at normal height, not lowered to floor.

At 8:45 AM Surveyor asked CNA O what she does to keep R1 from falling. CNA O indicated she puts non-skid socks on him and checks on him frequently. Surveyor asked about his bed height. CNA O indicated she could put it down to the lowest position. CNA O indicated she was not sure what R1's care plan stated.

At 9:15 AM during an interview, LPN T indicated R1's bed should be in the lowest position and her

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 _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMAH NURSING AND REHAB	1505 BUTTS AVE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5 and CNA O made sure that it was now. LPN T indicated CNAs should be following care plans. At 10:25 AM during an interview, DON B and NHA A indicated CNAs should have access to and follow resident care plans. DON B indicated R1's bed should not have been left up in the normal height position, but it should have been lowered to the floor and the brakes should have been locked.	F 689		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility did not ensure that its residents were free from significant medication errors for 1 of 3 residents (R1) reviewed for medication errors as R1 did not receive his scheduled Metoprolol, a beta blocker (heart medication), for three days. R1 was sent to the ER (Emergency Room) and admitted to the hospital for atrial fibrillation on 8/12/2020. In the ER and hospital, R1 had a very rapid pulse. R1 was treated with intravenous (IV) medications and transitioned back to the previous oral medications he was on prior to returning to the facility. R1's medication administration record (MAR) at the facility was incomplete for the three evenings prior to his hospitalization. This is evidenced by: According to Web MD atrial fibrillation with rapid	F 760		

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 _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMAH NURSING AND REHAB	1505 BUTTS AVE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 6	F 760		

ventricular response is a another term for an irregular heartbeat. "When your heart's electrical signals aren't working right, it can lead to a heartbeat that's too fast. This abnormal heart rhythm is what doctors call atrial fibrillation, or AFib for short. For most people, the faulty signals start in the heart's two upper chambers, called the atria.During atrial fibrillation, the heart's two upper chambers (the atria) beat chaotically and irregularly - out of coordination with the two lower chambers (the ventricles) of the heart.
Sometimes the misfiring signals can also make your heart's two bottom chambers, called ventricles, beat too quickly. That's a specific type of atrial fibrillation called AFib with rapid ventricular response. Symptoms of AFib With RVR: Feel like your heart is beating too fast, chest pain, dizzy, faint, short of breath, tired or weak. What Causes AFib With RVR?
Electrical signals make your heart beat in a coordinated way. First, the atria squeeze, or contract. Then the signal travels to the lower chambers, or ventricles. They squeeze and pump out blood to your lungs and body. In AFib, these signals don't go out correctly. Instead of contracting, the atria quiver. The flutters are too weak to send enough blood into the ventricles. In AFib with rapid ventricular response, the ventricles also beat too fast. These beats are too weak to push enough blood out of the heart to your lungs and body.
What Does AFib With RVR Feel Like? A normal heartbeat is 60 to 100 beats per minute (BPM). In AFib with RVR, your heart rate can reach more than 100 BPM.
What Are the Complications? Any type of AFib can lead to a stroke or heart failure. If you don't get treated, over time the condition can damage your heart muscle and lead to heart failure. But

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 _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMAH NURSING AND REHAB	1505 BUTTS AVE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 7	F 760		

the right treatment will bring your symptoms under control and get you back into a healthy rhythm."

The facility policy titled, "General Dose Preparation and Medication Administration," dated 2017, which states, in part ... "After medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application sight) on appropriate forms; ..."

R1 was initially admitted to the facility on 5/20/20 with diagnoses including, but not limited to, other persistent atrial fibrillation, ischemic cardiomyopathy, COPD (Chronic Obstructive Pulmonary Disease), PTSD (Post-traumatic stress disorder), Diabetes Mellitus type 2, and Encephalopathy. R1's most recent readmission to the facility was on 8/5/20 after a hospitalization for pneumonia.

According R1's MAR, R1 had an order for Metoprolol Succinate tablet extended release 24 hr; 200 mg; 1 tablet; oral - once a day, which he had been taking since his admission. Per the MAR (Medication Administration Record), this medication was to be given at HS (hour of sleep). R1 also had an order for a cholesterol reducing medication Atorvastatin tablet; 40 mg; 1 tablet; oral at bedtime, which was scheduled on the MAR to be given at 20:00 (8:00 PM).

Record review of R1's MAR shows the

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 _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMAH NURSING AND REHAB	1505 BUTTS AVE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 8	F 760		

medications Metoprolol Succinate and Atorvastatin were not signed out on 8/9/2020, 8/10/2020, and 8/11/2020.

On 8/12/2020, at 12:45 PM, Nurse's notes indicate R1 had a fall and was "noted to be confused and SOB (short of breath), Pulse is 140-150. MD notified, new orders received to transfer to ER for further eval and tx." At 7:27 PM, facility Nurse's Notes read, "Resident is admitted to [hospital] for Atrial Fibulation [sic] and Mental Status Changes."

On 8/12/20, at 3:13 PM, Emergency Room Provider Progress Notes state that the chief complaint is patient presents with fall. "The patient is a 75-year-old gentleman with history of dyslipidemia, COPD, congestive heart failure, type 2 diabetes, hypothyroidism, and hypertension. He is on chronic anticoagulation with Eliquis. He presents to the emergency department from [facility] for evaluation. I am given no report from [facility] nor did they call nursing staff. EMS (Emergency Medical Services) gave report that the patient fell more frequently and seems confused and this is all the report they have. The patient cannot provide history in [sic] this severely limits history of present illness." Under physical examination notes, comments state, "Heart rate is tachycardic and irregular."

On 8/12/20, at 3:20 PM, Emergency Department Course notes state, "Upon arrival to the emergency department is recommends the patient is in atrial fibrillation with rapid ventricular response (RVR) with rate in the 160-170 range. Twelve lead EKG was obtained this demonstrated atrial fibrillation with rapid ventricular response at

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 _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMAH NURSING AND REHAB	1505 BUTTS AVE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 9	F 760		

a rate of 156 without acute ST or T-wave changes. IV access established ... He is placed on Cardizem (medication to lower heart rate) drip with 15 mg bolus followed by 5 milligram/hour drip..." At 4:57 PM, Emergency notes state, "Frequent reassessments were made of the patient. He has improvement overall of his rate down to the 110-120 range. Patient remains very somnolent and unresponsive but is protecting airway and has stable vital signs at this time. I feel patient needs admission for observation, further workup, and continued rate control."

On 8/13/2020, Physician's Progress Notes during hospital stay read, "Subjective: Pt was interviewed in his room alone. He is coming in for atrial fibrillation with RVR. Some concern that he is not getting his Metoprolol in the nursing home setting over the last 4 days. Patient is not aware whether he is taking it or not. Regardless, responded to Diltiazem drip and is in the 80s to 90s now. He denies shortness of breath, chest pain, or palpitations ..."

On 8/14/2020, at 2:32 PM, R1's Discharge Summary signed by the provider indicates R1's admission diagnosis was atrial fibrillation with RVR and his condition on disposition: improving. R1's Hospital Course Summary states, "Patient was brought in with A Fib with RVR. He was started on diltiazem drip and tolerated this well with improvement in his rates. He eventually was switched back to his oral Metoprolol which he also tolerated. He was watched for an additional day on oral medications and remained rate controlled. He will return to the nursing home for continued strengthening with no changes in his medications." Physical exam on discharge indicated R1's heart is "irregularly irregular with a

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 _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMAH NURSING AND REHAB	1505 BUTTS AVE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 10	F 760		

normal rate." (Of note, R1 was discharged with the same dose of Metoprolol as he had been ordered prior to hospitalization, and the medication administration time was changed starting on 8/15/2020 to be given once a morning at 8:00 AM.)

On 9/11/2020, Surveyor reviewed the Facility Misconduct Incident Report and Investigation, which indicates the concern regarding R1's medications was reported to MDS/RN L (Minimum Data Set Registered Nurse) on 8/13/2020 by [hospital staff]. MDS/RN L then reported it to the interim Nursing Home Administrator, who is no longer at the facility, and the facility began investigating.

According to the facility investigation, MDS/RN L retrieved statements from the three Registered Nurses responsible for administering R1's PM shift medications from 8/9/20 to 8/11/20. Statements documented in the facility's investigation summary include the following:

On 8/9/20, RN K was assigned to R1:
Statement from [RN K] regarding meds for [R1] 8/9/20: RN K stated that he believes to the best of his knowledge that he would have given the HS meds unless the heart rate or blood pressure were out of parameters.
(Of note, RN K did not document any vital signs or Nurse's Notes for R1 on 8/9/20. The only Nurse's Note documented for R1 on 8/9/20 was done at 2:18 AM stating R1 rested well all shift with no signs or symptoms of distress. At 1:18 PM, on 8/9/20, R1's pulse was charted as 86/per minute.)

On 8/10/20, RN J was assigned to R1

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 _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMAH NURSING AND REHAB	1505 BUTTS AVE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 11	F 760		

Statement from [RN J] regarding [R1]
8/10/20: Yes, I did give [R1's] HS meds. "I didn't sign them out?" She stated that she was impressed that he didn't get nauseous afterwards because she was told that he does that.
8/11: [RN J] stated that she was not down that hall
8/13/2020 at 1621 (4:21 PM)
8/19/20 (Handwritten note added to sheet) 11:22 AM T. C. (telephone call) [RN J]
re: incident above. No answer. Left message for her to call writer back.

On 8/11/20, RN I was assigned to R1:
[RN I's] statement regarding [R1]
8/11: Resident had an emesis right before she had arrived. Assisted with cleaning up and then held meds. She was not sure if she gave them later.
8/13/20 at 1500 (3:00 PM)
Hand written statement from RN I reads: "I [RN I] held [R1's] meds on 8/11/20 on the PM shift due to having GI symptoms and an emesis. I do not remember if I gave them later in the shift."
(Of note, there is no documentation in the Nurse's Notes regarding R1 having an emesis or held medications.)
According to the facility investigation summary, RN I was interviewed on 8/13/20 and stated she was not sure if she gave the medications or not and when RN I was interviewed again on 8/19/20, RN I stated that she did give him the medications (Metoprolol and Atorvastatin) on 8/11/20.

On 9/9/20, at 2:30 PM, Surveyor spoke with RN I regarding R1 and the medications in question for 8/11/20. RN I stated that R1 had been back and forth from the hospital and said that, "[MDS/RN L] had called me, and I said I don't really remember

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 _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMAH NURSING AND REHAB	1505 BUTTS AVE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 12	F 760		

any specifics. I wish I could." Surveyor asked RN I about the facility's policy on medication administration documentation and what it meant if a blank was left on the MAR, and she stated there "aren't supposed to be any blanks ever." RN I indicated that all actions for an ordered medication have a "mark" for if it is held, refused, etc. "not blank." RN I could not specifically recall what type of education was provided by the facility after R1's medication concerns, but stated "probably had something about refusals and maybe talked about it at the nurse's station."

On 9/9/20, at 3:05 PM, Surveyor spoke with NHA A (Nursing Home Administrator), who began her role at the facility on 8/19/20. Surveyor asked NHA A what she knew of R1's hospitalization on 8/12/20 and why R1 was sent out, and she stated, "What I know is he went in (to ER, then hospital) and they found the MAR had holes in signatures on some dates." NHA A did not complete this self-report, but states she did review it along with the related documentation.

The facility's investigation summary indicates that "During the investigation, we obtained statements from the nurses that were responsible on the days the medications should have been provided. Regardless of their response as to have administered medication or not, it should have been documented in the MAR. Nurses did not document giving the medication in the MAR were re-educated and counseled on appropriate documentation of med administration. The facility concluded that the concern was substantiated and that all medication provided needs to be documented in the MAR. Of note, not all nurses were educated on the above.

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 _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMAH NURSING AND REHAB	1505 BUTTS AVE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 13 R1 did not receive his Metoprolol, a beta blocker medication which controls heart rate, for 3 days. R1 was sent to the ER with elevated heart rate and was diagnosed with Atrial Fibrillation with RVR (irregular, elevated heart rhytmn) R1 required IV medication to control his heart rhythm during hospitalization. Uncontrolled Afib can lead to stroke and/or heart failure.	F 760		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		

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 _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMAH NURSING AND REHAB	1505 BUTTS AVE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 14	F 880		

possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record

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 _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMAH NURSING AND REHAB	1505 BUTTS AVE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 15	F 880		

review, the facility did not maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases (such as COVID-19). This has the potential to affect 14 of 14 resident on TBP (Transmission Based Precautions) and 1 of 6 residents requiring blood glucose monitoring.

The facility failed to ensure staff were able to access the appropriate PPE, specifically isolation gowns, when caring for residents on TBP.

The facility failed to ensure staff followed current standards of practice when checking blood sugars and with cleaning of glucometers that were used by multiple residents.

This is evidenced by:
The facility's "(Facility Name). Infection Control Manual. 2019 Novel Coronavirus (COVID-19)" updated 7/2020, states in part: "Healthcare Personnel (HCP) should wear a facemask at all times when in the facility ... All non-dedicated medical equipment should be cleaned and disinfected according to manufacturer's policy between each resident ...

The facility's "(Facility Name). Infection Control Manual. Glucometer Cleaning. Policy: To prevent the transmission of infections the facility requires disinfecting Blood Glucose Meters between resident uses. Procedure: 3. Technique recommendations include, but are not limited to ... If glucometers are shared, the device must be cleaned and disinfected between each resident use. Wear gloves during finger stick blood glucose monitoring. Perform hand hygiene with soap and water or alcohol hand sanitizer immediately after removal of gloves and before

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 _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 16	F 880		

touching medical supplies intended for use on other residents.

According to the CDC (Centers for Disease Control), appropriate use of PPE for adherence to Standard Precautions include the use of gloves in situations involving possible contact with blood or body fluids, mucous membranes, non-intact skin (e.g., exposed skin that is chapped, abraded, or with dermatitis) or OPIM (other possible infectious material).

Example 1:
On 9/09/20 at 9:52 AM, Surveyor spoke with Corporate Consultant C. Surveyor asked Corporate Consultant C if it was possible to see the PPE storage area. Corporate Consultant C stated, "The central supply key is not available at this time. We only have one and someone is out of the building with it having another copy made."

On 9/09/20 at 9:53 AM, Surveyor interviewed Anonymous D. Surveyor asked Anonymous D if it would be possible to see the area that PPE is kept for staff. Anonymous D opened the medication room door for Surveyor. A small supply of surgical masks, gloves, gowns, N95's were noted sitting behind the door. Surveyor asked Anonymous D if staff always had access to the appropriate PPE. Anonymous D stated, "No." Surveyor asked Anonymous D what staff do when PPE is not available in the medication room. Anonymous D stated, "We tell the business office what we don't have and they get it for us." Surveyor asked Anonymous D what happens on the weekend or at night when PPE runs out or is unavailable. Anonymous D states, we call the business office manager at home. She will come in or is supposed to come in. I am not sure if that

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 _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMAH NURSING AND REHAB	1505 BUTTS AVE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 17	F 880		

always happens.

On 9/09/20 at 10:02 AM, Surveyor interviewed Anonymous E. Surveyor asked Anonymous E if she had ever had any trouble with not having or being able to access PPE. Anonymous E stated, "I have had to call before to have someone come get out PPE as the facility had it all locked up. The beauty shop only has one key."

On 9/09/20 at 11:12 AM, Surveyor interviewed Anonymous F. Surveyor asked Anonymous F if she always has access to PPE needed to care for residents. Anonymous F stated, "If not in isolation bins outside of rooms will take from another bin. There are times when it is just not available to anyone. We are to wear our surgical masks for 7 days. Gowns are not always available."

On 9/09/20 at 11:24 AM, Surveyor was able to observe beauty shop area that was converted in PPE storage room. IDO N (Interim Director of Operations) opened door to beauty shop for Surveyor. Surveyor asked IDO N if staff has access at all times to this storage area. IDO N stated, "They always have access to this room. I assume the charge nurse would have access to the PPE at night and on weekends."

On 9/09/20 at 11:30 AM, Surveyor interviewed Anonymous G. Surveyor asked Anonymous G if PPE is always available. Anonymous G stated, "No. You would think this would not be an issue it is not stocked properly." Surveyor asked Anonymous G what staff does when PPE is not available. Anonymous G stated, on any shift we go to the nurse who can get PPE from the medication room. There have been occasions

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 _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMAH NURSING AND REHAB	1505 BUTTS AVE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 18	F 880		

when PPE was not available in the medication room either and the nurse had to call someone to get us PPE."

On 9/09/20 at 11:33 AM, Surveyor interviewed BOM S (Business Office Manager). Surveyor asked BOM S if staff has access to PPE. BOM S informed Surveyor that staff always have PPE available. Nurses have PPE in the medication room but do not have access to the beauty shop.

On 9/09/20 at 11:50 AM, Surveyor interviewed Anonymous H. Surveyor asked Anonymous H if keys were available to managers on duty on the weekends. Anonymous H informed Surveyor that there was a key around till about 2-3 weeks ago. Staff have brought to me concerns of not having PPE available to them. It seems as if the main issue is the weekend about 50 percent of the time.

On 9/09/20 at 12:00 PM, Surveyor was approached by NHA A (Nursing Home Administrator) and Corporate Consultant C. NHA stated, "The process for the PPE storage rooms will be changing. Each Nurse on a cart will have a key."

Example 2
On 9/09/20 at 10:02 AM, Anonymous E indicated to Surveyor that direct care staff have used garbage bags as gowns when caring for residents when PPE is unavailable to them.

On 9/10/20 at 2:45 PM, Surveyor interviewed Anonymous E. Surveyor asked Anonymous E how many residents were on precautions when they had to wear garbage bags as PPE. Anonymous E stated, "14 residents." 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 _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMAH NURSING AND REHAB	1505 BUTTS AVE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 19	F 880		

asked why garbage bags were used by staff. Anonymous E stated, "We couldn't get to the PPE." Surveyor asked Anonymous E why staff did not wait for proper PPE. Anonymous E stated, "14 people were on quarantine after new admission and call lights were on. We could not wait for the appropriate PPE to be available, we did the best that we could."

Note: Staff had numerous concerns of not having PPE available to them.

Example 3
On 9/09/20 at 2:52 PM, Surveyor observed Maintenance U coming out of room 36 without any type of PPE on. Maintenance U upon seeing Surveyor went back into room 36 and put on a face mask and face shield before leaving the room.

On 9/09/20 at 3:10 PM, Surveyor observed CNA V at the nurse's station. CNA V had on a face mask and a face shield that was sitting on top of her head. Surveyor asked CNA V if a face shield was required to be worn by staff. CNA V stated, "Yes." Surveyor asked CNA V if she often wears her face shield up away from her face. CNA V stated, "I wear it up on top of my head when it is hot, no one has ever said anything to me." Surveyor asked CNA V if she thought she should wear her face shield up on top of her head and not covering her eyes and face. CNA V stated, "Probably not. I don't when I am in a resident's room, just when I am out here."

On 9/10/20 at 8:22 AM, Surveyor interviewed LPN W. Surveyor asked LPN W what PPE staff are required to wear when not in quarantine rooms. LPN W stated, "Any staff in resident care

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 _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMAH NURSING AND REHAB	1505 BUTTS AVE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 20	F 880		

areas are required to wear a face mask and face shield."

On 9/10/20 at 8:24 AM, Surveyor interviewed LPN T. Surveyor asked LPN T what PPE staff are required to wear when not in quarantine rooms. LPN T stated, "Staff in resident care areas are required to wear a face mask and face shield at all times."

On 9/10/20 at 8:25 AM, Surveyor interviewed CNA V. Surveyor asked CNA V what PPE staff are required to wear when not in quarantine rooms. CNA V stated, "A face mask and face shield in resident areas."

Example 4
On 9/09/20 at 3:02 PM, Surveyor observed RN I complete a glucose check on R10. RN I was observed gathering supplies to check R10's blood sugar. Once RN I had gathered the appropriate supplies she bent over R10 in the hall at the nurse's station. RN I used the lancet and placed a drop of blood on the testing strip. RN I did this without wearing any gloves. RN I put the used glucometer back into the basket to go back into the medication cart without cleaning it. Corporate Consultant C intervened at this time and had RN I gather all supplies used including the glucometer and come to the soiled utility room to discard any items used while checking resident blood sugar, wash hands and clean the glucometer used.

The facility failed to ensure staff were using approved PPE when caring for residents in droplet and contact precautions for COVID-19, which could result in cross contamination of staff. Staff were observed not wearing PPE appropriately in resident care areas. Staff did not

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 _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMAH NURSING AND REHAB	1505 BUTTS AVE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 21 have access to appropriate PPE. Staff did not disinfect shared glucometers appropriately which could lead to cross contamination to residents.	F 880		