STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525657	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Care Center	251 Forest Lane Montello, WI 53949

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** 43361 Based on staff interview and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for 2 residents (R) (R16 and R17) of 10 sampled residents. R16 stated in a resident council meeting that a staff kicked R16's foot off R16's chair on purpose and was rough with R16. The allegation of abuse was not reported to the State Agency (SA) or local law enforcement. R17 stated someone took money out of R17's purse. The allegation of misappropriation was not reported to the SA or local law enforcement. Findings include: The facility's Resident/Employee Abuse, Neglect, Mistreatment Policy and Procedure, dated 8/24/15, indicates: 1. Any alleged violation involving mistreatment, misappropriation of property, abuse, exploitation, neglect, or injuries of unknown source of a resident shall be immediately reported to the Administrator, the Clinical Manager or designee, the Division of Quality Assurance (DQA), and local law enforcement. 1. R16 was admitted to the facility on [DATE] and had diagnoses including nontraumatic cerebral hemorrhage, transient cerebral ischemic attack (stroke), and anxiety. R16's Minimum Data Set (MDS) assessment, dated 1/17/24, contained a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R16 had intact cognition. On 4/9/24, Surveyor reviewed the facility's resident council minutes from 3/7/24 that indicated: R16 thinks a Medication Technician kicked R16's foot off R16's chair on purpose and was rough with R16. On 4/9/24 at 12:35 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and requested an investigation for R16's allegation of abuse. NHA-A indicated NHA-A was not aware of the incident and didn't see the minutes from resident council meetings. NHA-A indicated if NHA-A knew about R16's concern, NHA-A would have reported the allegation. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R17 was admitted to the facility on [DATE] and had diagnoses including dementia, delusions, and anxiety. R17's MDS assessment, dated 2/26/24, contained a BIMS score of 6 out of 15 which indicated R17 had severe cognitive impairment. On 4/9/24, Surveyor reviewed the facility's grievances and noted a grievance, dated 9/24/23, that indicated: Activities reported to SS (Social Services) on 9/25/23 that R17 was agitated for a few hours on 9/24/23 and said someone took money out of R17's purse. R17 gets agitated over situations and items at times, but this is the first time R17 was upset about money missing from R17's purse. R17 gets agitated when someone tries to take R17's purse and keeps the purse with R17 at all times. Staff were not able to get the purse to look and do not know how much money R17 had in the purse. The Investigation section of the grievance indicated: Have to have someone go through R17's purse at a time R17 does not know the purse is missing. The Resolution section indicated: R17 was noncompliant with help to search. The Activity Director looked in R17's purse and nothing was missing. On 4/9/24 at 12:35 PM, Surveyor interviewed NHA-A who indicated R17 was [AGE] years old and had dementia. NHA-A stated R17 was confused and nobody thought R17 had money. NHA-A indicated NHA-A was not employed at the facility when the allegation was made, but confirmed the allegation of misappropriation was not reported to the SA or local law enforcement because of R17's memory and age.

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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** 43361 Based on staff interview and record review, the facility did not thoroughly investigate allegations of abuse and misappropriation for 2 residents (R) (R16 and R17) of 10 residents. R16 stated in a resident council meeting that staff kicked R16's foot of R16's chair on purpose and was rough with R16. The allegation of abuse was not thoroughly investigated. R17 stated someone took money out of R17's purse. The allegation of misappropriation was not thoroughly investigated. Findings include: The facility's Resident/Employee Abuse, Neglect, Mistreatment Policy and Procedure, dated 8/24/15, indicates: 4. The Administrator or designee shall thoroughly investigate all allegations and show evidence that they thoroughly investigated and must prevent further incidents while the investigation is in process. A thorough investigation includes but is not limited to: Interviewing alleged victims and witnesses, interviewing accused individuals, interviewing other residents to determine if they have ben abused or mistreated, interviewing staff who worked the same and previous shifts. 1. R16 was admitted to the facility on [DATE] and had diagnoses including nontraumatic cerebral hemorrhage, transient cerebral ischemic attack (stroke), and anxiety. R16's Minimum Data Set (MDS) assessment, dated 1/17/24, contained a Brief Interview for Mental Status Score (BIMS) score of 14 out of 15 which indicated R16 had intact cognition. On 4/9/24, Surveyor reviewed the facility's resident council minutes from 3/7/24 that indicated: R16 indicated a Medication Technician kicked R16's foot off R16's chair on purpose and was rough with R16. On 4/9/24 at 12:35 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and requested the investigation for R16's allegation of abuse. NHA-A stated NHA-A was not aware of the allegation and didn't see the minutes from resident council meetings. NHA-A indicated if NHA-A knew about R16's concern, NHA-A would have completed a full investigation, including providing protection for R16 and interviewing staff and residents. 2. R17 was admitted to the facility on [DATE] and had diagnoses including dementia, delusions, and anxiety. R17's MDS assessment, dated 2/26/24, contained a BIMS score of 6 out of 15 which indicated R17 had severe cognitive impairment. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/24, Surveyor reviewed the facility's grievances and noted a grievance, dated 9/24/23, that indicated: Activities reported to SS (Social Services) on 9/25/23 that R17 was agitated for a few hours on 9/24/23 and said someone took money out of R17's purse. R17 gets agitated over situations and items at times, but this is the first time R17 was upset about money missing from R17's purse. R17 gets agitated when someone tries to take R17's purse and keeps the purse with R17 at all times. Staff were not able to get the purse to look and do not know how much money R17 had in the purse. The Investigation section of the grievance indicated: Have to have someone go through R17's purse at a time R17 does not know the purse is missing. The Resolution section indicated: R17 was noncompliant with help to search. The Activity Director looked in R17's purse and nothing was missing. On 4/9/24 at 12:35 PM, Surveyor interviewed NHA-A who indicated R17 was [AGE] years old and had dementia. NHA-A stated R17 was confused and nobody thought R17 had money. NHA-A confirmed there was no further investigation, including resident and staff statements to determine if R17 had money and if other residents were missing money.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on observation, staff interview, and record review, the facility did not ensure necessary care and services were provided to promote healing and/or prevent pressure injuries from worsening or developing for 1 resident (R) (R6) of 17 sampled residents. R6's medical record indicated R6 had open area(s) on the buttocks on 1/10/24 and 3/27/24. R6's medical record did not contain assessments or proof of monitoring for effectiveness of treatments. Findings include: The facility's Pressure Ulcers/Skin Breakdown-Clinical Protocol document, with a revision date of April 2018, indicates: .1. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers .2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic (dead) tissue .d. Current treatments .4. The physician will assist the staff to identify the type (for example, arterial or stasis ulcer) and characteristics (presence of necrotic tissue, status of wound bed, etc.) of an ulcer . On 4/9/24, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] with diagnoses including traumatic subdural hemorrhage (bleeding between the layers of tissue that surround the brain) and aphasia (an inability to comprehend or formulate language because of damage to specific brain regions). R6's Minimum Data Set (MDS) assessment, dated 3/30/24, indicated R6 was never or rarely understood, was totally dependent on staff for activities of daily living, and had two stage 2 pressure injuries. Previously completed MDS assessments indicated R6 had no pressure injuries. R6's medical record indicated R6's court-appointed guardian was responsible for R6's healthcare decisions. R6's medical record included the following nurse progress notes which indicated: ~1/10/24: Small open area to left inner buttock. Zinc (thick paste used to protect skin) and foam dressing applied. ~1/18/24: Per night shift nurse during report, R6's air mattress deflated during the night when R6 was lying on it. Night shift changed mattress. Per CNA (Certified Nursing Assistant), R6 has spot on (buttock). Updated wound nurse to assess. ~3/27/24: Updated Doctor and POA (Power of Attorney/Guardian) about small open area on buttocks. A Skin Risk Assessment, dated 12/19/23, indicated R6 was at high risk for pressure injury. A Clinical Admission Observation, dated 1/5/24, indicated R6 had no open areas. A Wound Management Detail Report, dated 3/27/24, indicated R6 had a skin tear on the left buttock that measured 1 cm (centimeter) by 1 cm and a skin tear on the right buttock that measured 4 cm by 0.1 cm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Skin Integrity Wound Observation, dated 4/3/24, indicated: Redness to buttocks. Open areas resolved. On 4/9/24 at 10:06 AM, Surveyor observed Licensed Practical Nurse (LPN)-E and Medication Technician (MT)-F provide perineal care for R6. During the observation, Surveyor noted a scabbed area approximately 1 cm by 0.5 cm on R6's right buttock. LPN-E verified the scabbed area. Surveyor observed LPN-E apply zinc paste to R6's buttocks following perineal care. R6's care plan did not indicate R6 was at risk for pressure injuries or impaired skin integrity. On 4/9/24 at 3:31 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated DON-B just started as interim DON and DON-B's first day in the building was 4/8/24. DON-B indicated the facility's previous DON completed wound assessments. DON-B stated the facility could not locate the previous DON's documentation on R6's open areas. DON-B verified the above documentation in R6's medical record was conflicting and did not contain weekly wound assessments. DON-B verified a scabbed area on the skin should not be considered a healed area. On 4/9/24 at 3:44 PM, Surveyor conducted a follow-up interview with DON-B who verified R6's care plan did not address R6's risk for pressure injuries and impaired skin integrity.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43361 Based on observation and staff interview, the facility did not ensure medications were properly secured in a medication cart. This practice had the potential to affect multiple residents whose medications were stored in the cart. Surveyor observed R15 open a drawer of an unlocked medication cart in the lobby and remove two medication cards. Findings include: The facility's Security of Medication Cart policy, revised April 2007, indicates: .5. When the medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room. On 4/9/25, Surveyor reviewed R15's medical record. R15 was admitted to the facility on [DATE] with diagnoses including dementia. R15's Minimum Data Set (MDS) assessment, dated 1/24/24, contained a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R15 had severe cognitive impairment. On 4/9/24 at 2:12 PM, Surveyor entered the lobby and observed a medication cart next to the nurses' station. Surveyor observed R15 lean from R15's wheelchair toward the medication cart, open a drawer, and remove two medication cards. There were five residents in the lobby at the time. One resident stated to R15, Get out of there. Surveyor did not observe staff in the area, but observed four staff standing and talking in a group approximately halfway down a resident wing. Surveyor motioned for staff who removed the medication cards from R15's hand. Staff placed the medication cards on top the medication cart and pushed R15 back to R15's room. On 4/9/24 at 2:15 PM, Surveyor interviewed Medication Technician (MT)-F who indicated MT-F used the medication cart and confirmed the cart was unlocked. MT-F indicated MT-F schedules staff, works the floor, and was assisting administration and talking with staff to get Surveyor some requested items. MT-F confirmed the medication cart should have been locked. On 4/9/24 at 2:33 PM, Surveyor interviewed Director of Nursing (DON)-B who stated DON-B expects staff to lock the medication cart at all times when not in use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32768 Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to provide a safe and sanitary environment and prevent the transmission of communicable disease and infection. This practice had the potential to affect all 29 residents residing in the facility. In addition, staff did not perform appropriate hand hygiene during incontinence care for 2 residents (R) (R9 and R6) of 2 residents. The facility did not appropriately monitor for infections and outbreaks. Staff did not perform appropriate hand hygiene during incontinence care for R9 and R6. Findings include: The facility's Surveillance for Infections policy, dated 9/2017, indicates: .5. Nursing staff will monitor residents for signs and symptoms that may suggest infection, according to current criteria and definitions of infections and will document and report suspected infections to the charge nurse as soon as possible. Data Collection and Recording 1. For residents with infections that meet the criteria for definition of infection for surveillance, collect the following data as appropriate: a. Identifying information (i.e. resident's names, age, room number, unit, and attending physician). b. Diagnosis c. admitted , date of onset of infection (may list onset of symptoms, if known, or date of positive diagnostic test). h, Treatment measures and precautions (interventions and steps taken that may reduce risk). 4. For targeted surveillance using facility-created tools, follow theses guidelines: a. Daily record detailed information about the resident and infection on an individual infection report form (e. g., infection treatment/tracking report, infection report form, or similar form). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Handwashing/Hand Hygiene policy, revised October 2023, indicates: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections .Administrative Practices to Promote Hand Hygiene: 1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policies Indications for Hand Hygiene: 1. Hand hygiene is indicated: a. Immediately before touching a resident; b. Before performing an aseptic task .c. After contact with blood, body fluids, or contaminated surfaces; d. After touching a resident; e. After touching the resident's environment; f. Before moving from work on a soiled body site to a clean body site on the same resident; and g) Immediately after glove removal .4) Single-use disposable gloves should be used: .b. When anticipating contact with blood or body fluids .5. The use of gloves does not replace hand washing/hand hygiene. 1. On 4/9/24, Surveyor reviewed the facility's infection control line list for a COVID-19 outbreak that began on 1/1/24. Twelve residents and four staff tested positive for COVID-19. The line list contained the dates staff and residents tested positive, but did not identify any symptoms. In addition, staff and residents' symptoms were not monitored, including the date of their last symptom(s) and a return to work date. In addition, residents were identified as COVID-19 positive on 1/1/24 with documented onset of symptoms, but their symptoms were not monitored after that date and the line list did not include the date of their last symptom(s). On 4/9/24 at 2:17 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated the facility did not and does not maintain a line list for monitoring staff and residents' symptoms for COVID-19. DON-B indicated DON-B expects the Infection Preventionist (IP) and the nurses to do so. DON-B also indicated the facility is in the process of hiring a new IP and are working on keeping line lists up-to-date. 45942 2. On 4/9/24, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] with diagnoses including anxiety, colostomy, and atrial fibrillation (abnormal heart rhythm). R9 was alert and oriented and able to answer questions appropriately. On 4/9/24 at 10:31 AM, Surveyor observed Certified Nursing Assistant (CNA)-C and CNA-D perform incontinence care for R9. CNA-C and CNA-D completed hand hygiene prior to gathering supplies and donned gloves. CNA-C assisted R9 with removing R9's gown and handed R9 a wet washcloth to wash R9's face. CNA-C cleansed R9's upper body and assisted R9 with putting on a clean gown. CNA-C unfastened R9's brief and noted R9's colostomy bag was open and leaking stool onto R9's bed pad. CNA-C cleansed the soiled area with a wash cloth and closed and secured R9's colostomy bag. Without removing gloves or completing hand hygiene, CNA-C adjusted R9's gown and touched R9's upper body during repositioning. CNA-D provided pericare, removed gloves, and completed hand hygiene. CNA-D then donned clean gloves and put a new brief on R9. With the same soiled gloves, CNA-C adjusted R9's brief and clean bed pad. After positioning R9 on the left side, CNA-D removed gloves, sanitized hands, and donned clean gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/9/24 at 11:41 AM, Surveyor interviewed CNA-C regarding incontinence care and hand hygiene. CNA-C verified CNA-C did not remove gloves or complete hand hygiene after cleansing R9's stool. CNA-C verified CNA-C should have removed gloves and performed hand hygiene. On 4/9/24 at 1:03 PM, Surveyor interviewed DON-B who indicated DON-B expects staff to remove soiled gloves after incontinence care, complete hand hygiene, and don clean gloves if staff continues to provide care. 40342 3. On 4/9/24, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] with diagnoses including traumatic subdural hemorrhage (bleeding between the layers of tissue that surround the brain) and aphasia (an inability to comprehend or formulate language because of damage to specific brain regions). R6's Minimum Data Set (MDS) assessment, dated 3/30/24, indicated R6 was never or rarely understood, was totally dependent on staff for activities of daily living, and had two stage 2 pressure injuries. Previously completed MDS assessments indicated R6 had no pressure injuries. R6's medical record indicated R6's court-appointed guardian was responsible for R6's healthcare decisions. On 4/9/24 at 10:06 AM, Surveyor observed Licensed Practical Nurse (LPN)-E and Medication Technician (MT)-F provide incontinence care for R6 following a bowel movement. During the provision of care, MT-F completed rear perineal care. With the same soiled gloves, MT-F put a clean brief on R6 and assisted LPN-E with repositioning R6. MT-F then handed LPN-E a cleanser bottle, assisted with positioning while LPN-E provided additional care, and assisted LPN-E reposition R6 onto R6's back. MT-F then removed gloves and completed hand hygiene. On 4/9/24 at 10:35 AM, Surveyor interviewed MT-F who verified MT-F should have removed gloves, completed hand hygiene, and donned clean gloves when moving from dirty to clean tasks. On 4/9/24 at 1:09 PM, Surveyor interviewed DON-B who verified MT-F should have removed gloves, completed hand hygiene, and donned clean gloves when moving from dirty to clean tasks.