

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2015
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NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960
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K 000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 05/19/15</p> <p>Facility Number: 000072 Provider Number: 155152 AIM Number: 100287440</p> <p>At this Life Safety Code survey, Monticello Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility is located in a fully sprinklered facility consisted of a one story building of Type V (000) construction with a partial basement and on the first floor of a two story building determined to be Type V (111). The facility was surveyed as two building due to different construction Types. The facility has a fire alarm system with hard</p>	K 000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a post survey revisit on or after June 6, 2015.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.

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K 018 SS=E Bldg. 01	<p>wired smoke detection in the basement, corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has the capacity for 116 residents and had a census of 85 at the time of this survey.</p> <p>All areas accessible to residents are sprinklered. Areas providing facility services were sprinklered except a detached shed and building used for storage.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 2 of 8 smoke compartments could latch into the door</p>	K 018	It is the practice of this provider to ensure that doors protecting corridor openings in smoke compartments latch into the door frames.	06/06/2015			

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	<p>frame. This deficient practice affects staff, visitors and 10 or more residents in the locked unit and therapy smoke compartments.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 05/19/15 between 11:45 a.m. and 1:30 p.m., the double door sets protecting openings to the corridors for the two therapy rooms each had one inactive leaf with a manual flush bolt to secure the inactive leaf into the door frame. Unless the inactive door leaf was manually latched in these door sets, neither door was secured tightly into the door frame. The maintenance director acknowledged at the time of observations, each door could not latch automatically into the door frame.</p> <p>b. Based on observation with the maintenance director on 05/19/15 at 12:10 p.m., the door to resident room 147 did not latch after three repeated attempts to close the door. The maintenance director acknowledged at the time of observation the latch was not working to secure the door in the door frame.</p> <p>3.1-19(b)</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The double door set protecting the opening to the corridor for the therapy rooms has been repaired so that they automatically latch into the door frame.</p> <p>The door to resident room #147 has been repaired so the door can be secured tightly to the door frame.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected by the alleged deficient practice. Review of all other double doors was completed to ensure they automatically latch into the door frame. Modifications made as needed.</p> <p>Review of all other resident room doors was completed to ensure they automatically latch into the door frame. Modifications made as needed.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Double doors and resident room</p>		

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K 025 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 openings in a smoke partition, such as a ceiling, were sealed to limit the transfer of smoke.</p>	K 025	<p>doors will be visualized during monthly Preventative Maintenance rounds by Maintenance Director/Designee to ensure they automatically latch into the door frame.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>CQI Audits from monthly Preventative Maintenance rounds will be reported to the Safety Committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed to ensure compliance.</p> <p>Compliance Date: June 6, 2015</p> <p>It is the practice of this provider to ensure that smoke partitions are sealed to limit the transfer of smoke.</p>	06/06/2015	

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	<p>LSC 8.2.4.1 requires smoke partitions shall limit the transfer of smoke. This deficient practice could affect visitors, staff and 10 or more residents on 1 West.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 05/19/15 at 12:20 p.m., a two inch hole and one inch hole in the 1 West spa ceiling was unsealed. The maintenance director acknowledged the openings and demonstrated they were the result of the opening of a walk in tub door which when lifted to open, hit the ceiling to cause the holes.</p> <p>b. Based on observation with the maintenance director on 05/19/15 at 1:00 p.m., the attic access panel in the vending machine room did not fit tightly enough to maintain the smoke resistance of the ceiling. One side of the trim for the opening was missing leaving a half inch gap along one edge of the access panel. Another corner had been broken off creating a two inch hole. The maintenance director acknowledged at the time of observation, the compromised smoke resistance of the access panel.</p> <p>3.1-19(b)</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The 1 West spa ceiling has been sealed to limit the transfer of smoke. The attic access panel in the vending machine room has been repaired to limit the transfer of smoke.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected by the alleged deficient practice. Review of all ceilings has been completed to ensure that smoke partitions are sealed to limit the transfer of smoke. Modifications made as needed. Review of all attic access panels has been completed to ensure that smoke partitions are sealed to limit the transfer of smoke. Modifications made as needed.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Ceilings and attic access panels will be visualized during monthly Preventative Maintenance rounds by Maintenance Director/Designee to ensure they limit the transfer of</p>				

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K 044 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure fire doors separating 2 of 8 smoke compartments were arranged to automatically close and latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect staff, visitors, and 20 or more residents in the</p>	K 044	<p>smoke.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>CQI Audits from monthly Preventative Maintenance rounds will be reported to the Safety Committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed to ensure compliance.</p> <p>Compliance Date: June 6, 2015</p> <p>It is the practice of this provider to ensure that all fire doors separating smoke compartments are arranged to automatically close and latch.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The doors in the fire door set near the west nurses' station were repaired to automatically close and latch.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective</p>	06/06/2015
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K 062 SS=E Bldg. 01	<p>west smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/19/15 at 12:05 p.m., doors in the fire door set near the west nurses station were tested twice manually to observe their self closing function. One door in the fire door set failed to latch each time the doors were released to close. The doors failed to latch again at 12:05 p.m. when the fire alarm was activated. The maintenance director agreed at the time of observations, there was a problem with the latching mechanism.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating</p>		<p>action will be taken?</p> <p>All residents have the potential to be affected by the alleged deficient practice. Review of all fire doors has been completed to ensure that they automatically close and latch. Modifications made as needed.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Fire doors will be visualized during monthly Preventative Maintenance rounds and with each fire drill by Maintenance Director/Designee to ensure they automatically close and latch.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>CQI Audits from monthly Preventative Maintenance rounds will be reported to the Safety Committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed to ensure compliance.</p> <p>Compliance Date: June 6, 2015</p>		

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	<p>condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 3 dining rooms were free of foreign materials, such as grime and paint. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects staff, visitors and 10 or more residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/19/15 between 11:45 a.m. and 1:30 p.m., three sprinkler heads in the main dining room located near HVAC supply vents were covered with thick, gray fuzzy grime. The maintenance director said at the time of observations, he "cleaned" the heads monthly.</p> <p>3.1-19(b)</p> <p>2. Based on observation, the facility failed to ensure sprinkler heads providing protection for 1 of 8 smoke compartments were maintained. This deficient practice could affect all staff, visitors and 10 or more residents on 1 West.</p>	K 062	<p>It is the practice of this provider to ensure that sprinkler heads are free of foreign materials and maintained.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The three sprinkler heads in the main dining room located near the HVAC supply vents have been cleaned of foreign materials. The escutcheon was replaced on the sprinkler in the 1 West spa.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected by the alleged deficient practice. Review of all sprinkler heads has been completed to ensure that they are free of foreign materials and escutcheons are in place. Modifications made as needed.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Sprinkler heads will be visualized during monthly Preventative</p>	06/06/2015			

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K 064 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on observation with the maintenance director on 05/19/15 at 12:20 p.m., the escutcheon was missing for a sprinkler providing protection in the 1 West spa. The maintenance director acknowledged at the time of observation the sprinkler installation was incomplete.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation, the facility failed to ensure portable fire extinguishers in 1 of 8 smoke compartments were installed as required. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires that the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be no more than three and one half feet (42 inches) above the floor. This deficient</p>	K 064	<p>Maintenance rounds by Maintenance Director/Designee to ensure they are free of foreign materials and escutcheons are in place.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>CQI Audits from monthly Preventative Maintenance rounds will be reported to the Safety Committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed to ensure compliance.</p> <p>Compliance Date: June 6, 2015</p> <p>It is the practice of this provider to ensure that fire extinguishers are installed as required.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The portable fire extinguisher in the mechanical room near the elevator has been installed at the correct height.</p>	06/06/2015

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	<p>practice affects visitors, staff and 10 or more residents in the elevator room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/19/15 at 12:30 p.m., the portable fire extinguisher in the mechanical room near the elevator was mounted at 67 inches above the finished floor. The maintenance director acknowledged at the time of observation, the fire extinguisher exceeded the minimum height allowed.</p> <p>3.1-19(b)</p>		<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected by the alleged deficient practice. Review of all fire extinguishers has been completed to ensure that they are installed at the correct height. Modifications made as needed.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Fire extinguishers will be visualized during monthly Preventative Maintenance rounds by Maintenance Director/Designee to ensure they are installed at the correct height.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>CQI Audits from monthly Preventative Maintenance rounds will be reported to the Safety Committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed to ensure compliance.</p>	

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K 130 SS=E Bldg. 01	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 cylinders of non-flammable gas was secured in a cart or hand truck with appropriate chains or stays to prevent accidental damage. NFPA 99, 8-5.2.1 requires the construction for nonpatient gas cylinder carts and hand trucks shall be constructed for the intended purpose and shall be self-supporting. They shall be provided with appropriate chains or stays to retain cylinders in place. This deficient practice affects visitors, staff and 10 or more residents in the oxygen storage room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/19/15 at 1:10 p.m., a helium cylinder was free standing in the storage room across the corridor from the oxygen supply storage room. A chain lay on the floor beside the large free standing cylinder. The maintenance director agreed at the time of observation, the tank should have been secured.</p> <p>3.1-19(b)</p>	K 130	<p>Compliance Date: June 6, 2015</p> <p>It is the practice of this provider to ensure that cylinders of non-flammable gas are secured in a cart or hand truck with appropriate chains or stays to prevent accidental damage.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The helium cylinder in the storage room across the corridor from the oxygen supply storage room has been secured.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected by the alleged deficient practice. Review of all non-flammable gas tanks has been completed to ensure that they are secured to prevent accidental damage. Modifications made as needed.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p>	06/06/2015			

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K 147 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring. NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect visitors, staff and 10</p>	K 147	<p>Non-flammable gas tanks will be visualized during monthly Preventative Maintenance rounds by Maintenance Director/Designee to ensure they are secured.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>CQI Audits from monthly Preventative Maintenance rounds will be reported to the Safety Committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed to ensure compliance.</p> <p>Compliance Date: June 6, 2015</p> <p>It is the practice of this provider to ensure that flexible cords are not used as a substitute for fixed wiring.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The extension cords used to supply power to the electric organ in the main dining room and the</p>	06/06/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2015
NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960		
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	<p>or more residents in the main dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/19/15 between 11:45 a.m. and 1:30 p.m., extension cords were used to supply power to and electric organ in the main dining room and a refrigerator in the staff development office. The maintenance director said at the time of observations, the use of extension cords was against facility policy.</p> <p>3.1-19(b)</p>		<p>refrigerator in the staff development office have been removed.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected by the alleged deficient practice. Review of all flexible cords has been completed to ensure that they are not used as a substitute for fixed wiring. Modifications made as needed.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Power strips will be visualized during monthly Preventative Maintenance rounds by Maintenance Director/Designee to ensure they are used correctly.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>CQI Audits from monthly Preventative Maintenance rounds will be reported to the Safety Committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed to ensure compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2015
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NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960
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K 000 Bldg. 03	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 05/19/15</p> <p>Facility Number: 000072 Provider Number: 155152 AIM Number: 100287440</p> <p>At this Life Safety Code survey, Monticello Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>The 2012 renovation was determined to be of Type II (111) construction and fully sprinklered. The renovated wing was surveyed as a third building due to the renovation after 2012. The facility has a fire alarm system with hard wired smoke</p>	K 000	<p>Compliance Date: June 6, 2015</p> <p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a post survey revisit on or after June 6, 2015.</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2015
NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960		
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	<p>detection in the basement, corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has the capacity for 116 residents and had a census of 85 at the time of this survey.</p> <p>All areas accessible to residents are sprinklered.</p> <p>Areas providing facility services were sprinklered excepts a detached shed and building used for storage.</p>				