

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525657	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Montello Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38793</p> <p>Based on staff interview and record review, the facility did not ensure an allegation of abuse was reported to the State Agency (SA) for 2 residents (R) (R1 and R5) of 5 sampled residents.</p> <p>On 9/7/24, R1 and R5 were involved in a physical altercation that involved hitting and slapping at each other. The resident-to-resident altercation was not reported to the SA.</p> <p>Findings include:</p> <p>The facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, with a revision date of April 2021, indicates: Residents have the right to be free from abuse .Objectives: 1. Protect residents from abuse, neglect .by anyone .If resident abuse .is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law .The Administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; .e. Law enforcement officials . Upon receiving an allegation of abuse .the administrator is responsible for determining what actions (if any) are needed for the protection of residents .Within five business days of the incident, the administrator will provide a follow-up investigation report .</p> <p>On 10/18/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including a fall with a fracture and dementia. R1's most recent Minimum Data Set (MDS) assessment, dated 8/13/24, had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated R1 had severe cognitive impairment. R1 had an activated Power of Attorney for Healthcare (POAHC).</p> <p>Surveyor reviewed R1's care plan, revised on 8/20/24, and noted an intervention for staff to provide 1:1 supervision for R1 as needed. A nursing station update board indicated R1 should be on 1:1 supervision when out of R1's room.</p> <p>On 10/18/24, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] with diagnoses including dementia and depression. R5's most recent MDS assessment, dated 9/28/24, had a BIMS score of 8 out of 15 which indicated R5 had moderate cognitive impairment.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/18/24, Surveyor reviewed a facility file regarding an altercation between R1 and R5 that occurred on 9/7/24. The file indicated R1 was in a common area while Med Tech (MT)-C prepared evening medications. R1 became agitated at MT-C and called MT-C names. R5 got upset, approached R1, shook a finger at R1, and said, Don't you say that . Before MT-C could intervene, R1 and R5 hit each other. R1 and R5 were separated and assessed for injuries.</p> <p>On 10/18/24 at 11:26 AM, Surveyor interviewed MT-C regarding the incident. MT-C stated R1 was not being provided 1:1 supervision at the time the altercation occurred and MT-C was preparing medication. MT-C could not recall who hit who first.</p> <p>On 10/18/24 at 1:14 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified the altercation was not reported to the SA because R1 and R5 did not incur physical injuries.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38793</p> <p>Based on observation, staff interview, and record review, the facility did not ensure staff provided adequate supervision to prevent resident-to-resident altercations for 4 residents (R) (R1, R3, R4, and R5) of 5 sampled residents.</p> <p>On 7/20/24, R1 rolled R1's wheelchair into R2's foot. R2 said ouch and R1 raised R1's fists as if to hit R2.</p> <p>On 7/31/24, R1 was found in R3's room yelling at R3. R1 was placed on 15-minute checks.</p> <p>On 8/20/24, R1 was observed yelling at R4 in the hallway. R1 grabbed R4's shirt and hit R4's chest. R1 was placed on 1:1 supervision until a motion sensor and an audio monitor were in place.</p> <p>On 9/7/24, R1 became agitated and yelled at Med Tech (MT)-C. R5 approached R1 and said, Don't do that . R1 and R5 then hit each other. R1 was not provided 1:1 supervision at the time of the incident.</p> <p>Findings include:</p> <p>On 10/18/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including a fall with a fracture and dementia. R1's most recent Minimum Data Set (MDS) assessment, dated 8/13/24, had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated R1 had severe cognitive impairment.</p> <p>On 10/18/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including stroke and seizure disorder. R2's most recent MDS assessment, dated 7/19/24, had a BIMS score of 15 out of 15 which indicated R2 had intact cognition.</p> <p>On 10/18/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] with diagnoses including dementia, Parkinson's disease, and anxiety. R3's most recent MDS assessment, dated 8/30/24, had a BIMS score of 2 out of 15 which indicated R3 had severe cognitive impairment.</p> <p>On 10/18/24, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] with diagnoses including dementia, depression, anxiety, and delusional disorder. R4's most recent MDS assessment, dated 8/21/24, had a BIMS score of 4 out of 15 which indicated R4 had severe cognitive impairment.</p> <p>On 10/18/24, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] with diagnoses including dementia and depression. R5's most recent MDS assessment, dated 9/28/24, had a BIMS score of 8 out of 15 which indicated R5 had moderate cognitive impairment.</p> <p>On 10/18/24, Surveyor reviewed facility-reported incidents (FRIs) submitted to the State Agency (SA) that indicated:</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>~ On 7/20/24, R1 rolled R1's wheelchair into R2's foot. R2 said ouch. R1 leaned forward toward R2 and raised R1's fists as if to hit R2. Staff intervened. The facility submitted a report to the SA and completed an investigation.</p> <p>~ On 7/31/24, R1 was found in R3's room yelling at R3. Staff intervened and separated R1 and R3. R3 alleged R1 hit R3. An assessment was completed with no signs of injury. The facility submitted a report to the SA and completed an investigation. R1 was placed on 15-minute checks and moved to a different wing.</p> <p>~ On 8/20/24, R1 was observed yelling at R4 in the hallway. Staff observed R1 grab and hit R4 on the left side of R4's chest. R1 was placed on 1:1 supervision for 48 hours until a motion sensor and audio monitor were installed in R1's room. The facility submitted a report to the SA and completed an investigation. On 8/29/24, staff were educated regarding the motion sensor and audio monitoring interventions for R1. Upon review of the education sign-in sheet, Surveyor noted only 8 of 25 nursing staff signed the education sheet as of 10/18/24.</p> <p>A progress note in R1's medical record, dated 9/7/24, indicated R1 had a resident-to-resident altercation.</p> <p>The facility's file regarding the incident on 9/7/24 between R1 and R5 indicated during the PM shift on 9/7/24, MT-C was preparing medication at the medication cart outside the nurses' station when R1 became agitated at the sound of MT-C crushing medication. R1 yelled at MT-C and called MT-C names. R5 was in the area and wheeled toward R1, shook a finger at R1, and told R1 to stop. Before MT-C could intervene, R1 and R5 began hitting each other.</p> <p>Surveyor reviewed R1's care plan, revised on 8/20/24, and noted an intervention for staff to provide 1:1 supervision for R1 as needed.</p> <p>On 10/18/24 at 11:26 AM, Surveyor interviewed MT-C regarding the incident. MT-C stated R1 was not being provided 1:1 supervision at the time of the altercation and MT-C was preparing medication when the altercation occurred. MT-C could not recall who hit who first.</p> <p>On 10/18/24 at 11:27 AM, Surveyor observed the nursing station update board which indicated R1 should be on 1:1 supervision when out of R1's room.</p> <p>On 10/18/24 from 11:28 AM to 11:39 AM and 12:17 PM to 12:34 PM, Surveyor observed Licensed Practical Nurse (LPN)-E leave R1's motion sensor receiver unattended at the nurses' station.</p> <p>On 10/18/24 at 11:29 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding education and interventions for R1. NHA-A verified the education sign-in sheet was the most current sign-in sheet. NHA-A verified nursing staff should keep the receiver for the motion sensor with them when they leave the nurses' station. NHA-A also indicated R1 should be on 1:1 supervision when R1 leaves R1's room. NHA-A stated there was no specific education related to the monitoring interventions nor was anyone assigned to provide 1:1 supervision. NHA-A indicated it was up to the nurse on duty to assign staff to provide 1:1 supervision when R1 was out of R1's room. NHA-A indicated 1:1 supervision meant staff should be within arms length of the resident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/18/24 at 12:36 PM, Surveyor interviewed LPN-E regarding R1's audio monitoring and motion sensor devices. LPN-E verified the audio monitor was at the nurses' station. LPN-E was not aware where the motion sensor receiver was located or where it rang from. LPN-E verified that R1 was suppose to be provided 1:1 supervision when outside of R1's room.</p> <p>On 10/18/24 at 1:14 PM, Surveyor interviewed NHA-A who verified R1 was supposed to be on 1:1 supervision when out of R1's room on the evening of 9/7/24. NHA-A stated staff failed to provide 1:1 supervision on 9/7/24. NHA-A verified R1's care plan was not updated to reflect 1:1 supervision when out of R1's room until 10/18/24.</p> <p>On 10/18/24 at 1:53 PM, Surveyor interviewed LPN-D regarding R1's audio monitoring and motion sensor devices. LPN-D verified LPN-D usually worked the PM shift and brought the motion sensor receiver with LPN-D on the medication cart. LPN-D stated if LPN-D was in a resident's room with the door closed, LPN-D could not hear the motion sensor alarm from the medication cart.</p>