

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 10/22/2025
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)
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. (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

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure allegations of abuse were reported to the State Agency (SA) for 1 Resident (R) (R1) of 8 sampled residents. R1 was admitted to the facility for a 5-day respite stay and had a diagnosis of Alzheimer's disease. On the evening of 9/25/25, R1 became agitated when staff tried to help R1 get ready for bed. R1 attempted to leave the facility through multiple doors, however, staff held the doors shut and put hands on R1 to prevent R1 from leaving. A crisis report indicated staff held R1 in a chair. A police report indicated R1 stated that R1 had been attacked by numerous individuals. The facility did not report the allegations of abuse to the SA. Findings include: The facility's Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy indicates: If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the Administrator and to other officials according to state law. 2. The Administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility. On 10/13/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] for a 5-day respite stay and had diagnoses including Alzheimer's disease with early onset, dementia in other diseases without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, encounter for palliative care, and anxiety disorder. R1 had an activated Power of Attorney for Healthcare (POAHC). R1 received Hospice services from Hospice Company (HC)-C. R1 discharged from the facility with Hospice staff and family friends on 9/25/25 at approximately 10:45 PM. A progress note, dated 9/25/25 at 10:45 PM, indicated at approximately 6:30 PM, R1 became extremely agitated and combative. R1's change in mood/behavior was likely due to R1's first time respite status and unfamiliarity with staff, residents, and the environment. R1 choked, punched, kicked, slammed, and threw multiple staff. The police were called for assistance. Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Hospice staff, and R1's POAHC were notified. Law enforcement contacted Adult Protective Services (APS) for further direction. APS and Hospice staff, including a Hospice nurse and R1's Hospice case worker, worked to find a resolution since R1's POAHC was out of state at the time. R1 discharged from the facility with two family friends and the assistance of Hospice staff on 9/25/25 at approximately 10:45 PM. A police report, dated 9/25/25, indicated Sergeant (SGT)-I arrived at the facility and observed numerous staff who appeared to be crying, out of breath, or disheveled. SGT-I observed R1 seated in a chair without a shirt. A person behind R1 appeared to be standing there to make sure R1 did not leave the chair. SGT-I was informed that R1 had dementia and attempted to elope from the facility. When staff stopped R1 from leaving, R1 became violent and struck, kicked, punched, and threw staff into door frames and walls. SGT-I attempted to talk to R1, however, R1 was unable to formulate sentences and seemed confused. R1 indicated at one point that R1 was attacked by numerous individuals at the facility. The police report indicated SGT-I contacted the county crisis line. On 10/13/25, Surveyor obtained county crisis documentation for the incident. The documentation indicated SGT-I was called to the facility for a disorderly resident (R1) who had dementia. SGT-I reported that R1 became violent when staff would not let R1 leave the facility. SGT-I informed the writer that staff were holding R1 in a chair when SGT-I arrived citing safety concerns. On 10/13/25 at 3:51 PM, Surveyor interviewed NHA-A who indicated the incident was not reported to the SA because there were no resident injuries and the incident was related to R1's increase in behaviors. NHA-A stated R1 did not elope from the facility and there were no resident-to-resident altercations. NHA-A confirmed the facility did not complete interviews with staff who worked the night of the incident and only had statements that were obtained by law enforcement. NHA-A had not obtained the county crisis documentation that indicated staff held R1 in a chair or the police report that indicated R1 alleged that R1 was attacked by numerous individuals. NHA-A acknowledged the allegations of abuse should have been reported to the SA.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure allegations of abuse were thoroughly investigated for 1 Resident (R) (R1) of 8 sampled residents. R1 was admitted to the facility for a 5-day respite stay and had a diagnosis of Alzheimer's disease. On the evening of 9/25/25, R1 became agitated when staff tried to help R1 get ready for bed. R1 attempted to leave the facility through multiple doors, however, staff held the doors shut and put hands on R1 to prevent R1 from leaving. A crisis report indicated staff held R1 in a chair. A police report indicated R1 stated that R1 had been attacked by numerous individuals. The facility did not thoroughly investigate the incident by ensuring all staff involved were interviewed. The facility also did not obtain the police report or county crisis documentation which included allegations of abuse. Findings include: The facility's Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy, revised September 2022, indicates: Investigating Allegations: 1. All allegations are thoroughly investigated. The Administrator initiates the investigation .7. The individual conducting the investigation at a minimum: Interviews any witnesses to the incident; Reviews all events leading up to the alleged incident; and Documents the investigation completely and thoroughly. Guidelines for conducting interviews: Each interview is conducted separately and in a private location. Witness statements are obtained in writing, signed, and dated. The witness may write his/her statement or the investigator may obtain a statement. On 10/13/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] for a 5-day respite stay and had diagnoses including Alzheimer's disease with early onset, dementia in other diseases without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, encounter for palliative care, and anxiety disorder. R1 had an activated Power of Attorney for Healthcare (POAHC). R1 received Hospice services from Hospice Company (HC)-C. R1 discharged from the facility with Hospice staff and family friends on 9/25/25 at approximately 10:45 PM. A progress note, dated 9/25/25 at 10:45 PM, indicated at approximately 6:30 PM, R1 became extremely agitated and combative. R1's change in mood/behavior was likely a result of R1's first time respite status and unfamiliarity with staff, residents, and the environment. R1 choked, punched, kicked, slammed, and threw multiple staff. The police were called for assistance. Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Hospice staff, and R1's POAHC were also notified. Law enforcement contacted Adult Protective Services (APS) for further direction. APS and Hospice staff, including a Hospice nurse and R1's Hospice case worker, worked to find a resolution since R1's POAHC was out of state at the time. R1 discharged from the facility with two family friends and the assistance of Hospice staff on 9/25/25 at approximately 10:45 PM. A police report, dated 9/25/25, indicated Sergeant (SGT)-I arrived at the facility and observed numerous staff who appeared to be crying, out of breath, or disheveled. SGT-I observed R1 seated in a chair without a shirt. A person behind R1 appeared to be standing there to make sure R1 did not leave the chair. SGT-I was informed that R1 had dementia and attempted to elope from the facility. When staff stopped R1 from leaving, R1 became violent and struck, kicked, punched, and threw staff into door frames and walls. SGT-I attempted to talk to R1, however, R1 was unable to formulate sentences and seemed confused. R1 indicated at one point that R1 was attacked by numerous individuals at the facility. The police report indicated SGT-I contacted the county crisis line. On 10/13/25, Surveyor obtained county crisis documentation for the incident. The documentation indicated SGT-I was called to the facility for a disorderly resident (R1) who had dementia. SGT-I reported that R1 became violent when staff would not let R1 leave the facility. SGT-I informed the writer that staff were holding R1 in a chair when SGT-I arrived citing safety concerns. On 10/13/25 at 11:37 AM, Surveyor interviewed agency Certified Nursing Assistant (CNA)-G who worked the 9/25/25 PM shift. CNA-G was working on the other side of the building when Licensed Practical Nurse (LPN)-L sprinted down the hall and asked for help. CNA-G indicated R1 wanted to go home. CNA-G observed R1 hitting CNA-E. When R1 saw staff approaching, R1 stopped hitting CNA-E and ran to an exit door. R1 sought out the fire exits but staff blocked the doors. CNA-G indicated one staff was outside of the doors that R1 tried to open. CNA-G asked CNA-F to hold the door shut in case R1 got out. R1 was swinging. Staff tried to stay out of R1's line of sight and moved residents into their rooms for protection. CNA-G had previous experience in similar situations and instructed staff to give R1 space. R1 stated R1 didn't know anyone and was trying to get to R1's spouse. R1 was calm when the police arrived. CNA-G indicated the police took statements, however, facility staff did not ask CNA-G for a statement. CNA-G indicated CNA-G worked 3 or 4 days after the incident but did not</p>		

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not provide appropriate dementia care to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 Resident (R) (R1) of 8 sampled residents. R1 was admitted to the facility on [DATE] for a 5-day respite stay. R1 had a history of elopement but no physically aggressive behavior. On the evening of 9/25/25, staff attempted to assist R1 to get R1 ready for bed. R1 resisted the care and stated only R1's wife does that. R1 became physically aggressive with staff and stated R1 wanted to leave the facility and go home. R1 attempted to exit multiple doors. Multiple staff pursued R1 through the facility, blocked exit doors from the inside and outside, and put hands on R1 to keep R1 from exiting which increased R1's agitation. Staff called law enforcement due to R1's heightened aggression. When law enforcement arrived, R1 indicated that R1 had been attacked by numerous individuals. Findings include: The facility's undated Communicating with an Agitated Resident Competency Skills: Behavioral Health training was provided to Surveyor on 10/13/25. The training indicates: Does the student: Approach resident from the front? Reassure resident using a calm voice throughout? Try to determine meaning behind resident's body language and gestures? Avoid arguing with resident? Monitor own body language and gestures? Maintain safe distance of approximately 6 feet away to the side of resident? Engage using the least restrictive measures first such as: allowing time and space to let outburst dissipate, redirect, or draw attention to something else? The facility's Identifying Involuntary Seclusion and Unauthorized Restraint policy, revised 9/2022, indicates: .2. Examples of involuntary seclusion include: a. Any attempt to keep a resident confined to a certain area by blocking the exit with furniture or a closed door . 4. Behavioral issues that arise among residents are managed according to strategies documented in the care plan and approved by the behavioral team. 5. The negative physical and psychological impacts of physical restraint use may include: .g. Agitation, aggression, anxiety, or development of delirium. The facility's Wandering and Elopements (2001 Med-Pass, Inc.) policy indicates: .2. If an employee observes a resident leaving the premises, he/she should: a. Attempt to prevent the resident from leaving in a courteous manner. On 10/13/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] for a 5-day respite stay and had diagnoses including Alzheimer's disease with early onset, dementia in other diseases without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety disorder, and encounter for palliative care. R1 had an activated Power of Attorney for Healthcare (POAHC) and received Hospice services. A behavioral symptom care plan, initiated 9/25/25, indicated R1 wandered (moved with no rational purpose, seemingly oblivious to needs or safety.) The care plan contained interventions, dated 9/25/25, to approach from the front and walk in step with (R1) first before redirecting; Avoid overstimulation (e.g., noise, crowding, other physically aggressive residents); If (R1) looks for family/significant other, reassure that others know where to find (R1); Maintain a calm environment and approach to (R1); When (R1) begins to wander, provide comfort measures for basic needs (e.g., pain, hunger, toileting, too hot/cold, etc.). A progress note, dated 9/25/25 at 10:00 AM, indicated the writer met with R1 and R1's POAHC to complete admission paperwork for a 5-day respite stay. The writer asked R1's POAHC for permission to put a WanderGuard on R1 for safety because R1 liked to wander. A progress note, dated 9/25/25 at 10:45 PM and written by Director of Nursing (DON)-B, indicated R1 became extremely agitated and combative at approximately 6:30 PM. R1 choked, punched, kicked, slammed, and threw multiple staff. The change in mood/behavior was likely a result of R1's first time respite status and unfamiliarity with staff and the environment. DON-B, NHA-A, Hospice staff, R1's POAHC, and law enforcement were notified. Law enforcement responded and contacted Adult Protective Services (APS) for further direction. APS and Hospice staff worked toward a resolution. R1's POAHC was out of state and two family friends picked up R1 at approximately 10:45 PM. Hospice staff followed them home to help get R1 situated. On 10/13/25 at 9:54 AM, Surveyor interviewed Hospice Case Manager (HCM)-D who indicated R1 had received Hospice services since 8/19/25. HCM-D indicated R1 did not have a history of violence and had always been cheerful with staff. R1 resided at home with R1's spouse and attended adult daycare on Mondays and Wednesdays with no known incidents. HCM-D indicated the respite stay was the first time R1 had stayed in a skilled nursing facility. On 10/13/25 at 11:50 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-E who worked with R1 on the evening of 9/25/25. CNA-E was told at shift change that R1 was easy going and not difficult to care for. CNA-F was assisting R1 with getting ready for bed when R1 became upset and stated R1 wanted</p>		