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	06/12/2025

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 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** Based on observation, staff and resident interview, and record review, the facility did not ensure 1 resident (R) (R2) of 3 sampled residents received the necessary care and services to prevent pressure injuries and/or promote healing. On 5/25/25, staff reported to Director of Nursing (DON)-B that R2's wound vac (negative pressure wound therapy) dressing was not adhered properly. DON-B did not assess the wound vac dressing or ensure R1's wound vac was functioning appropriately. Findings include: The facility's Negative Pressure Wound Therapy policy, revised 2/2014, indicates: The purpose of this procedure is to provide guidelines for establishing and maintaining negative pressure wound therapy .change dressing per physician orders and manufacturer guidelines .secondary layer of barrier adhesive .create a vacuum seal over the wound . The facility's Prevention of Pressure Injuries policy, revised 3/1/21, indicates: .For prevention measures associated with specific devices, consult current clinical practice guidelines .Review the interventions and strategies for effectiveness on an ongoing basis . On 6/12/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including traumatic spinal cord injury, neurogenic bladder, diabetes, cerebral vascular accident, quadriplegia, acute osteomyelitis of left ankle and foot, colostomy, muscle wasting and atrophy, and extended spectrum beta lactamase (ESBL) resistance. R2 had an activated Power of Attorney for Healthcare (POAHC) for medical decision making. R2's Minimum Data Set (MDS) assessment, dated 4/21/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R2 had intact cognition. R2's medical record indicated Primary Wound Provider (PWP)-M placed a wound vac dressing on R2 on 5/16/25. A progress note, dated 5/19/25 at 12:26 PM and written by Assistant Director of Nursing (ADON)-L, indicated the wound vac was changed because the suction tubing was under the transparent dressing which had created an indentation in R2's skin. Registered Nurse (RN)-C completed an assessment of the wound on 5/19/25 at 12:30 PM which indicated R2 had worsening maceration with overall deteriorating condition. The wound vac dressing was replaced and running correctly. (continued on next page)

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
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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	A progress note, dated 5/25/25 at 11:00 AM and written by DON-B, indicated R2's wound vac was patent and running at 125 millimeters of mercury (mmHg) with no leaks present. A progress note, dated 5/25/25 at 9:22 and written by RN-N, indicated a malodorous odor was noted during wound care and R2 had a 99.5 degree temperature. PWP-M was notified and an order was received for ceftriaxone 2 grams (g) daily first dose administered now (regimen completed 5/27/25) and metronidazole 500 milligrams (mg) three times daily now through 5/27/25 for a urinary tract infection. On 6/12/25 at 9:49 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-K who indicated if a wound vac was not adhered correctly, CNA-K would ask a nurse to assess the wound vac. CNA-K indicated when CNA-K worked with R2 approximately three to four weeks ago, R2's wound vac dressing was bunched up and not suctioning. CNA-K told DON-B who was working as a floor nurse. DON-B indicated to CNA-K that the wound vac was working properly. On 6/12/25 at 10:01 AM, Surveyor interviewed R2 who indicated R2's wounds were healing. R2 indicated a wound provider and ADON-L (who took care of wounds when the wound provider was not present) assessed R2 each week. R2 indicated the wound provider tried the wound vac for a while, however, the wound vac didn't do what was expected and it was removed. On 6/12/25 at 10:14 AM, Surveyor interviewed RN-C who indicated R2 could go septic quickly. RN-C indicated the wound vac dressing pump did not always alarm if there were problems with the dressing, including if the dressing was not applied correctly. RN-C arrived for work on the 5/26/25 AM shift and was informed the wound vac was removed. RN-C indicated the wound was odorous to the point where RN-C could smell the wound in the hallway. RN-C received report from ADON-L who indicated R2's wound vac dressing was falling off during the previous PM shift. Alternative treatment was provided and the wound provider was scheduled to assess R2's wound on 5/27/25. ADON-L informed RN-C that R2 was started on antibiotics the previous night because R2's body was turning red and R2 had a fever. The provider ordered a urinalysis (UA) and culture. RN-C indicated R2 was sent to the hospital multiple times and continued to decline. RN-C indicated RN-C had concerns with DON-B completing a wound vac dressing change. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 10:47 AM, Surveyor interviewed ADON-L who was a Licensed Practical Nurse and indicated ADON-L took a wound certification course but did not take a wound care certification test. ADON-L completed wound care in the facility and did rounds with PWP-M weekly or more often. ADON-L indicated PWP-M provided wound vac dressing change education to nurses who were at the facility when the wound vac was initially placed on R2 on 5/16/25. ADON-L was not aware of any other education for wound vac dressing changes. ADON-L verified PWP-M changed R2's wound vac orders on 5/23/25 to allow nurses who were uncomfortable with wound vac dressing changes to use an alternative dressing to pack the wound with collagen. ADON-L worked the PM shift on 5/25/25 with an RN. ADON-L indicated R2 was in a motorized wheelchair when ADON-L arrived. When R2 was laid down, it was noted that R2's wound vac dressing was not intact. ADON-L indicated the foam was not suctioning even though the suction was on and the bandage was all bunched. ADON-L indicated there was a very strong odor at the wound site. R2 had a low-grade fever and R2's arms, face, and neck were red. ADON-L asked RN-N to assess R2. RN-N completed an assessment and contacted PWP-M who ordered a UA which was completed that night. ADON-L stated R2's wound vac dressing was not reapplied and the wound was packed with calcium alginate dressing. ADON-L indicated the event occurred at 7:30 PM and DON-B was the AM shift nurse that day. ADON-L indicated RN-N and DON-B completed verbal report at shift change and RN-N did not mention any issues with R2's wound vac from shift report with DON-B. ADON-L indicated R2 usually stays in R2's motorized wheelchair until supper then staff assist R2 back to bed to offload. R2 ate dinner in bed which was when ADON-L was notified that the wound vac was not properly attached. On 6/12/25 at 1:42 PM, Surveyor interviewed RN-N via phone who indicated RN-N did not do the dressing change but received report from R2's nurse (ADON-L) that R2 needed to be assessed. RN-N indicated R2 was prone to septic infection and had been on intravenous (IV) antibiotics in the past. On 6/12/25 at 1:51 PM, Surveyor interviewed PWP-M who indicated PWP-M started the wound vac dressing on 5/16/25 and decided on 5/23/25 to provide alternative wound dressing options so nurses who were uncomfortable with wound vac dressings would have options if a dressing change was needed. PWP-M recalled the 5/19/25 event which was part of the reason for the alternative dressing option ordered on 5/23/25. PWP-M indicated R2's buttock (ischial) wound worsened after R2 was hospitalized in April for osteomyelitis of the left heel. PWP-M indicated R2's wound was complicated but felt progress was occurring in the healing process. On 6/12/25 at 2:23 PM, Surveyor interviewed CNA-P who indicated R2's wound vac dressing did not look right on the 5/25/25 AM shift because the tape was balled up and CNA-P informed DON-B. CNA-P said DON-B indicated the dressing was fine and asked CNA-P to get R2 up. CNA-P indicated DON-B completed R2's wound treatments prior to when CNA-P noted the dressing was balled up. CNA-P indicated CNA-P did not assist R2 back to bed during the AM shift because R2 stayed up until the PM shift started at 2:00 PM. On 6/12/25 at 2:39 PM, Surveyor interviewed DON-B via phone. DON-B indicated a wound vac dressing change was not completed on the 5/25/25 AM shift. DON-B did not recall being informed by a CNA that the wound vac dressing was not functioning properly. DON-B indicated DON-B may have trimmed the edges of the wound vac dressing on 5/25/25 but indicated the wound vac was still suctioning. DON-B indicated DON-B was planning on educating nursing staff about wound vac dressings changes but since there were no longer any wound vacs in the facility after R2's was removed, DON-B decided against wound vac dressing change education. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 2:55 PM, Surveyor again interviewed CNA-K who indicated R2's wound vac was not suctioning on the 5/25/25 AM shift. CNA-K indicated CNA-K and CNA-P told DON-B the wound vac did not appear to be suctioning properly, however, DON-B stated everything was fine. CNA-K agreed with CNA-P that DON-B did not assess R2's wound vac after CNA-K and CNA-P informed DON-B there was a problem with the dressing. CNA-K indicated CNA-K and CNA-P got R2 up and into a motorized wheelchair for lunch and did not assist R2 back to bed during the rest of the AM shift.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not provide adequate supervision and assistance to prevent accidents and did not ensure a fall was thoroughly investigated to determine a root cause for 1 resident (R) (R1) of 1 sampled resident. On 4/26/25, R1 fell out of bed and called 911 when staff did not respond to R1's calls for assistance. The facility did not complete a thorough investigation to determine the root cause of R1's fall. Findings include: The facility's Falls and Fall Risk, Managing policy, revised 3/2018, indicates: Based on previous evaluations and current data, staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling .According to the Minimum Data Set (MDS), a fall is defined as: Unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an overwhelming external force .A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. The facility's Assessing Falls and Their Causes Policy, revised 3/2018, indicates: The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall .Identifying Causes of a Fall or Fall Risk: 1. Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident. Refer to resident-specific evidence including medical history, known functional impairments, etc. 2. Evaluate chains of events or circumstances preceding a recent fall, including: a. Time of day of the fall; b. Time of the last meal; c. What the resident was doing; d. Whether the resident was standing, walking, reaching, or transferring from one position to another; f. Whether the resident was trying to get to the toilet, g. Whether any environmental risk factors were involved (e.g., slippery floor, poor lighting, furniture or objects in the way); and/or h. Whether there is a pattern of falls for this resident . Documentation: When a resident falls, the following information should be recorded in the resident's medical record: 1. The condition in which the resident was found (e.g., resident found lying on the floor between bed and chair), 2. Assessment data, including vital signs and any obvious injuries, 3. Interventions, first aid, or treatment administered, 4. Notification of physician and family, as indicated, 5. Completion of a falls risk assessment, 6. Appropriate interventions taken to prevent future falls, 7. The signature and title of the person recording the data. On 6/12/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including intraspinal abscess and granuloma, cervical discitis, status post cervical laminectomy, diabetes, Parkinson's disease, and extrapyramidal and movement disorder. R1's MDS assessment, dated 4/30/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. R1 made R1's own healthcare decisions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed a Sheriff's Office Detail Incident Report, dated 4/26/25 at 11:36 PM, that indicated an officer arrived at the facility on 4/26/25 at 11:42 PM because R1 called 911 and requested assistance after R1 fell out of bed. The officer assisted with transferring R1 before R1 was transported to the hospital. A provider note, dated 4/27/25 at 12:34 AM, indicated R1 was transferred to the Emergency Department (ED) due to neck and back pain after a fall out of bed. Per Emergency Medical Services (EMS), R1 had fallen out of bed, was helped back into bed, and then fell out of bed again and was on the floor for approximately 30 minutes. R1 called for help but staff did not respond so R1 called 911. EMS arrived and brought R1 to the ED. R1 reported R1 already had pain from a recent decompressive cervical spine surgery due to a spinal epidural abscess. R1 was given acetaminophen for pain. After being helped to the bathroom, R1 slipped out of bed and was helped back into bed, but fell again afterward. R1 reported pain between R1's shoulder blades. R1 denied hitting R1's head or losing consciousness. A computed tomography (CT) scan of the cervical spine showed no evidence of significant traumatic injury. R1 was diagnosed with acute midline thoracic back pain and discharged back to the nursing home. An Event Report, dated 4/28/25 with a closed date of 5/16/25, indicated R1 called 911 and an officer responded. R1 was observed on the floor in R1's room and stated R1 hit R1's head. The fall was unwitnessed and R1 was not injured. Following the fall, R1 did not exhibit dizziness, headache, nausea/vomiting, or seizure. The Falls Program was initiated and R1's care plan was updated. The Event Report did not contain nursing documentation, resident or staff interviews, or a root cause analysis. In addition, R1's medical record did not contain a nursing progress note about the fall or nursing actions taken immediately after the fall. There was no documentation of the condition of R1's surgical neck wound or a description of R1's initial fall on 4/26/25 after R1 returned from the bathroom. Surveyor reviewed R1's physical therapy notes for 4/28/25 to 5/27/25. An assessment summary indicated R1 had limitations in strength and endurance which resulted in deficits in dynamic balance, bed mobility, transfer ability, and ambulation. R1 underwent a cervical laminectomy on 4/12/25 due to a spinal infection and had been bedridden since surgery. R1 had a history of Parkinson's disease and a recent history of vertigo. A Musculoskeletal System Assessment indicated R1 had impaired trunk strength and required moderate assistance for bed mobility and maximum assistance for transfers. On 6/12/25 at 11:06 AM, Surveyor interviewed R1 who was in a wheelchair wearing shoes and had visible extrapyramidal symptoms; R1's upper body was in constant movement during the interview. When asked about R1's fall on 4/26/25, R1 indicated R1 was in bed and a male Certified Nursing Assistant (CNA) (unknown name) was going to help reposition R1 in bed. The CNA instructed R1 to roll to the left side and R1 fell onto the floor. R1 indicated the CNA left R1's room prior to the fall to assist another resident. R1 called for help but no one came. The call light was not in reach, however, R1 got to the phone and called 911. Police and EMS arrived, got R1 off the floor and onto a gurney, and transported R1 to the ED. R1 stated R1 was wearing slippery pajamas at the time of the fall. R1 denied hitting R1's head and denied injury. On 6/12/25 at 2:28 PM, Surveyor interviewed Registered Nurse (RN)-F who indicated RN-F was not present during R1's fall on 4/26/25 but was familiar with R1. RN-F indicated R1 had spastic limbs/involuntary motions which put R1 at risk for falls. RN-F indicated R1 liked to be independent despite the need for assistance with transfers. RN-F indicated staff attempt to keep an eye on R1, use a gait belt, and ensure R1 has grippy socks or shoes to prevent falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 3:05 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified the investigation for R1's fall was not complete. NHA-A verified the Event Report was opened/initiated by RN-E (who was an agency nurse) and was closed by Director of Nursing (DON)-B. The Event Report did not indicate a root cause for the fall. In addition, the investigation did not include resident or staff interviews. On 6/12/25 at 5:20 PM, Surveyor interviewed DON-B via phone regarding the incident and Event Report which was closed without a root cause analysis. DON-B indicated R1 had fallen out of bed and couldn't reach the call light but could not recall the root cause analysis or why the fall occurred.

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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 observation, staff and resident interview, and record review, the facility did not ensure 1 resident (R) (R1) of 2 sampled residents was provided safe and accurate administration of drugs and biologicals. R1 was not administered a dose of an intravenous (IV) antibiotics on 5/25/25. Findings include: On 6/12/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including fibromyalgia, history of venous thrombosis embolism, Parkinson's disease, osteomyelitis of vertebra thoracic region, sciatica, and candidal stomatitis. R1's Minimum Data Set (MDS) assessment, dated 4/30/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. R1 made R1's own medical decisions. R1 had an order for cefazolin reconstituted solution administer 6 grams in sodium chloride 0.9 % 320 milliliters (mls) intravenous (IV) to run continuously 24 hours once a day every morning for osteomylitis of vertebra, thoracic region. A continuous ambulatory delivery device (CADD) pump was used to administer the antibiotic with a cassette or cartridge with medication that was changed as ordered. On 6/12/25 at 8:52 AM, Surveyor interviewed R1 who indicated R1 had an infection that was better and was on an IV antibiotic. R1 indicated a nurse couldn't figure out how to change the cartridge one day and R1 missed a dose of the antibiotic. R1 indicated Registered Nurse (RN)-C changed the cartridge the next morning and got the IV restarted. On 6/12/25 at 12:27 PM, Surveyor interviewed RN-C who indicated R1 was on an IV antibiotic with a CADD pump. RN-C indicated the antibiotic cartridge should have been changed on 5/25/25 but was missed. RN-C indicated when RN-C arrived to work on 5/26/25, the cartridge was dry and was the same cartridge RN-C had changed the previous day. RN-C indicated Director of Nursing (DON)-B worked the 6:00 AM to 2:00 PM shift on 5/25/25 when the cartridge should have been changed. RN-C indicated the cartridge would not run dry unless it was not changed. RN-C reported the missed antibiotic dose to Nursing Home Administrator (NHA)-A but was not sure if anything was done. RN-C also notified R1's physician and Assistant Director of Nursing (ADON)-L. On 6/12/25 at 12:56 PM, Surveyor interviewed NHA-A who confirmed staff reported that R1's antibiotic dose was missed on 5/25/25. NHA-A asked DON-B about the missed dose who indicated DON-B did not believe the dose was missed. NHA-A indicated the antibiotic was entered as administered. NHA-A indicated NHA-A did not investigate any further or interview R1 because NHA-A trusted what DON-B had said. NHA-A indicated NHA-A now believes the dose was missed by DON-B. NHA-A indicated NHA-A should have investigated further at the time of the incident and stated NHA-A is working with corporate to educate DON-B. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 1:19 PM, Surveyor interviewed RN-C who again indicated R1's antibiotic was missed on 5/25/25. RN-C indicated pharmacy sent the facility the cartridges needed to complete the order and there was one left over that was discarded. RN-C indicated the cartridge would not have been discarded unless it was missed. On 6/12/25 at 2:14 PM, Surveyor interviewed Medication Technician (MT)-K who recalled that R1 was on an IV antibiotic. MT-K also indicated R1 had missed a dose of the antibiotic on 5/25/25 when DON-B was working. MT-K indicated MT-K and RN-C discarded a cartridge that was leftover from R1's prescribed dose. MT-K indicated the leftover cartridge was discarded because it was missed.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 1 resident (R) (R10) of 1 sampled resident had a medical record that contained complete and accurate information. Director of Nursing (DON)-B did not update R10's medical record when an observation and assessment was completed for R10. Findings include: The facility's Charting and Documentation policy, revised July 2017, indicates: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .2. The following information is to be documented in the resident's medical record: a. Objective observations; .d. Changes in the resident's condition; .3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. On 6/12/25 Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including pneumonitis due to inhalation of food and vomit, dysphagia, and respiratory failure. R10's Minimum Data Set (MDS) assessment, dated 5/30/25, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R had severe cognitive impairment. R10 had an activated Power of Attorney for Healthcare (POAHC). A progress note, dated 6/5/25 at 2:30 PM and written by Registered Nurse (RN)-C, indicated RN-C was updated on R10's change in condition by a Medication Technician and was occupied with another resident. RN-C asked DON-B to assess R10. DON-B assessed R10 and reported to RN-C that R10 was at baseline with continued congestion. DON-B indicated R10's lower lungs were clear and upper lungs were noisy due to swallowing, nasal drainage, and coughing. RN-C indicated an Occupational Therapist/Physical Therapist requested RN-C reassess R10 prior to therapy. RN-C assessed R10 and heard audible wheezing and congestion. RN-C indicated R10's upper and lower lungs had coarse crackles with inspiratory and expiratory wheezing. RN-C stated R10 was unable to expectorate and clear R10's airway by coughing. R10 had both clear and brown discharge draining from R10's nares. R10 indicated R10 was asymptomatic. R10 had three plus pitting edema in the bilateral lower extremities and extremely puffy bilateral upper extremities. R10 also had a large emesis during supper on 6/3/25. RN-C reported the findings to the on-call provider who ordered labs and a chest X-ray, however, R10 refused labs. RN-C updated Nursing Home Administrator (NHA)-A and oncoming staff and left a voicemail for R10's POAHC. R10's medical record did not contain DON-B's documentation of the observation and assessment on 6/6/25. (continued on next page)

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	06/12/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 10:50 AM, Surveyor interviewed RN-C who indicated Physical Therapy Assistant (PTA)-D approached RN-C with concerns regarding R10's change in status. R10 was in the dining room when RN-C arrived and heard audible wheezing. RN-C assessed R10 and called the on-call provider who ordered labs and a chest X-ray. RN-C indicated R10 was discharged from hospitalization for respiratory failure and pneumonia on 5/12/25. RN-C stated RN-C attempted to communicate with DON-B, however, DON-B had left for the day. R10 was sent to hospital on 6/6/25 and passed away at the hospital at 6/8/25. On 6/12/25 at 3:39 PM, Surveyor interviewed PTA-D who indicated an Occupational Therapist reported concerns with R10's audible respiratory sounds and bilateral increased hand swelling on 6/6/25. PTA-D indicated DON-B had assessed R10 and stated R10 was fine and there were no concerns. PTA-D indicated PTA-D discussed the observations with RN-C who assessed R10 and contacted the provider. On 6/12/25 at 5:20 PM, Surveyor interviewed DON-B who indicated therapy staff asked DON-B to assess R10's respiratory status on 6/5/25. DON-B assessed R10's lung sounds and stated R10 had upper airway noise but the bases of R10's lungs were clear. DON-B indicated DON-B verbally reported the information to RN-C and confirmed DON-B did not document the observation or assessment in R10's medical record. DON-B confirmed DON-B should have documented the assessment in R10's medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection for 1 resident of (R) (R2) of 1 sampled resident. Registered Nurse (RN)-C did not complete proper hand hygiene during wound care for R2 and used soiled scissors to trim a clean dressing. Findings include: The facility's Handwashing/Hand Hygiene policy, revised 10/2023, indicates: .Hand hygiene is indicated .g. Immediately after glove removal .4. Single-use disposable gloves should be used .5. The use of gloves does not replace hand washing/hand hygiene . The facility's undated Wound Care policy indicates: .2. Wash and dry your hands thoroughly .4. Put on exam glove. Loosen tape and remove dressing .5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 6. Put on gloves .21. Wipe reusable supplies with alcohol as indicated (i.e., .scissor blades, etc.) . On 6/12/25 at 9:20 AM, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including traumatic spinal cord injury, diabetes, cerebral vascular accident, quadriplegia, acute osteomyelitis of left ankle and foot, and extended spectrum beta lactamase (ESBL) resistance. R2's Minimum Data Set (MDS) assessment, dated 4/21/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R2 had intact cognition. R2 had an activated Power of Attorney for healthcare (POAHC) for medical decision making. On 6/12/25 at 11:32 AM, Surveyor observed Assistant Director of Nursing (ADON)-L, RN-C, Certified Nursing Assistant (CNA)-K, and CNA-O don personal protective equipment (PPE) after completing hand hygiene prior to wound care for R2. RN-C then cut and removed the soiled dressing from R2's left heel and sprayed the wound with Betadine wound cleanser. RN-C removed packing from the wound, applied more Betadine cleanser, wiped the area, and removed gloves. Surveyor noted RN-C had a second pair of gloves underneath the first pair. RN-C then inserted packing in the wound with a cotton tipped applicator, painted R2's heel with Betadine, applied a non-adhesive dressing, and wrapped the heel in Kerlix. RN-C then cut the Kerlix with the scissors used to to cut R2's soiled heel dressing, taped the Kerlix, and dated and initialed the dressing. RN-C then removed gloves, completed hand hygiene, and donned two new pair of gloves while the other staff assisted R2 onto R2's side. Surveyor observed an extended wound area that contained a stage 4 pressure injury in the upper right corner of R2's buttock. Macerated skin with drainage was noted throughout the buttock area down to the posterior scrotum. RN-C removed the dressing from R2's upper right buttock, removed RN-C's first set of gloves, applied Betadine to the wound, and wiped drainage from the wound bed. RN-C then removed the second pair of gloves, completed hand hygiene, and donned clean gloves. RN-C packed the wound with calcium alginate, removed gloves, completed hand hygiene, and donned clean gloves while ADON-L applied silicone barrier to R2's buttock/scrotum area. All staff removed PPE and completed hand hygiene prior to exiting R2's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 2:48 PM, Surveyor interviewed RN-C who indicated hand hygiene should have been completed between glove changes. RN-C indicated RN-C did not think to sanitize the scissors used to cut off R2's soiled dressing prior to cutting the Kerlix. On 6/12/25 at 3:11 PM, Surveyor interviewed ADON-L who indicated it was not appropriate for RN-C to wear two sets of gloves during wound care. ADON-L indicated RN-C should have worn one pair of gloves, completed hand hygiene, then donned clean gloves. ADON-L also indicated staff should use clean scissors to cut a clean dressing during wound care.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and staff interview, the facility did not provide a safe, functional, and sanitary environment for residents outside the facility. This practice had the potential to affect more than 4 of the 28 residents residing in the facility. On 6/12/25, the front of the facility appeared unkempt which included weeds, dirt and landscaping bark, an open dumpster that contained garbage, a laundry bin that contained items, a plastic chair that contained cardboard, and exposed wires from a missing doorbell. In addition, the front door was reported to be unlocked when it should have been locked. On 6/12/25 from 9:00 AM to 5:45 PM, Surveyor made observations of the front of the facility which faced the main parking lot and public roadway. Surveyor noted long weeds along the front of the facility, under residents' windows, along and under the fencing, and around trees. A dumpster in the front of the facility was open and contained garbage bags. There were three walls of privacy fence around the dumpster, however, the front did not have fence panels. The unfenced area faced the main parking lot and public roadway. There were two plastic chairs in the same area, one contained cardboard that had been wet and then dried. Surveyor also observed a garbage can labeled laundry that contained items and did not have a lid. The front of the facility also had a raised flower bed with flowers. The bottom of the flower bed contained a pile of dry dirt and landscaping bark that appeared to have been removed from a planted flower bed nearby. The pile of dirt was along the path to the front doors of the facility. Surveyor also observed three garbage cans at the front entrance, one with ice melt, one for garbage, and one for cans with a stained lid. Above the garbage can for cans and next to the main entrance door, Surveyor observed exposed wires where a doorbell once was. During the investigation, Surveyor noted the facility had recently implemented a procedure to lock the front doors on the night shift for safety from 11:00 PM to 5:00 AM. On 6/12/25 at 2:55 and 5:35 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated staff know they need to lock the doors. NHA-A indicated NHA-A worked next door at the assisted living facility at night and returned to NHA-A's office at the facility and no one knew NHA-A was there. NHA-A confirmed the front doors were not locked and it was within the timeframe the doors should have been locked. NHA-A indicated a process is being implemented but has not yet started where Assistant Director of Nursing (ADON)-L will conduct audits to ensure the doors are locked when they should be. NHA-A also confirmed the dumpster should be closed.