| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155152 | | 04/15/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONTICELLO HEALTHCARE | 1120 N MAIN ST<br>MONTICELLO, IN 47960 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00195844.<br><br>Complaint IN00195844 was substantiated with deficiency cited at F242.<br><br>Survey dates: April 10, 11, 12, 13, 14, and 15, 2016.<br><br>Facility number: 000072<br>Provider number: 155152<br>AIM number: 100287440<br><br>Census bed type:<br>SNF/NF: 82<br>SNF: 13<br>Total: 95<br><br>Census payor type:<br>Medicare: 25<br>Medicaid: 54<br>Other: 16<br>Total: 95<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. | F 0000 | Monticello Health Care is respectfully requesting a desk review in lieu of on site revisit.<br>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONTICELLO HEALTHCARE | 1120 N MAIN ST<br>MONTICELLO, IN 47960 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Quality review completed by 32883 on 4/20/16. | | | |
| F 0157<br>SS=D<br>Bldg. 00 | 483.10(b)(11)<br>NOTIFY OF CHANGES<br>(INJURY/DECLINE/ROOM, ETC)<br>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>The facility must also promptly notify the resident and, if known, the resident's legal | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. | | | |
| | Based on record review and interview, the facility failed to notify the Physician in a timely manner of a resident's abnormal lab results for 1 of 1 residents reviewed for hydration. (Resident #61)<br><br>Finding includes:<br><br>The record for Resident #61 was reviewed on 4/12/16 at 2:15 p.m. The diagnoses included, but were not limited to, chronic kidney disease, diabetes mellitus, depression and hypertension (high blood pressure).<br><br>The Physician's Order dated 3/28/16 indicated a laboratory order for a CBC (Complete Blood Count) and a CMP (Comprehensive Metabolic Panel).<br><br>A review of the resident's record lacked a laboratory result from 3/28/16.<br><br>A review of the Nurses' Notes from 3/26/16 through 4/10/16 lacked | F 0157 | **What corrective action(s) willbe accomplished for those residents found to have been affected by thedeficient practice?**<br>·Resident #61 physician notified on 4/12/16 of lab results from lab draws on 3/28/16. Additional labs on Resident #61 ordered andphysician notified.<br>**How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?**<br>·All residents who have labs drawn whichrequire physician notification have thepotential to be affected by the alleged deficient practice.<br>·Complete audit of all labs drawn for thelast thirty (30) days to ensure physician. Notification.<br>·Daily audit by DNS and/or designee hasbeen initiated to ensure labs are drawn, and physician notified.<br><br>**What measures will be put intoplace or what systemic changes you will make to ensure that the** | 05/05/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | documentation of the Physician being notified of the 3/28/16 laboratory results.<br><br>Interview with the West Unit Manager on 4/12/16 at 2:54 p.m., indicated there was no laboratory result documented in the record from the 3/28/16 test.<br><br>The laboratory result from 3/28/16 was reviewed after the West Unit Manger called the laboratory and had the result faxed. The laboratory indicated a blood sugar of 150, which the normal range was 83-110, and a high EOS% (Eosinophil count-elevated levels of white blood cells area to which is a good indicator of infection or illness) of 6.01, to which the normal range was 1-3.<br><br>Interview with the Director of Nursing (DON) on 4/12/16 at 5:32 p.m., indicated the Nurse Practitioner did not receive the abnormal result and did not know for sure if the Physician received the abnormal laboratory results. The nurse had faxed laboratory results on 3/28/16 to the Physician's office, but the fax confirmation cover sheet only indicated another resident's name with 2 pages attached.<br><br>The policy tilted, "Resident Change of Condition," was provided by the Nurse Consultant on 4/12/16 at 4:26 p.m. and | | **deficientpractice does not recur?**<br>.<br>·An in-service will be completed by theDirector of Nursing and/or designee by May 5, 2016, or prior to returning towork for licensed nurses on the following: Lab Procedure review; Physician / responsible party notification; labfacsimile procedure; and Lab Tracking internal tools.<br><br>**How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place?**<br><br>·CQI audit tools “Lab Diagnostic CQI”, willbe utilized by the Director of Nursing and/or designee to monitor compliance. Audits will be completed weekly X 4 weeks,monthly X 2 months, and quarterly thereafter for at least two quarters.<br>·Results of Audit tools will be presentedto the CQI Committee monthly to review for compliance and follow-up. Identifiednoncompliance may result in staff re-education and/or disciplinary action.<br>·If threshold of 95% is not achieved, anaction plan will be developed to achieve desired threshold. Data will be submitted to the CQI committeefor review and follow up. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155152 | | 04/15/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONTICELLO HEALTHCARE | 1120 N MAIN ST<br>MONTICELLO, IN 47960 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | indicated was current, indicated "...3. Routine Medical Change: a. All symptoms and unusual signs will be documented i the medial record and communicated to the attending physician promptly. Routine changes are a minor change in physical and mental behavior, abnormal laboratory...."<br><br>3.1(a)(2) | | | |
| F 0242<br>SS=D<br>Bldg. 00 | 483.15(b)<br>SELF-DETERMINATION - RIGHT TO MAKE CHOICES<br>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.<br>Based on interview and record review, the facility failed to ensure a resident was bathed according to the stated preference for 1 of 3 residents reviewed for choices of the 4 residents who met the criteria for choices. (Resident #B) | F 0242 | **What corrective action(s) willbe accomplished for those residents found to have been affected by thedeficient practice?**<br>·All resident bathing preferencesreviewed and updated.<br>·Shower schedule audited to ensure thatthe schedule matched | 05/05/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Finding includes:<br><br>Interview with Resident #B on 4/11/16 at 10:12 a.m., indicated only one shower had been received since admission.<br><br>The record for Resident #B was reviewed on 4/13/16 at 8:44 a.m. The resident's admission date was 3/13/16 and diagnoses included, but were not limited to, heart failure, hip fracture and depression.<br><br>The 14 day MDS (Minimum Data Set) assessment dated 3/24/16 indicated the resident had mild confusion, was a two person assist with personal hygiene and bathing, was totally dependent with bathing, and placed high importance on the type of bathing.<br><br>The form titled, "Presences," dated 3/23/16, indicated the resident preferred a shower, 2 times a week in the a.m.<br><br>Review of the resident's shower report indicated a completed bed bath on 3/23/16, 3/29/16, 4/2/16 and 4/8/16.<br><br>Interview with the West Unit Manager on 4/13/16 at 10:41 a.m. indicated if a resident refused a shower and a completed bed bath was given instead of a shower, the refusal would have been | | resident preferences.<br>·Care Plan held with Resident B and herfamily to ensure that her preferences were effectively being communicated andmet.<br>·Resident #B is no longer a resident ofthe facility.<br>**How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?**<br>·All residents have the potential to beaffected by the alleged deficient practice.<br>·Complete review of all residentpreferences completed and shower schedule audited to ensure that it meetsresident preferences.<br>·Daily audit by DNS and/or designee toensure showers are offered and completed per resident preference.<br>**What measures will be put intoplace or what systemic changes you will make to ensure that the deficientpractice does not recur?**<br>.<br>·An in-service will be completed by theDirector of Nursing and/or designee by May 5, 2016, or prior to returning towork for all nursing staff on the following: Resident preference for Bathing; shower schedules; and shower sheets foreffective documentation.<br><br>**How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155152 | | 04/15/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONTICELLO HEALTHCARE | 1120 N MAIN ST<br>MONTICELLO, IN 47960 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | indicated on the shower report.<br><br>This Federal Tag relates to Complaint # IN00195844.<br><br>3.1-3(u)(1)<br>3.1-3(u)(3) | | **assurance program will be put into place?**<br><br>·CQI audit tools "Bathing and Oral Care",will be utilized by the Director of Nursing and/or designee to monitorcompliance. Audits will be completedweekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least twoquarters.<br>·Results of Audit tools will be presentedto the CQI Committee monthly to review for compliance and follow-up. Identifiednoncompliance may result in staff re-education and/or disciplinary action.<br>·If threshold of 95% is not achieved, anaction plan will be developed to achieve desired threshold. Data will be submitted to the CQI committeefor review and follow up. | |
| F 0282<br>SS=D<br>Bldg. 00 | 483.20(k)(3)(ii)<br>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br>Based on observation, interview and record review, the facility failed to follow | F 0282 | **What corrective action(s) willbe accomplished for those residents found to have been affected by** | 05/05/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | the residents' care plans for oral hygiene and nectar thick liquids for 2 of 3 residents reviewed for ADL's (Activities of Daily Living) of the 3 who met the criteria for ADL's and for 1 of 1 residents reviewed for hydration of the 1 who met the criteria for hydration. (Resident's #105, #153 and #61)<br><br>Findings include:<br><br>1. Interview with Resident #105 on 4/11/16 at 9:43 a.m., indicated oral hygiene care had not been provided by staff and further indicated he did not have a toothbrush after having repeatedly asked for one.<br><br>Follow up interview with the resident on 4/12/2016 at 1:37 p.m., indicated no oral hygiene was performed last night or today.<br><br>Interview with CNA #1 on 4/12/16 at 1:41 p.m., indicated staff assisted the resident with teeth brushing before bedtime, and the CNA located a new toothbrush and new tube of toothpaste in the resident's bedside dresser.<br><br>The record for Resident #105 was reviewed on 4/12/16 at 11:07 a.m. The resident's diagnoses included, but were not limited to, contracture left hand, | | **thedeficient practice?**<br>·Resident #105 Complete oral assessmentcompleted. ADL care plan reviewed and updated. Care plan reviewed to reflect current oral hygiene needs. Residentscheduled to see the dentist on May 4, 2016, for complete assessment of hiscurrent dental health. Facility toensure additional dental care and follow-up per dentist recommendations and in accordancewith resident preference.<br>·Resident #153 Complete oral assessmentcompleted. ADL care plan reviewed and updated. Care plan reviewed to reflect current oral hygiene needs. Residentfamily denied offer to have resident be seen by a Dentist for a completeassessment of her current dental health at this time. Facility to ensure additional dental care andfollow-up per dentist recommendations and in accordance with residentpreference.<br>·Resident #61, on 4/12/16 thin liquidswere promptly removed from residents room and resident never received the thinliquids in question. All nursing staffincluding LPN #2 in-serviced regarding residents on thickened liquids.<br><br>**How will you identify otherresidents having the potential to be affected by the same deficient** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155152 | | 04/15/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONTICELLO HEALTHCARE | 1120 N MAIN ST<br>MONTICELLO, IN 47960 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | diabetes mellitus, and hemiplagia-left side affected (unable to independently move the left side of the body).<br><br>The Annual MDS (Minimum Data Set) assessment dated 3/9/16 indicated the resident had mild confusion, was a 1 person assist with personal hygiene, had an impairment on one side - upper extremity, and had obvious or likely cavity or broken natural teeth.<br><br>Review of the resident's oral hygiene record indicated only p.m. care was performed on 3/31/16.<br><br>Review of the resident's care plan dated 11/19/14 included a care plan for dental care. The interventions included, but were not limited to, assist the resident with oral care.<br><br>Interview with MDS Director on 4/12/16 at 3:02 p.m., indicated there was no documentation oral hygiene was performed other than on 3/31/16.<br><br>During an observation of the resident's teeth on 4/12/2016 at 5:29 p.m., two discolored teeth on the bottom front of the resident's mouth were noted and the other teeth were also noted to have a yellowish discoloration. | | **practiceand what corrective action will be taken?**<br>·All residents who require assistancewith oral care have the potential to be affected by the alleged deficientpractice.<br>·All residents who require assistancewith Oral Care have been identified and AM/PM care added to facility trackingsystem to document AM/PM care including oral care.<br>·The Care Plans and Profiles for allresidents who require assistance with oral care have been reviewed and updatedto reflect any changes.<br>·All residents who are on thickenedliquids have the potential to be affected by the alleged deficient practice.<br>·All residents who receive thickenedliquids have been identified.<br>·Complete audit of residents currently onthickened liquids completed to ensure profile reflects physician orders forthickened liquids.<br>·The Care Plans and Profiles for allresidents who have a physicians order for thickened liquids have been reviewedand updated to reflect any changes.<br>·All staff educated regarding theprovision of thickened liquids and how to identify residents that are onthickened liquids.<br>**What measures will be put intoplace or what systemic changes you will make to ensure that the deficientpractice does not recur?** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 2. The record for Resident #153 was reviewed on 4/13/16 at 9:29 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, visual disturbance and disease of the gallbladder. The resident's admission date was 3/14/16.<br><br>The 5 day MDS assessment dated 3/21/16, indicated the resident was cognitively impaired, was a 1 person assist with personal hygiene and no dental issues.<br><br>Review of the care plan dated 3/15/16 for risk for self care deficit related to Alzheimer's disease indicated an intervention to provide oral care at least 2 times a day.<br><br>Interview with CNA #2 on 4/13/16 at 9:10 a.m., indicated the resident needed her toothbrush set up and cueing with personal hygiene in the morning. She further indicated the resident was assisted with oral care before breakfast.<br><br>Interview with CNA #3 on 4/13/16 at 9:13 a.m., indicated the resident needed set up and cueing for personal hygiene.<br><br>Interview with MDS Director on 4/13/16 at 10:38 a.m., indicated personal hygiene included oral care and was only | | .<br>·An in-service will be completed by theDirector of Nursing and/or designee by May 5, 2016, or prior to returning towork for all staff on the provision of oral care/ AM/PM care documentation.<br>·An in-service will be completed by theDirector of Nursing and/or designee by May 5, 2016, or prior to returning towork for all staff on the provision of thickened liquids and how to identifyresidents that are on thickened liquids.<br><br>**How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place?**<br><br>·CQI audit tools “Altered FluidConsistency”, will be utilized by the Director of Nursing and/or designee tomonitor compliance. Audits will becompleted Daily X5 days, weekly X 4 weeks, monthly X 2 months, and quarterlythereafter for at least two quarters.<br>·CQI audit tools “Bathing and Oral Care”,will be utilized by the Director of Nursing and/or designee to monitorcompliance. Audits will be completed weeklyX 4 weeks, monthly X 2 months, and quarterly thereafter for at least twoquarters.<br>·Results of Audit tools will be presentedto the CQI Committee monthly to review for compliance | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155152 | | 04/15/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONTICELLO HEALTHCARE | 1120 N MAIN ST<br>MONTICELLO, IN 47960 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | documented for p.m. personal care yesterday.<br><br>The resident's teeth were observed with no current visible debris on 4/13/2016 at 10:12 a.m,<br><br>3. On 4/12/16 at 9:54 a.m. LPN #2 was observed passing ice water to residents on the West Unit. On resident #61's dresser, a cup of ice water dated 4/12 with the initials KL was observed.<br><br>On 4/12/16 at 11:26 a.m., the same cup of ice water was observed on the resident's dresser.<br><br>Resident #61 was interviewed on 4/12/16 at 3:09 p.m. and indicated he was thirsty. At that time, the same cup of ice water was observed on his dresser with the initials KL dated 4/12.<br><br>The record for Resident #61 was reviewed on 4/12/16 at 2:15 p.m. The diagnoses included, but were not limited to, chronic kidney disease, diabetes mellitus, depression and COPD (Chronic Obstructive Pulmonary Disease-disease of the lungs).<br><br>Review of the Physician's Order Summary for April 2016 indicated a diet order for nectar thick liquids dated | | and follow-up.<br>Identifiednoncompliance may result in staff re-education and/or disciplinary action.<br>·If threshold of 95% is not achieved, anaction plan will be developed to achieve desired threshold. Data will be submitted to the CQI committeefor review and follow up. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 4/7/16.<br><br>Review of the resident's care plan dated 8/5/15 for risk for aspiration included an intervention of nectar thick liquids.<br><br>Interview with LPN #2 on 4/12/16 at 5:14 p.m., indicated the resident's water was ice with a little bit of water and it should have been a carton of nectar thick water.<br><br>3.1-35(g)(2) | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155152 | | 04/15/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONTICELLO HEALTHCARE | 1120 N MAIN ST<br>MONTICELLO, IN 47960 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 0309<br>SS=D<br>Bldg. 00 | 483.25<br>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br>Based on observation, record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to the monitoring and assessment of bruises for 1 of 3 residents reviewed for non pressure related skin conditions of the 3 residents who met the criteria for non pressure related skin conditions. (Resident #155)<br><br>Finding includes:<br><br>On 4/11/16 at 10:01 a.m., Resident #155 was observed to have three large dark purple discolorations to his inner right forearm. Interview with the resident at the time of the observation indicated he believed they came from having blood work.<br><br>On 4/12/16 at 10:01 a.m., Resident #155 was observed lying in bed with his arms up and his hands under his head. The three large dark purple discolorations were still observed on his inner right | F 0309 | **What corrective action(s) willbe accomplished for those residents found to have been affected by thedeficient practice?**<br>·Resident #155 Head to toe assessment ofresident completed. Discolorationobserved on 4/11/16, 4/12/16, and 4/13/16, continues to resolve. Physician and Family notified. No new orders regarding treatment of skincondition.<br>**How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?**<br>·All residents require treatment andservices related to the monitoring and assessment of bruises for non pressureskin conditions have the potential to be affected by the alleged deficientpractice.<br>·Complete skin sweep completed for allresidents currently residing in the facility.<br>·All residents to receive a weekly skinassessment.<br>·All residents will receive a weeklyaudit by DNS and/or | 05/05/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | forearm.<br><br>On 4/13/16 at 3:49 p.m., Resident #155 was observed sitting in his wheelchair in his room. The three dark purple discolorations were still observed on his inner right forearm.<br><br>Record review for Resident #155 was completed on 4/13/16 at 12:48 p.m. The resident's diagnoses included, but were not limited to, hypertension, diabetes mellitus, anxiety and depression.<br><br>The Admission Minimum Data Set (MDS) assessment completed on 4/2/16 indicated the resident had a BIMS (Brief Interview of Mental Status) score of 12 which indicated the resident's cognition was moderately impaired. The assessment indicated the resident needed an extensive 2+ person assist for bed mobility, walking, toileting, and personal hygiene; extensive 1 person assist for transfers and dressing.<br><br>Review of a Nursing Admission Assessment completed on 3/26/16 indicated the resident had multiple bruises to both arms related to blood draw sticks.<br><br>Review of Weekly Nursing Summary and Skin Assessments completed on 3/31/16 | | designee to ensure monitoring and assessment of bruisesrelated to non-pressure skin conditions are being completed.<br>**What measures will be put intoplace or what systemic changes you will make to ensure that the deficientpractice does not recur?**<br>.<br>·An in-service will be completed by theDirector of Nursing and/or designee by May 5, 2016, or prior to returning towork for all nursing staff on the following: Skin Management Program.<br>·All residents to receive a weekly skinassessment.<br>·All residents will receive a weeklyaudit by DNS and/or designee to ensure monitoring and assessment of bruisesrelated to non-pressure skin conditions are being completed.<br><br>**How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place?**<br><br>·CQI audit tools “Bruises”, will beutilized by the Director of Nursing and/or designee to monitor compliance. CQI Audits will be completed weekly X 4 weeks,monthly X 2 months, and quarterly thereafter for at least two quarters.<br>·Results of Audit tools will be presentedto the CQI Committee monthly to review for compliance | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONTICELLO HEALTHCARE | 1120 N MAIN ST<br>MONTICELLO, IN 47960 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | and 4/11/16 indicated the resident currently had no bruising.<br><br>Review of Nursing Notes from 3/26/16 through 4/13/16 lacked any indication the discolorations were monitored since the admission Nursing Note on 3/26/16.<br><br>Interview with Unit Manager #1 on 4/13/16 at 3:58 p.m., indicated she was unaware the resident currently had any discolorations. She indicated when a resident had any discolorations observed they are measured and monitored for 72 hours. She indicated when the resident was admitted his discolorations should have been measured and continued to be assessed for 72 hours and this had not been completed. She further indicated his weekly skin assessments should have indicated he still had the discolorations and this had not been completed.<br><br>3.1-37(a) | | and follow-up.<br>Identifiednoncompliance may result in staff re-education and/or disciplinary action.<br>·If threshold of 95% is not achieved, anaction plan will be developed to achieve desired threshold. Data will be submitted to the CQI committeefor review and follow up. | |
| F 0312<br>SS=D<br>Bldg. 00 | 483.25(a)(3)<br>ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Based on interview, observation and record review, the facility failed to ensure ADL (Activities of Daily Living) assistance with oral hygiene was provided for 2 of 3 residents reviewed for ADL's of the 3 residents who met the criteria for ADL's. (Resident #B and #153)<br><br>Findings include:<br><br>1. Interview on 4/11/16 at 10:19 a.m. with Resident #B, indicated the staff did not assist with oral care because they were too busy.<br><br>Interview with CNA #4 on 4/12/16 at 2:08 p.m., indicated the supplies for oral hygiene were handed to the residents to brush their teeth in the morning.<br><br>Interview on 4/13/2016 at 10:39 a.m. with the MDS (Minimum Data Set) Director, indicated a.m. care was only documented as completed for 4/13/16.<br><br>The resident's teeth were observed on 4/13/16 at 10:58 a.m. He was noted to be missing two lower teeth and had no visible debris in his dentures or natural teeth.<br><br>The record for Resident #B was reviewed on 4/13/2016 at 10:58 a.m. Diagnoses | F 0312 | **What corrective action(s) willbe accomplished for those residents found to have been affected by thedeficient practice?**<br>·Resident #B Complete oral assessmentcompleted. ADL care plan reviewed and updated. Care plan reviewed to reflect current oral hygiene needs andpreferences. Care Plan meeting held with Resident B and her family to ensurethat her preferences were effectively being communicated and met and to reviewthe current care plan regarding the provision of oral care. Resident B no longer resides in the facility.<br>·Resident #153 Complete oral assessmentcompleted. ADL care plan reviewed and updated. Care plan reviewed to reflect current oral hygiene needs. Care Plan meetingheld with Resident 153 and her family to ensure that her preferences wereeffectively being communicated and met and the provision of oral care. Resident family denied offer to have residentbe seen by a Dentist for a complete assessment of her current dental health atthis time. Facility to ensure dentalcare and follow-up provided in accordance with resident and family wishes.<br>·AM/PM care added to facility trackingsystem to document AM/PM care including oral care for residents #B and #153.<br><br>**How will you identify otherresidents having the potential** | 05/05/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | included, but were not limited to, heart failure, hip fracture and depression.<br><br>The 14 day MDS assessment dated 3/24/16 indicated the resident had mild confusion and was a 2 person assist with personal hygiene.<br><br>Review of the resident's care plan dated 3/14/16 indicated the resident had missing teeth, wore upper dentures, and had an intervention of assist with oral care.<br><br>2. The record for Resident #153 was reviewed on 4/13/16 at 9:29 a.m. The diagnoses included, but were limited to, Alzheimer's disease, visual disturbance and disease of the gallbladder. The resident's admission date was 3/14/16.<br><br>The 5 day MDS assessment dated 3/21/16, indicated the resident was cognitively impaired, was a 1 person assist with personal hygiene and had no dental issues.<br><br>Review of the care plan dated 3/15/16 for risk for self care deficit related to Alzheimer's disease indicated an intervention included, but not limited to, provide oral care at least 2 times a day.<br><br>Interview with a family member for | | **to be affected by the same deficient practiceand what corrective action will be taken?**<br>·All residents who require assistancewith oral care have the potential to be affected by the alleged deficientpractice.<br>·All residents who require assistancewith Oral Care have been identified and AM/PM care added to facility trackingsystem to document AM/PM care including oral care.<br>·The Care Plans and Profiles for allresidents who require assistance with oral care have been reviewed and updatedto reflect any changes.<br>**What measures will be put intoplace or what systemic changes you will make to ensure that the deficientpractice does not recur?**<br>.<br>·An in-service will be completed by theDirector of Nursing and/or designee by May 5, 2016, or prior to returning towork for all staff on the provision of oral care and AM/PM care documentation.<br><br>**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?**<br><br>·CQI audit tools “Bathing and Oral Care”,will be utilized by the Director of Nursing and/or designee to monitor compliance. Audits will be completed weekly X 4weeks, | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | resident #153 on 4/11/16 at 2:17 p.m. indicated the resident had not received oral hygiene.<br><br>Interview with CNA #2 on 4/13/16 at 9:10 a.m., indicated the resident needed her toothbrush set up and cueing with personal hygiene in the morning. She further indicated the resident was assisted with oral care before breakfast.<br><br>Interview with CNA #3 on 4/13/16 at 9:13 a.m., indicated the resident needed set up and cueing for personal hygiene.<br><br>Interview with MDS (Minimum Data Set) Director on 4/13/16 at 10:38 a.m., indicated personal hygiene included oral care and was only documented for evening personal care for 4/12/16.<br><br>Observation of the resident's teeth on 4/13/2016 at 10:12 a.m., indicated no noted debris in the teeth.<br><br>3.1-38(a)(3)(c) | | monthly X 2 months, and quarterly thereafter for at least two quarters.<br>·Results of Audit tools will be presentedto the CQI Committee monthly to review for compliance and follow-up. Identifiednoncompliance may result in staff re-education and/or disciplinary action.<br>·If threshold of 95% is not achieved, anaction plan will be developed to achieve desired threshold. Data will be submitted to the CQI committeefor review and follow up. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONTICELLO HEALTHCARE | 1120 N MAIN ST<br>MONTICELLO, IN 47960 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 0329<br>SS=D<br>Bldg. 00 | 483.25(l)<br>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br>Based on record review and interview, the facility failed to ensure a resident's drug regime remained free of unnecessary medications related to the lack of an Abnormal Involuntary Movement Scale (AIMS) assessment completed for a | F 0329 | **What corrective action(s) willbe accomplished for those residents found to have been affected by thedeficient practice?**<br>·Resident #58 had a Abnormal Involuntary Movement Scale(AIMS) assessment | 05/05/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | resident receiving an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medication. (Resident #58)<br><br>Finding includes:<br><br>Record review for Resident #58 was completed on 4/12/16 at 2:19 p.m. The resident's diagnoses included, but were not limited to restlessness, agitation and pseudobulbar affect (neurologic disorder with involuntary emotional displays).<br><br>A Significant Change Minimum Data Set (MDS) assessment completed on 3/10/16 indicated the resident had a BIMS (Brief Interview of Mental Status) score of 3 which indicated the resident was severely cognitively impaired. The assessment indicated the resident had received an antipsychotic medication 7 times in the 7 day assessment period.<br><br>Review of the April 2016 Physician Order Summary indicated the resident received Risperdal (medication to treat mental and mood disorders) 0.25 mg (milligrams) twice a day for pseudobulbar affect.<br><br>Review of the resident's plan of care indicated the resident had received Risperdal since 1/13/16. | | completed on April13,2014. Physician and Familynotified.<br>**How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?**<br>·All residents who require an AbnormalInvoluntary Movement Scale (AIMS) assessment due to receiving anti-psychotic medications have thepotential to be affected by the alleged deficient practice.<br>·All residents who are currentlyreceiving anti-psychotic medication have been identified and all assessmentswere determined to be up to date.<br>**What measures will be put intoplace or what systemic changes you will make to ensure that the deficientpractice does not recur?** .<br>·An in-service will be completed by theDirector of Nursing and/or designee by May 5, 2016, or prior to returning towork for all nursing staff regarding the administration of the AbnormalInvoluntary Movement Scale ( AIMS) assessment.<br>·The Director of Social Services and/ordesignee will track all parties on anti-psychotic medications to ensureadministration of the Abnormal Involuntary Movement Scale (AIMS) assessment per company policy. **How the** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONTICELLO HEALTHCARE | 1120 N MAIN ST<br>MONTICELLO, IN 47960 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | The record lacked any indication an AIMS (Abnormal Involuntary Movement Scale) assessment had been completed on the resident for the antipsychotic medication Risperdal.<br><br>Interview with Director of Nursing on 4/13/16 at 12:15 p.m., indicated the resident did not have an AIMS assessment completed. She further indicated one would be completed as soon as the resident returned from a doctor appointment.<br><br>3.1-48(a)(3) | | **correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place?**<br>·CQI audit tools "Unnecessary Medications"and "Psychoactive Management", will be utilized by the Director of Nursingand/or designee to monitor compliance. Audits will be completed weekly X 4 weeks,monthly X 2 months, and quarterly thereafter for at least two quarters.<br>·Results of Audit tools will be presentedto the CQI Committee monthly to review for compliance and follow-up. Identifiednoncompliance may result in staff re-education and/or disciplinary action.<br>·If threshold of 95% is not achieved, anaction plan will be developed to achieve desired threshold. Data will be submitted to the CQI committeefor review and follow up. | |
| F 0356<br>SS=C<br>Bldg. 00 | 483.30(e)<br>POSTED NURSE STAFFING INFORMATION<br>The facility must post the following information on a daily basis:<br>o Facility name.<br>o The current date.<br>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>- Registered nurses.<br>- Licensed practical nurses or licensed | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155152 | | 04/15/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONTICELLO HEALTHCARE | 1120 N MAIN ST<br>MONTICELLO, IN 47960 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | vocational nurses (as defined under State law).<br>- Certified nurse aides.<br>o Resident census.<br><br>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:<br>o Clear and readable format.<br>o In a prominent place readily accessible to residents and visitors.<br><br>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. | | | |
| | Based on observation and interview, the facility failed to ensure the current staffing pattern was posted on a daily basis. This had the potential to affect the 95 residents residing in the facility.<br><br>Finding includes:<br><br>On 4/10/16 at 9:05 a.m., no staffing posting was observed in the facility.<br><br>On 4/10/16 at 3:30 p.m., no staffing posting was observed in the facility.<br><br>Interview with the Director of Nursing (DON) on 4/12/2016 at 8:53 a.m., | F 0356 | **What corrective action(s) willbe accomplished for those residents found to have been affected by thedeficient practice?**<br>·Facility posts in a prominent place thefollowing information in a clear and readable format a daily basis:<br>·Facility Name<br>·The Current Date<br>·Resident Census<br>·The total number and the actual hoursworked by the following categories of licensed and unlicensed nursing staffdirectly responsible for resident care per shift:<br>·RegisteredNurses<br>·Licensedpractical nurses or licensed vocational nurses | 05/05/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONTICELLO HEALTHCARE | 1120 N MAIN ST<br>MONTICELLO, IN 47960 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | indicated the Unit Manager on the weekends usually posts the staffing on the North end bulletin board, but this weekend, the Unit Manager did not come until the 3-11 shift, and it should have been posted in the morning. Upon admission, the residents and families were told that the staffing would be posted at the North entrance only.<br><br>Interview with the DON on 4/14/16 at 10:09 a.m., indicated there was not a policy for staff postings.<br><br>3.1-13(a) | | ·CertifiedNurse Aides.<br>·Designee appointed for weekend postingof the required facility staffing information.<br>**How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?**<br>·All residents who lived in the facility have the potential to beaffected by the alleged deficient practice.<br>·Daily audit by DNS and/or designee hasbeen initiated to ensure that required staffing information is posted on adaily basis at the beginning of each shift.<br>·Facility Policy for staff postingsidentified and communicated to staff.<br>**What measures will be put intoplace or what systemic changes you will make to ensure that the deficientpractice does not recur?**<br>.<br>·An in-service will be completed by theDirector of Nursing and/or designee by May 5, 2016, for all nursing weekendmanagers on how and where the daily staffing is to be posted.<br>·Daily Staffing audit tool initiated toensure that daily staffing has been posted.<br><br>**How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | **into place?**<br><br>·Daily Staffing audit tool, will beutilized by the Director of Nursing and/or designee to monitor compliance. Audits will be completed daily.<br>·Results of Audit tools will be presentedto the CQI Committee monthly to review for compliance and follow-up. Identifiednoncompliance may result in staff re-education and/or disciplinary action.<br>·If threshold of 100% is not achieved, anaction plan will be developed to achieve desired threshold. Data will be submitted to the CQI committeefor review and follow up. | |
| F 0365<br>SS=D<br>Bldg. 00 | 483.35(d)(3)<br>FOOD IN FORM TO MEET INDIVIDUAL NEEDS<br>Each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br>Based on observation, record review, and interview, the facility failed to ensure a resident received food in correct form related to thickened liquids for 1 of 1 residents reviewed for hydration. (Resident #61)<br><br>Finding includes:<br><br>On 4/12/16 at 9:54 a.m. LPN #2 was observed passing ice water to residents on the West Unit. On resident #61's | F 0365 | **What corrective action(s) willbe accomplished for those residents found to have been affected by thedeficient practice?**<br>·Resident #61 On 4/12/16 the thin liquidswere promptly removed from residents room and resident never received the thinliquids in question.<br>·New hydration plan completed forResident #61 on 4/12/16 and plan of care was updated to reflect the assessment.<br>·All nursing staff including LPN #2in-serviced regarding residents | 05/05/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | dresser, a cup of ice water dated 4/12 with the initials KL was observed.<br><br>On 4/12/16 at 11:26 a.m., the same cup of ice water was observed on the resident's dresser.<br><br>Resident #61 was interviewed on 4/12/16 at 3:09 p.m. and indicated he was thirsty. At that time, the same cup of ice water was observed on his dresser with the initials KL dated 4/12.<br><br>The record for Resident #61 was reviewed on 4/12/16 at 2:15 p.m. The diagnoses included, but were not limited to, chronic kidney disease, diabetes mellitus, depression and COPD (Chronic Obstructive Pulmonary Disease-disease of the lungs).<br><br>Review of the Physician's Order Summary for April 2016 indicated a diet order for nectar thick liquids dated 4/7/16.<br><br>Review of the resident's care plan dated 8/5/15 for risk for aspiration included an intervention of nectar thick liquids.<br><br>Interview with LPN #2 on 4/12/16 at 5:14 p.m., indicated the resident's water was ice with a little bit of water and it should have been a carton of nectar thick | | on thickened liquids.<br>**How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?**<br>·All residents who are on thickened liquidshave the potential to be affected by the alleged deficient practice.<br>·All residents who receive thickenedliquids have been identified.<br>·Complete audit of residents currently onthickened liquids completed to ensure profile reflects physician orders forthickened liquids and hydration assessments complete.<br>·The Care Plans and Profiles for allresidents who require thickened liquids have been reviewed and updated toreflect any changes.<br>·Dietary department completed audit oftray cards to ensure that all residents currently on thickened liquids have the physicians orders reflected on theirdietary slip.<br>·All staff educated regarding theprovision of thickened liquids and how to identify residents that are onthickened liquids.<br>**What measures will be put intoplace or what systemic changes you will make to ensure that the deficientpractice does not recur?**<br>.<br>·An in-service will be completed by theDirector of Nursing and/or designee by May 5, 2016, or prior | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155152 | | 04/15/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONTICELLO HEALTHCARE | 1120 N MAIN ST<br>MONTICELLO, IN 47960 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | water.<br><br>3.1-21(a)(3) | | to returning towork for all staff on the provision of thickened liquids and how to identifyresidents that are on thickened liquids.<br><br>**How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place?**<br><br>·CQI audit tools “Altered FluidConsistency”, will be utilized by the Director of Nursing and/or designee tomonitor compliance. Audits will becompleted Daily X5 days, weekly X 4 weeks, monthly X 2 months, and quarterlythereafter for at least two quarters.<br>·Results of Audit tools will be presentedto the CQI Committee monthly to review for compliance and follow-up. Identifiednoncompliance may result in staff re-education and/or disciplinary action.<br>·If threshold of 95% is not achieved, anaction plan will be developed to achieve desired threshold. Data will be submitted to the CQI committeefor review and follow up. | |
| F 0406<br>SS=D<br>Bldg. 00 | 483.45(a)<br>PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES<br>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155152 | | 04/15/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONTICELLO HEALTHCARE | 1120 N MAIN ST<br>MONTICELLO, IN 47960 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. | | | |
| | Based on record review and interview, the facility failed to ensure a resident who required a yearly review from the Pre-Admission Screening Level Two assessment received one in a timely manner for 1 of 1 residents reviewed for Pre-Admission Screening of the 1 resident who met the criteria for Pre-Admission Screening. (Resident #103)<br><br>Finding includes:<br><br>The record for Resident #103 was reviewed on 4/12/16 at 1:30 p.m. The resident's diagnoses included, but were not limited to, depression, schizophrenia, anxiety, and diabetes mellitus.<br><br>The Quarterly Minimum Data Set assessment dated 2/3/16 indicated the resident was cognitively impaired and the Pre-Admission screening Level Two assessment indicated the resident had a mentally ill disability.<br><br>Review of the Pre-Admission screening | F 0406 | **What corrective action(s) willbe accomplished for those residents found to have been affected by thedeficient practice?**<br>·Resident #103 Level II screeningcomplete.<br>**How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?**<br>·All residents who require annual LevelII screenings have the potential to be affected by the alleged deficientpractice.<br>·All residents receiving Level II serviceshave been audited to determine if any resident requires an annual screening.<br>**What measures will be put intoplace or what systemic changes you will make to ensure that the deficientpractice does not recur?**<br>.<br>·All residents requiring Level IIservices to be tracked by Social Services Director and/or designee using LevelII Tracking Tool.<br><br>**How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put** | 05/05/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155152 | | 04/15/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONTICELLO HEALTHCARE | 1120 N MAIN ST<br>MONTICELLO, IN 47960 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | for the resident indicated the last annual review was completed on 10/10/14. The annual review indicated the next case review would be in 2015.<br><br>Interview with the Social Services Director on 4/12/16 at 1:45 p.m., indicated the resident's annual review was missed and she had just started recently at this facility, so she did not know the resident was due for a yearly review. She further indicated she had spoken with Social Services at Wabash and they were to review the resident in a couple of weeks.<br><br>*3.1-23(a)(2)* | | **into place?**<br><br>·CQI audit tools "Unnecessary Medications"and "Psychoactive Management", will be utilized by the Director of Nursingand/or designee to monitor compliance. Audits will be completed weekly X 4 weeks,monthly X 2 months, and quarterly thereafter for at least two quarters.<br>·Results of Audit tools will be presentedto the CQI Committee monthly to review for compliance and follow-up. Identifiednoncompliance may result in staff re-education and/or disciplinary action.<br>·If threshold of 95% is not achieved, anaction plan will be developed to achieve desired threshold. Data will be submitted to the CQI committeefor review and follow up. | |
| F 0441<br>SS=D<br>Bldg. 00 | 483.65<br>INFECTION CONTROL, PREVENT SPREAD, LINENS<br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155152 | | 04/15/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONTICELLO HEALTHCARE | 1120 N MAIN ST<br>MONTICELLO, IN 47960 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | | | |
| | Based on observation, interview and record review, the facility failed to ensure proper infection control standards and practices were followed related to a resident's tracheostomy (surgical airway through the neck) tubing lying on the floor for 1 of 1 residents reviewed for tracheostomy care. (Resident #140)<br><br>Finding includes:<br><br>On 4/12/16 at 9:37 a.m., Resident #140 was observed lying in bed watching television. The resident's tracheostomy tubing was observed lying on the floor. | F 0441 | **What corrective action(s) willbe accomplished for those residents found to have been affected by thedeficient practice?**<br>·On 4/12/16 a basin was provided toResident #140 to prevent her tracheostomy tubing from coming into contact withthe floor.<br>·Resident #140 successfully discharged tohome on 4/13/16.<br>**How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?** | 05/05/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | On 4/12/16 at 10:16 a.m., Resident #140 was observed receiving tracheostomy care from LPN #1. The resident's tracheostomy tubing was observed lying on the floor. After the resident's tracheostomy care was complete, LPN #1 indicated she was unsure if the tracheostomy tubing should be on the floor or not. She picked up the tubing and placed it on the night stand. She further indicated she was unsure how to keep it off the floor because when the resident would get up to use the restroom the tubing would still be touching the floor.<br><br>Interview with the Director of Nursing on 4/12/16 at 11:46 a.m., indicated the facility did not have a specific policy regarding if oxygen tubing should be touching floor. She indicated they do put oxygen tubing in bags so it does not touch the floor. She further indicated they had put the residents tracheostomy tubing that was touching the floor into a wash basin so it would no longer touch the floor.<br><br>Record review for Resident #140 was completed on 4/12/16 at 10:53 a.m. The resident's diagnoses included, but were not limited to, anemia, heart failure, hypertension, COPD (Chronic | | ·All residents who requiring tracheostomycare have the potential to be affected by the alleged deficient practice.<br>·Complete audit of residents currently inthe facility to determine if any resident requires tracheostomy care.<br>·As of May 5, 2016, there are noresidents in the facility requiring tracheostomy care.<br>**What measures will be put intoplace or what systemic changes you will make to ensure that the deficientpractice does not recur?** .<br>·An in-service will be completed by theDirector of Nursing and/or designee by May 5, 2016, or prior to returning towork for all staff on the importance of keeping tubing including tracheostomytubing off the floor and its importance proper infection control. **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place?**<br>·CQI audit tools “Oxygen Therapy”, will beutilized by the Director of Nursing and/or designee to monitor compliance. Audits will be completed Daily X5 days, weeklyX 4 weeks, monthly X 2 months, and quarterly thereafter for at least twoquarters.<br>·Results of Audit tools will be presentedto the CQI Committee monthly to review for compliance | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONTICELLO HEALTHCARE | 1120 N MAIN ST<br>MONTICELLO, IN 47960 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Obstructive Pulmonary Disease) and respiratory failure.<br><br>The 5 day Minimum Data Set (MDS) assessment completed on 4/1/16 indicated the resident had received tracheostomy care.<br><br>A Nursing Note on 4/4/16 at 4:01 p.m., indicated the resident had some redness around the tracheostomy site with a small amount of yellow colored drainage observed. The resident had received a new order for clindamycin (antibiotic) 450 mg (milligrams) three times a day for 10 days.<br><br>3.1-18(a) | | and follow-up.<br>Identifiednoncompliance may result in staff re-education and/or disciplinary action.<br>·If threshold of 95% is not achieved, anaction plan will be developed to achieve desired threshold. Data will be submitted to the CQI committeefor review and follow up. | |
| F 0465<br>SS=E<br>Bldg. 00 | 483.70(h)<br>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>Based on observation and interview, the facility failed to maintain an environment that was clean and in a state of good repair, related to marred walls and discolored window panes and windowsills for 3 of the 4 Halls throughout the facility. (North Hall, B-C-D Hall and the West Hall) | F 0465 | **What corrective action(s) willbe accomplished for those residents found to have been affected by thedeficient practice?**<br>1.NorthHall<br>1.InRoom #143, the wall by the heating and air conditioning unit was repaired andpainted.<br>2.InRoom #146, the wall above the TV was repaired and | 05/06/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Findings include:<br><br>During the Environmental Tour on 4/14/16 from 1:15 p.m. until 1:55 p.m. with the Administrator and the Director of Nursing, the following was observed:<br><br>1. North Hall:<br><br>a. In Room #143, the wall was gouged by the air/heating unit. There were two residents who resided in this room.<br><br>b. In Room #146. the wall was gouged above the TV. There were two residents who resided in this room.<br><br>c. In Room #153, the wall was gouged behind the head board by bed B and a brown stain was noted on the windowsill. There were two residents who resided in this room.<br><br>d. In Room #154, the wall was gouged above the bed and behind the headboard, and there were black mars on the wall beside bed A. There were two residents who resided in this room.<br><br>e. In Room #156, the windowpane had chipped paint and a large brown discoloration on the side of the window panel. The bedroom wall also had chipped paint. There were two residents | | painted.<br>3.InRoom #153, the wall behind the headboard and the windowsill was repaired andpainted.<br>4.InRoom #154, the walls in the bedroom were repaired and painted.<br>5.InRoom #156, the windowpane and the walls of the room were repaired and painted.<br>2.B-C-D<br>1.InRoom #128, the bottom of the inside of the bathroom doors were cleaned andpainted.<br>2.InRoom #130, the bathroom wall was repaired and painted.<br>3.InRoom #136, the walls in the bedroom were repaired and painted / the mars on thewall in the bathroom were repaired and painted.<br>4.InRoom #139, the gouge in the bedroom by bed A and the gouge in the gouged wallsin the bathroom were repaired and painted.<br>5.InRoom #140, the chipped paint on the wall beside bed A and the black marks onthe bottom of the inside of the bathroom doors were repaired and painted.<br>3.WestHall<br>1.InRoom #161, the wall next to bed B was repaired and painted; the bathroom wallswere repaired and painted; and the toilet paper holder was replaced.<br>2.InRoom #166, the wall across from the bathroom door | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | who resided in this room.<br><br>2. B-C-D Hall:<br><br>a. In Room #128, the bottom of the inside bathroom doors had black mars. There were 3 residents who shared this bathroom.<br><br>b. In Room #130, there was chipped paint on the bathroom wall. There were 4 residents who shared this bathroom.<br><br>c. In Room #136, the wall by both beds had chipped paint and there were black mars on the bathroom walls. There were two resident who resided in this room and four residents who shared this bathroom.<br><br>d. In Room #139, the wall was gouged by bed A and the bathroom had gouged walls. There were two residents who resided in this room and four residents who shared this bathroom.<br><br>e. In Room #140, the wall beside bed A had chipped paint and there were black mars on the bottom inside of the bathroom doors. There were two residents who resided in this room and four residents who shared this bathroom.<br><br>3. West Hall: | | and the bathroom walls wererepaired and painted.<br>3.InRoom #167, the bathroom walls wererepaired and painted; the sink was recaulked; and the inside of the bathroomdoors have been repaired.<br>4.InRoom #170, the bathroom walls were repaired and painted..<br>5.InRoom #171, the bathroom walls wererepaired and painted.<br>**How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?**<br>·All residents have the potential to beaffected by the alleged deficient practice.<br>·An inspection of all resident rooms andbathrooms was conducted by the executive director to identify and repair any rustedtoilet paper holders; caulked sinks; marred, chipped or gouged walls; and marred doors.<br>·During Customer service room rounds, thecustomer service Representatives will note any needed repairs and report themto the Maintenance Supervisor.<br>·Customer Service Representatives werere-educated by the executive director related to noting any needed repairs andreporting them to the Maintenance Supervisor by May 5, 2016. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | a. In Room #161, the wall next to bed B was marred, the bathroom walls were marred and the toilet paper holder was rusted. There were two residents who resided in this room and four residents that shared this bathroom.<br><br>b. In Room #166, the wall was marred across from the bathroom door and the bathroom walls were marred. There were two residents who resided in this room and four residents who shared this bathroom.<br><br>c. In Room #167's bathroom, the walls were marred, the caulk around the sink was cracked and the inside bottom of the doors were marred. There were four residents that shared this bathroom.<br><br>d. In Room #170 the bathroom walls were marred. There were four residents who shared this bathroom.<br><br>e. In Room #171 the bathroom walls were marred. There were four residents who shared this bathroom.<br><br>Interview with the Administrator after the tour, indicated all of the above were in need of repair and or cleaning.<br><br>3.1-19(f) | | ·During daily cleaning, housekeepingstaff will note any needed repairs and report them to the MaintenanceSupervisor.<br>·Housekeeping staff were re-educated bythe Maintenance Supervisor related to noting any needed repairs and reporting them to the Maintenance Supervisor by May 5, 2015.<br>·The Maintenance Supervisor or hisdesignee will be responsible to ensure that all repairs are completed within areasonable time frame.<br>·Non-compliance with facility policy and proceduremay result in employee re-education and/or disciplinary action.<br>**What measures will be put intoplace or what systemic changes you will make to ensure that the deficientpractice does not recur?** .<br>·It is the practice of this provider toensure that the resident's environment is in good repair.<br>·During Customer service room rounds, thecustomer service Representatives will note any needed repairs and report themto the Maintenance Supervisor.<br>·Customer Service Representatives werere-educated by the executive director related to noting any needed repairs andreporting them to the Maintenance Supervisor by May 5,2016.<br>·During daily cleaning, housekeepingstaff will note any | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155152 | | 04/15/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONTICELLO HEALTHCARE | 1120 N MAIN ST<br>MONTICELLO, IN 47960 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | needed repairs and report them to the MaintenanceSupervisor.<br>·Housekeeping staff were re-educated bythe Maintenance Supervisor related to noting any needed repairs and reporting them to the Maintenance Supervisor by May 5, 2016.<br>·The Maintenance Supervisor or hisdesignee will be responsible to ensure that all repairs are completed within areasonable time frame.<br>·The Executive Director or his designeewill review repair list weekly to ensure repairs are within a reasonable timeframe.<br>·Non-compliance with facility policy and proceduremay result in employee re-education and/or disciplinary action. **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place?**<br>·CQI audit tools "Resident RoomMaintenance CQI" will be utilized by theInterdisciplinary Team to monitor compliance. Audits will be completed weekly X 4 weeks,monthly X 2 months, and quarterly thereafter for at least two quarters.<br>·Results of Audit tools will be presentedto the CQI Committee monthly to review for compliance and follow-up. Identifiednoncompliance may result in staff re-education and/or disciplinary action. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 04/15/2016 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONTICELLO HEALTHCARE | 1120 N MAIN ST<br>MONTICELLO, IN 47960 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | ·If threshold of 95% is not achieved, anaction plan will be developed to achieve desired threshold. Data will be submitted to the CQI committeefor review and follow up.<br>·The Maintenance Supervisor or designeeis responsible to maintain and document weekly repair list. | |