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	05/11/2026

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

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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 - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure resident-to-resident altercations and a potential allegation of abuse were thoroughly investigated for 6 residents (R) (R3, R4, R1, R2, R5, and R6) of 6 sampled residents. On 2/16/26, R3 and R4 were involved in a resident-to-resident altercation. The facility did not thoroughly investigate the altercation. On 2/24/26, R1 and R2 were involed in a resident-to-resident altercation. The facility did not thoroghly investigate the altercation. In addition, the facility's investigation indicated R2 would be on 1:1 supervison. The facility did not have documentation that 1:1 supervision was provided for R2. On 4/22/26, R5 and R3 were involved in a resident-to-resident altercation. The facility did not thoroughly investigate the altercation. On 2/21/26, R6 reported a staff member was aggressive during peri-care. The facility did not thoroughly investigate the potential allegation of abuse. Findings include: The facility's Abuse, Neglect, and Exploitation policy, revised 1/2026, indicates: .V. Investigation of Alleged Abuse, Neglect, and Exploitation: A. An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. B. Written procedures for investigations include: .4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations . 1. On 5/4/26, Surveyor reviewed R3's medical record. R3 had diagnoses including dementia, mild cognitive impairment, unspecified mood disorder, insomnia, anxiety, and emotional liability and mood disorder. R3's Minimum Data Set (MDS) assessment, dated 4/20/26, had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated R3 had severe cognitive impairment. R3 had an activated Power of Attorney for Healthcare (POAHC). On 5/4/26, Surveyor reviewed R4's medical record. R4 had diagnoses including dementia, anxiety, major depressive disorder, and unspecified psychosis. R4's MDS assessment, dated 2/23/26, had a BIMS score of 2 out of 15 which indicated R4 had severe cognitive impairment. R4 had an activated POAHC. On 5/4/26, Surveyor reviewed a facility-reported incident (FRI) submitted to the State Agency (SA) that indicated on 2/16/26 at approximately 4:30 PM, R3 self-propelled a wheelchair toward the lobby and bumped into R4's wheelchair. A staff who witnessed the incident was not sure if R3 grabbed the back of R4's wheelchair or if R3 accidentally bumped R4's shoulder. R3 told R4 to get out of the way. R4 turned and swatted at R3. Initially, it was reported that R4 swatted at R3's head; however, further investigation determined R4 swatted at R3's forearm. The investigation included interviews with R3 and R4, but did not include interviews with other residents who may have witnessed the incident or experienced a similar occurrence. (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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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(See interview under example 4.) 2. On 5/4/26, Surveyor reviewed R1's medical record. R1 had diagnoses including anoxic brain damage, depression, and anxiety. R1's MDS assessment, dated 3/16/26, had a BIMS score of 5 out of 15 which indicated R1 had severe cognitive impairment. R1 had an activated POAHC. On 5/4/26, Surveyor reviewed R2's medical record. R2 had diagnoses including neurocognitive disorder with Lewy Body, anxiety, unspecified psychosis, and insomnia. R2's MDS assessment, dated 1/26/26, had a BIMS score of 00 of 15 which indicated there was an inability to assess R2 due to cognitive impairment. R2 had an activated POAHC. On 5/4/26, Surveyor reviewed a FRI submitted to the SA that indicated on 2/24/26 at 4:26 PM, R1 and R2 were in a lounge where residents congregate while waiting for meals. R2 backed up R2's wheelchair to move around other residents and accidently backed into R1 who yelled move it. Staff attempted to deescalate the situation. R1 moved R1's hand in a grabbing motion toward R2. When R1 touched R2, R2 moved R2's arms in a swinging motion. Staff attempted to separate R1 and R2 and were not sure if the swinging motion resulted in contact. R2 was agitated upon separation and after a cool down period. R2 was placed on 1:1 supervision until a review was completed and R2's behaviors decreased. The 24-hour report board indicated to monitor R1 and R2. Overstimulation of R2 was determined to be the root cause. The facility could not determine if an actual physical altercation occurred. The investigation included interviews with R1 and R2, but did not include interviews with other residents who may have witnessed the incident or experienced a similar occurrence. In adddition, the facility did not have documentation of R2's 1:1 supervision. (See interview under example 4.) 3. On 5/4/26, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had a diagnosis of wedge compression fracture of the first lumbar vertebra. R5's MDS assessment, dated 4/17/26, had a BIMS score of 13 out of 15 which indicated R5 had intact cognition. On 5/4/26, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including dementia with behavioral disturbance, mild cognitive impairment, and emotional lability mood disturbance, insomnia, anxiety, and depression. R3's MDS assessment, dated 4/20/26, had a BIMS score of 5 out of 15 which indicated R3 had severely impaired cognition. R3 had an activated POAHC. On 4/22/26 at approximately 3:30 PM, staff reported an altercation between R3 and R5 (R3's roommate). Staff overheard R5 yell at R3 to get out of R5's bed. R3 grabbed R5's sheet and started pulling. While pulling the sheet, R3 hit/punched R5 in the knee/leg. R5 reported to staff that R5 did not feel it was intentional, but was due to R3 struggling to pull the sheet. The facility interviewed R3 and R5 but did not interview other residents who may have witnessed the incident or experienced a similar occurrence. (See interview under example 4.) 4. On 5/4/26, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including acute chronic respiratory failure with hypoxia, bipolar disorder, and anxiety. R6's MDS assessment, dated 3/24/26, had a BIMS score of 11 out of 15 which indicated R6 had moderate cognitive impairment. R6 had a Guardian. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/4/26, Surveyor reviewed a FRI submitted to the SA that indicated in the late afternoon/early evening on 2/21/26, R6 reported that a male Certified Nursing Assistant (CNA) entered R6's room, closed the door, and washed R6's vagina and buttocks roughly and aggressively with a washcloth. R6 stated R6 tried to scream for help, but no one came. The investigation included an interview with R6 and a police investigation. R6 was sent to the hospital for a Sexual Assault Nurse Examiner (SANE) examination which was negative. The investigation did not include resident interviews to see if other residents had similar concerns or staff interviews to see if staff witnessed something similar or received similar complaints from residents. On 5/4/26 at 11:26 AM and 12:48 PM, Surveyor interviewed NHA-A who indicated staff and resident interviews should be completed whenever there is an allegation of abuse. NHA-A verified the facility did not have resident and/or staff interviews for the 4 FRIs noted above. NHA-A stated Former Director of Nursing (FDON)-L left employment on 2/27/26 and may have destroyed the documents.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure an appropriate discharge process for 1 resident (R) (R7) of 1 sampled resident.On 4/23/26, the facility called Emergency Medical Services (EMS) after R7 made suicidal statements and had a call light cord wrapped around R7's neck. Crisis was notified and developed a plan to keep R7 safe in the facility. Nursing Home Administrator (NHA)-A told Power of Attorney (POAHC)-K the facility could not meet R7's needs and R7 could not return to the facility. POAHC-K did not receive a written transfer notice. R7's medical record did not contain a bed hold or transfer notice, discharge summary, or recapitulation of stay. Findings include:The facility's Transfer, Emergency Acute Care policy, dated March 2025, indicates: Residents transferred to an acute care setting for emergency treatment are provided with a notice of transfer and permitted to return to the facility .2. When a resident is temporarily transferred to an acute care facility, a notice of transfer is provided to the resident and resident representative as soon as practicable before the transfer.On 5/4/26, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including depression and chronic pain. R7's Minimum Data Set (MDS) assessment, dated 4/6/26, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R7 had moderate cognitive impairment. R7 had an activated Power of Attorney for Healthcaer (POAHC-K). R7's medical record contained a Discharge MDS assessment, dated 4/23/26, that indicated R7's return was not anticipated. R7's medical record did not contain a bed hold or transfer notice, discharge summary, or recapitulation of stay. On 5/4/26 at 10:56 AM, Surveyor interviewed NHA-A regarding R7's transfer to the hospital. NHA-A verified R7 was found with a call light cord wrapped around R7's neck on the morning of 4/23/26. R7's Primary Care Provider ((PCP)-I) was notified. NHA-A stated EMS arrived and talked with R7, POAHC-K, and a crisis team (via telephone) and determined R7 did not need to go to the hospital. R7 and POAHC-K declined transfer to the hospital at that time. NHA-A stated the facility could not meet the needs of the safety plan that was developed by the crisis team, including the removal of cords from R7's room and increased supervision. NHA-A stated after a lengthy discussion with EMS management and POAHC-K, it was decided to send R7 to the hospital for evaluation. NHA-A informed POAHC-K and EMS staff that R7 could not return to the facility because the facility could not meet R7's mental health needs.On 5/4/26 at 11:12 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-D regarding R7's hospital transfer. CNA-D verified CNA-D found R7 with a call light cord wrapped around R7's neck on 4/23/26 and EMS was notified. CNA-D stated POAHC-K was emotional about the situation and the statement by NHA-A that R7 could not return to the facility. On 5/4/26 at 12:02 PM, Surveyor interviewed Family Member (FM)-F regarding R7's discharge. FM-F stated R7 and POAHC-K were told R7 had to leave the facility because R7 was suicidal despite the fact a crisis team stated R7 was safe to remain in the facility.On 5/4/26 at 1:57 PM, Surveyor interviewed Hospital Case Manager (HCM)-G regarding R7's readmission to the facility. HCM-G stated R7, POAHC-K, and R1's family were refusing to allow R7 to be readmitted to the facility due to the events that led to R7's transfer to the hospital.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 staff interview and record review, the facility did not provide adequate supervision for 1 resident (R) (R7) of 3 sampled residents who expressed suicidal ideation and threats of self-harm. On 4/19/26, R7 expressed suicidal ideation and was placed on 15-minute checks for 72 hours which the facility failed to complete in full. On 4/22/26, R7 pulled the call light out of the wall and threatened to wrap the cord around R7's neck. The facility failed to implement increased supervision for R7 despite the threats of self-harm. On 4/23/26, R7 was found with the call light cord wrapped around R7's neck. The facility's failure to provide adequate supervision after R7 expressed suicidal ideation and self-harm created a finding of immediate jeopardy that began on 4/22/26. Nursing Home Administrator (NHA)-A was notified of the immediate jeopardy on 5/4/26 at 4:35 PM. The immediate jeopardy was removed on 5/11/26; however, the deficient practice continues at a scope/severity level D (Potential for Harm/Isolated) as the facility continues to implement its action plan.Findings include:The facility's Suicide Prevention policy, dated 1/1/2026, indicates: It is the policy of the facility to act quickly and appropriately if a resident expresses thoughts of suicide. Compliance guidelines indicate: 1. All staff members will immediately report any suicidal ideation to the resident's charge nurse and the Social Worker. 2. Immediately notify the resident's physician if the resident presents with suicidal ideation, even if they are not specific about a plan/intent. 3. If applicable, notify the resident's responsible party of the resident's suicidal ideation. 4. The resident will not be left alone. One-on-one care will be provided after an attempt is made until they receive emergency psychiatric care or until a physician determines the risk of suicide is no longer present. 5. Objectively document the resident's mood and behaviors as well as all actions taken in the medical record.R7 was admitted to the facility on [DATE] with diagnoses to include type II diabetes, neuropathy, depression, and chronic pain. R7's most recent Minimum Data Set (MDS) assessment, dated 4/6/26, stated R7's Brief Interview for Mental Status (BIMS) score was 9 out of 15, indicating moderate cognitive impairment. R7's Power of Attorney for Healthcare (POAHC) was activated during this admission.A care plan, initiated 4/2/26, contained a goal for R7 to adjust comfortably to the facility. The care plan contained interventions to check in with R7 to see how R7 was adjusting, describe the layout of the facility, and accompany R7 to meals/therapy/bathroom/activities/etc., as needed.A hospital Discharge summary, dated [DATE], indicated R7 had a diagnosis of depression and was prescribed sertraline 25 milligrams (mg) daily.A progress note, dated 4/6/26, indicated R7 experienced confusion and hallucinations and called out frequently. A urinalysis was negative for a urinary tract infection (UTI). A progress note, dated 4/8/26, indicated R7 was confused and calling out.A progress note, dated 4/19/26, indicated R7 was screaming, rude, argumentative, and disturbing other residents.A progress note, dated 4/19/26 at 3:13 PM, indicated R7 expressed suicidal ideation and stated R7 was going to kill themself. R7 was placed under close observation and monitored for safety and changes in behavior.A progress note, dated 4/20/26 at 1:16 AM, indicated R7 had episodes of screaming at night, wanting to know R7's whereabouts, wanting to go home, and using foul/argumentative language. R7 remained on 15-minute checks. A progress note, dated 4/20/26 at 8:30 AM, stated R7 felt down and wished R7 was dead. R7 was moved to a room closer to the nurses' station for monitoring and was placed on 15-minute checks for 72 hours. R7 expressed frustration with changes, including the inability to walk independently and not be home. (Of note: Surveyor reviewed documentation of R7's 15-minute checks. Documentation began on 4/19/26 at 2:00 PM and was completed on 4/21/26 at 10:00 PM which was 56 hours instead of 72 hours.)A physician visit note, dated 4/20/26 and written by Primary Care Provider (PCP)-I, indicated R7's urine culture was negative for a UTI. R7 had a recent increase in behaviors which occurred more in the evening. R7 became more aggressive and exhibited suicidal ideation after R7's spouse (POAHC-K) left the facility in the evening. The note indicated R7's behavior could be more in (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	line with anxiety or another Diagnostic and Statistical Manual (DSM)-V (the principal authority for psychiatric diagnoses) diagnosis psychosis. The note indicated R7 had suicidal ideation on the evening of 4/19/26 and the possibility of cognitive behavioral therapy (CBT) would be explored via consult. (Of note: The recommendation for CBT was not explored.)R7's care plan was updated on 4/22/26 to include behavior symptoms. The care plan indicated R7 made accusations of self harm or of a negative nature triggered by POAHC-K leaving the facility. The care plan contained interventions to notify R7's PCP if R7 mentions suicidal thoughts, offer 1:1 conversation following negative statements, and figure out when R7 is upset and offer activities of liking when POAHC-K leaves to help distract from negative thoughts. (Of note: R7's care plan did include threats of self-harm or behaviors due to R7's spouse leaving in the evening prior to the update on 4/22/26. R7 also did not have a care plan related to depression or antidepressant medication.)On 5/4/26 at 1:45 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-C regarding R7's suicidal ideation and behavior. CNA-C verified CNA-C observed R7 yelling in R7's room at approximately 10:00 PM on 4/22/26. R7 pulled the call light out of the wall, attempted to hit CNA-C with it, and stated R7 wanted to kill themself and was going to wrap the call light cord around R7's neck. CNA-C reported the incident to agency Licensed Practical Nurse (LPN)-J. CNA-C stated R7 was not on increased supervision or 15-minute checks at that time.On 5/4/26 at 1:07 PM and 4:12 PM and on 5/5/26 at 9:02 AM, Surveyor attempted to call LPN-J and left voicemails. The calls were not returned as of this writing. A physician visit note, dated 4/22/26, indicated PCP-I would continue sertraline 25 mg for R7; however, if R7's behaviors continued to increase after POAHC-K left at night, PCP-I would consider the use of quetiapine 50 mg at night for a behavioral component (not purely dementia-related).On 5/4/26 at 11:12 AM, Surveyor interviewed CNA-D regarding R7's suicidal ideation. CNA-D verified CNA-D found R7 on the morning of 4/23/26 at approximately 7:00 AM with the call light cord wrapped twice around R7's neck. R7 was screaming that R7 wanted to kill themself. CNA-D stated Director of Nursing (DON)-B was notified and staff contacted Emergency Medical Services (EMS). CNA-D was told during report at the start of the 4/23/26 AM shift that R7 yelled that R7 wanted to kill themself and hit staff with the call light on the 4/22/26 PM shift. CNA-D verified R7's behavior and suicidal ideation increased when POAHC-K left the facility in the evening. CNA-D did not think R7 was on increased supervision after expressing suicidal ideation on the evening of 4/22/26. (Of note: R7's medical record did not contain progress notes related to the incidents on 4/22/26 or 4/23/26.)On 5/4/26 at 3:20 PM, Surveyor interviewed LPN-H regarding R7's suicidal ideation and behavior. LPN-H verified LPN-H worked the NOC shift from 4/22/26 to 4/23/26. LPN-H indicated R7 was upset on 4/22/26 at the beginning of LPN-H's shift and confirmed LPN-H had to replace R7's call light because R7 ripped it out of the wall. LPN-H verified R7 was not on 15-minute checks/increased supervision during the shift. On 5/4/26 at 3:01 PM, Surveyor interviewed DON-B regarding R7's suicidal ideation and behavior. DON-B verified staff discovered R7 screaming with the call light cord wrapped around R7's neck on the morning of 4/23/26. EMS was notified and R7 was hospitalized . DON-B was not aware of any other instances (other than 4/19/26) in which R7 made suicidal comments. DON-B verified R7 should have been on 15-minute checks from 4/19/26 through 4/22/26 (72 hours) and could not provide documentation for the missing 16 hours.On 5/4/26 at 10:58 AM, Surveyor interviewed NHA-A regarding R7's suicidal ideation. NHA-A verified CNA-D found R7 on 4/23/26 at approximately 7:00 AM with the call light cord wrapped around R7's neck. NHA-A stated R7 made suicidal comments on 4/19/26, however, NHA-A was not aware R7 made any other threats of self-harm. NHA-A verified R7 was sent to the hospital on 4/23/26 because NHA-A thought R7 was actively suicidal, and the facility could not meet R7's mental health needs.The failure to provide adequate supervision for a resident who expressed suicidal ideation created a reasonable likelihood for serious harm which led to a finding of immediate jeopardy. The facility removed the jeopardy on 5/11/26 when it completed the following:1. Reviewed all residents with a history/diagnosis of depression and suicidal ideation and implemented/reviewed/revised care plans.2. Implemented Suicide Prevention and Suicide (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Assessment policies and reviewed them with the Medical Director.3. Completed staff education, including suicide assessment and prevention basics, shift-to-shift report, security checks, notification, care plan updates, and increased supervision/1:1 monitoring.4. Initiated 24-hour report board audits 5 times per week for behavioral changes in condition and/or comments that could be interpreted as suicidal ideation or increasing depression.