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	12/04/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure a potential allegation of abuse was thoroughly investigated for 1 resident (R) (R5) of 1 sampled resident.On [DATE], staff discovered R5 in R5's room between the wall and the bed. Staffs' statements were inconsistent regarding R5's injuries. The facility did not investigate the discrepancy regarding the injuries. Findings include: From [DATE] to [DATE], Surveyor reviewed R5's medical record. R5 was admitted to facility on [DATE] and had diagnoses including anoxic brain damage, epilepsy, palliative care, asthma, hemiplegia, encephalopathy, and thrombocytosis. R5's Minimum Data Set (MDS) assessment, dated [DATE], indicated R5 was dependent for cares, transfers, and mobility. R5 had a legal Guardian. From [DATE] to [DATE], Surveyor reviewed a facility-reported incident that indicated R5 had a swollen right eye and face and abrasions on the right shoulder and arm on [DATE]. Administration was notified and started an investigation. The proper notifications were made and X-rays were ordered. The facility's 5-day investigation was submitted to the State Agency (SA) on [DATE]. Staff interviews indicated Licensed Practical Nurse (LPN)-N discovered R5 in bed with R5's left upper body on the edge of the air mattress and right upper body leaning toward the wall. R5's lower extremities were in the bed. LPN-N put R5's upper body back in bed, ensured R5 was safely positioned, and asked Certified Nursing Assistant (CNA)-O to help reposition R5. After R5 was repositioned, CNA-O asked if CNA-O could return to the resident CNA-O was caring for prior to assisting with R5. LPN-N then cleaned R5's face and obtained vital signs which were within normal limits. The facility updated R5's care plan and educated staff on abuse/reporting. Resident interviews indicated they were happy with care at the facility and felt safe. It was determined that a seizure caused R5's injuries. On [DATE] at 11:26 AM, Surveyor interviewed CNA-O who indicated (LPN-N) asked CNA-O to assist in R5's room on [DATE]. When CNA-O entered R5's room, R5's face appeared swollen and bloodied. (LPN-N) was caring for R5 and CNA-O asked to go back and finish with the resident CNA-O had been caring for. When CNA-O returned to R5's room, R5's face was clean. Wash cloths next to R5 appeared bloody. CNA-O did not ask what was on the wash cloths or report anything because CNA-O thought (LPN-N) would do so. On [DATE] at 11:39 AM, Surveyor interviewed LPN-N who indicated LPN-N found R5 between the bed and the wall on [DATE]. LPN-N assisted R5 back into bed and asked CNA-O for assistance. CNA-O then went back to help another resident. LPN-N cleaned up sputum on R5's face and made sure R5 was positioned correctly. LPN-N stated R5 did not have any injuries or swelling and was not bleeding at all. LPN-N reported the information to the next shift and indicated to monitor R5. LPN-N did not document the findings in R5's medical record. On [DATE], Surveyor reviewed investigation statements from CNA-O and LPN-N which were consistent with Surveyor's interviews. On [DATE] at 11:59 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated LPN-N found R5 with R5's face against the wall. NHA-A verified LPN-N did not document the incident. NHA-A stated LPN-N's statement indicated there were no injuries and LPN-N wiped sputum off of R5's face. NHA-A vaguely remembered CNA-O's statement and was not aware of the discrepancy between the statements. NHA-A verified that NHA-A did not follow-up and investigate and the discrepancy between CNA-O and LPN-N's statements.