STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	155152		05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTICELLO HEALTHCARE	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
K 0000 Bldg. 01	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). Survey Date: 05/26/16 Facility Number: 000072 Provider Number: 155152 AIM Number: 100287440 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. This facility is located in a fully sprinklered facility of Type V (000) construction and was fully sprinklered 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 buildings due to different construction Types. The facility has a fire alarm system with hard wired	K 0000		

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:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155152		05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTICELLO HEALTHCARE	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
	smoke detection in the basement, corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has a capacity of 116 and had a census of 89 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas which provide facility services were sprinklered except for the detached shed and building used for facility storage which were not sprinklered. Quality Review completed on 06/01/16 - DA			
K 0020 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 Based on observation and interview, the facility failed to ensure 1 of 1 vertical openings were protected with a one hour fire rated door. This deficient practice could affect 24 residents on 100 hall, first floor as well as visitors and staff. Findings include: Based on observation on 05/26/16 at 2:30 p.m. the stairway fire door separating the	K 0020	1. No residents were found to have been affected.The fire door separating the first floor and the basement has been replaced with one of a fire rating of one hour. 24 residents on 100 hall as well as staff and visitors have the potential to be affected. All fire doors were observed to have the correct fire rating. Maintenance or designee will continue to observe fire doors throughout the building quarterly or more often as needed, to ensure they are	06/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155152		05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTICELLO HEALTHCARE	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
	basement from the first floor had a twenty minute fire rating. Based on interview concurrent with the observation with the Maintenance Supervisor it was acknowledged the fire door was only a twenty minute door and needed to be a one hour fire rating. 3.1-19(b)		proper ratings. A CQI tool will be completed following each observation of the fire doors and submitted to the CQI committee for 1 year. If threshold of 95% is not achieved,an action plan will be developed to ensure compliance. All corrective actions will be completed on or before 6/24/16.	
K 0038 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 6 of 7 delayed egress locks met all conditions of LSC 7.2.1.6.1 so it would be readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that:	K 0038	No resident were found to have been affected.The sign “Push door until alarm sounds. Door will open in fifteen seconds” was added to all exits with delayed egress locks. All residents, staff and visitors have the potential to be affected. All exits with delayed egress locks were observed to have the appropriate sign, “Push door until alarm sounds. Door will open in fifteen seconds” Maintenance or designee will continue to observe exits with delayed egress locks throughout the building quarterly or more often as needed, to ensure they have a sign stating “Push door until alarm sounds. Door will open in fifteen seconds” A CQI tool will be completed following each observation of the exits with	06/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155152		05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTICELLO HEALTHCARE	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) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6. (b) The doors unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15		delayed egress locks and submitted to the CQI committee for 1 year. If threshold of 100% is not achieved, an action plan will be developed to ensure compliance. All corrective actions will be completed on or before 6/24/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155152		05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTICELLO HEALTHCARE	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
	SECONDS This deficient practice could affect all residents as well as staff and visitors. Findings include: Based on observations on 05/26/16 during the tour between 1:30 pm. to 3:30 p.m. with the Maintenance Supervisor only the Front exit door provided with a delayed egress lock had a sign stating "Push the door until alarm sounds. Door will open in fifteen seconds". Based on interview concurrent with the observations, it was acknowledged by the Maintenance Supervisor all the other exits with delayed egress locks were not provided with signs complying with requirement (d). 3.1-19(b)			
K 0051 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155152		05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTICELLO HEALTHCARE	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
	are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6			
	Based on observation and interview, the facility failed to identify the location of the breaker for 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff. Findings include: Based on observation on 05/26/16 at 1:54 with the Maintenance Supervisor the breaker for the fire alarm panel could not be located. Based on interview	K 0051	No residents were found to have been affected. The fire alarm circuit control has been located. Maintenance staff were re-inserviced on location of fire alarm circuit. All residents, staff and visitors have potential to be affected. Fire alarm circuit control has been located and is identified in red lettering “Fire alarm circuit control” and is only accessible to authorized personnel. Maintenance or designee will continue to observe fire alarm circuit control in the building quarterly or more often as needed, to ensure location, labeling and security. A CQI tool will be completed following each observation of the fire alarm circuit and submitted to the CQI committee for 1 year. If threshold of 100% is not achieved, an action plan will be developed to	06/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155152		05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTICELLO HEALTHCARE	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
	concurrent with the observation with the Maintenance Supervisor it was acknowledged the location of the fire alarm circuit breaker was unknown. 3.1-19(b)		ensure compliance. All corrective actions will be completed on or before 6/24/16.	
K 0054 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 Based on record review and interview, the facility failed to ensure 54 of 54 smoke detectors had been tested to ensure the detectors were within their listed and marked sensitivity range. LSC Section 9.6.1.3 says the provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2.1 requires that each smoke detector be within its listed and marked sensitivity range by testing using either: (a) A calibrated test method, or (b) The manufacturer's calibrated and sensitivity test instrument, or (c) Listed control equipment arranged for that purpose, or (d) A smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable	K 0054	No residents were found to have been affected. The smoke detector sensitivity test has been done. All residents, staff and visitor have the potential to be affected. The smoke detector sensitivity test was completed. Smoke detector sensitivity test was observed to be up to date. Maintenance or designee will continue to ensure smoke detector sensitivity test is up to date quarterly or more often as needed to ensure smoke detector sensitivity test is up to date. A CQI tool will be completed following each observation of the sprinkler pipes and submitted to the CQI committee for 1 year. If threshold of 100% is not achieved, an action plan will be developed to ensure compliance. All corrective actions will be completed on or before 6/24/16.	06/25/2016

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 05/26/2016
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
	sensitivity range, or (e) Other calibrated sensitivity test method acceptable to the authority having jurisdiction. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. Smoke detector sensitivity shall be checked within one year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detectors have remained within their listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended not to exceed five years. NFPA 72, 7-5.2 requires that inspection, testing and maintenance reports shall be provided for the owner or a designated representative. It shall be the responsibility of the owner to maintain these records for the life of the system and to keep them available for examination by the authority having jurisdiction. Paper or electronic media shall be acceptable. This deficient practice could affect any resident, staff and visitor in the facility. Findings include: Based on review of Smoke Detector Inspection records on 05/26/16 at 4:05 p.m., with the Maintenance Supervisor			

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 05/26/2016
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 last smoke detector sensitivity test was done in January, 2014. No other documentation was available to review for the current sensitivity test which was due in January 2016. Based on interview on 05/26/16 at 4:08 p.m., with the Maintenance Supervisor it was acknowledged there was no written documentation or other evidence the 54 smoke detectors in the facility had been tested for sensitivity since January, 2014. 3.1-19(b)			
K 0056 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 1. Based on observation and interview, the facility failed to ensure 4 of 5 steel armover sprinkler pipes observed in the Memory Care lounge was installed in accordance with the requirements of NFPA 13, Standard for the Installation of	K 0056	1. No residents were found to have been affected.The steel armover sprinkler pipe has been corrected in corridor above residentroom #125, in corridor above resident room #131, in corridor next to maindining room, in corridor above resident room	06/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155152		05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTICELLO HEALTHCARE	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
	Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice could affect all residents in the building if the sprinkler system required repair as well as staff or visitors. Findings include: Based on observations on 05/26/16 during the tour between 2:15 p.m. to 3:30 p.m. with the Maintenance Supervisor, the following metal sprinkler pipes were observed to be over twenty four inches in length and unsupported: a. The armover in corridor above resident room # 125 measured to be forty one inches in length. b. The armover in corridor above resident # 131 measured to be fifty three inches in length. c. The armover in corridor next to Main dining room measure to be thirty eight inches in length. d. The armover in corridor above resident room # 141 measured to be thirty one inches in length. e. The armover in resident room # 141 measured to be seventy inches in length. Based on interview on 05/26/16		#141, and in resident room #141. All residents in the building have thepotential to be affected. All sprinkler pipes have been observed to ensure theyare properly installed. Maintenance or designee will continue to observesprinkler pipes throughout the building quarterly or more often as needed, toensure they are properly installed. A CQI tool will be completed following eachobservation of the sprinkler pipes and submitted to the CQI committee for 1year. If threshold of 95% is not achieved, an action plan will be developed to ensurecompliance. All corrective actions will be completed on or before 6/24/16. 2. No residents were found to have been affected.The sprinkler heads located in resident room #141 measuring less than six feetapart have been corrected. 14 residents of C hall have the potential to beaffected. All sprinkler pipes have been observed to ensure they are properlyinstalled. Maintenance or designee will continue to observe sprinkler pipesthroughout the building quarterly or more often as needed, to ensure they areproperly installed. A CQI tool will be completed following each observation ofthe sprinkler pipes and submitted to the CQI committee for 1 year. If thresholdof 95% is not achieved, an action plan will be developed to ensure compliance.All	

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 05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTICELLO HEALTHCARE	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
	concurrent with the observations with the Maintenance Supervisor it was acknowledged the aforementioned steel sprinkler pipe armovers exceeded twenty four inches in length and were unsupported. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure sprinkler heads were spaced a minimum of 6 feet apart for 1 of 1 automatic sprinkler systems. NFPA 13, Section 5-6.3.4, " Minimum Distance between Sprinklers ", states sprinklers shall be spaced not less than 6 feet on center. This deficient practice could affect 14 residents on Center hall as well as staff or visitors. Findings include: Based on observation on 05/26/16 at 2:59 p.m. with the Maintenance Supervisor, two pendant sprinkler heads located below the ceiling in resident room # 141 was measured to be five feet apart. Based on interview concurrent with the observation with Maintenance Supervisor, it was acknowledged the aforementioned sprinkler heads observed were less than six feet apart. 3.1-19(b)		corrective actions will be completed on or before 6/24/16. 3. No residents were found to be affected. Theunprotected sprinkler space at the top of the stairwell has been corrected. Allresidents, staff and visitors utilizing the 100 hall south exit have thepotential to be affected. All sprinkler pipes have been observed to ensure theyare properly installed. Maintenance or designee will continue to observesprinkler pipes throughout the building quarterly or more often as needed, toensure they are properly installed. A CQI tool will be completed following eachobservation of the sprinkler pipes and submitted to the CQI committee for 1year. If threshold of 95% is not achieved, an action plan will be developed toensure compliance. All corrective actions will be completed on or before6/24/16.	

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 05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTICELLO HEALTHCARE	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
	3. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 1 stairwells in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice could affect any resident, staff and visitor utilizing the 100 hall south exit. Findings include: Based on observation on 05/26/16 at 2:18 p.m. with the Maintenance Supervisor, inside and at the top of the stairwell just before it takes a ninety degree turn to down to the basement there was an unprotected space which requires sprinkler head. Based on interview concurrent with the observation it was acknowledged by the Maintenance Supervisor the top portion of the stairwell was left without sprinkler protection. 3.1-19(b)			
K 0144 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised			

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 05/26/2016
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
	under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Based on record review and interview, the facility failed to ensure monthly load tests for 2 of 2 new emergency generators installed December 2015 were conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all	K 0144	1. No residents were found to be affected. Thegenerator system testing has been corrected to achieve 30 percent load monthly.Maintenance staff has been re-inserviced on generator system testing monthlyload test. All residents, staff and visitors have potential to be affected. Generatorsystem testing has been observed to ensure that a monthly load test of 30percent is reached. Maintenance or designee will continue to observe monthlygenerator system testing quarterly or more often as needed, to ensure that amonthly load test of 30 percent is reached. A CQI tool will be completedfollowing each observation of the generator system testing and submitted to theCQI committee for 1 year. If threshold of 100% is not achieved, an action planwill be developed to ensure compliance. All corrective actions will becompleted on or before 6/24/16.	06/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	155152		05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTICELLO HEALTHCARE	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
	residents as well as staff and visitors. Findings include: Based on review of Generator System Testing records and Maintenance logs on 05/26/16 at 4:34 p.m. with the Maintenance Supervisor, the amperage during load could not be verified to be at thirty percent of the EPS nameplate rating for the past five months and no other method was used to document monthly load. Based on interview concurrent with record review with the Maintenance Supervisor, it was acknowledged the facility had been running the generators monthly under load, but could not achieve 30 percent load when calculated and no other equivalent method was used to comply with percentage of load capacity for the past twelve months. 3.1-19(b)			
K 0147 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 1. Based on observation and interview, the facility failed to ensure 3 of 3 extension cords observed were not used as a substitute for fixed wiring. LSC	K 0147	No residents were found to beaffected. Extension cords in the basement and service corridor were removed. Allresidents, staff and visitors	06/25/2016

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 05/26/2016
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
	19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 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 would affect all residents as well as visitors and staff. Findings include: Based on observations on 05/26/16 during the tour from 2:00 pm. to 4:00 p.m. with the Maintenance Supervisor, the following was noted: a) In Service corridor an extension cord was used to power a large fan. b. In the basement an extension cord was used to power an air compressor. c. In the basement an extension cord was used to power a fan. Based on interview it was acknowledged by the Maintenance Supervisor at the time of observations extension cords were used in the aforementioned areas. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 2 electrical boxes observed in the Laundry		have the potential to be affected. All extension cords have been removed.Maintenance or designee will continue to observe building quarterly or moreoften as needed, to ensure the use of no extension cords. A CQI tool will becompleted following each observation of extension cords and submitted to theCQI committee for 1 year. If threshold of 95% is not achieved, an action planwill be developed to ensure compliance. All corrective actions will becompleted on or before 6/24/16. No residents were found to beaffected. The nine unprotected wires in the two electrical junction boxes inthe laundry closet were corrected. 24 residents on 100 hall have the potentialto be affected. The unprotected electrical junction boxes were covered. Allelectrical junction boxes were observed to unsure no unprotected wires.Maintenance or designee will continue to observe electrical junction boxesthroughout the building quarterly or more often as needed, to ensure electricaljunction boxes are properly covered. A CQI tool will be completed followingeach observation of the electrical junction boxes and submitted to the CQIcommittee for 1 year. If threshold of 95% is not achieved, an action plan willbe developed to ensure compliance. All corrective actions will be completed onor before 6/24/16.	

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 05/26/2016
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
	closet confined electrical wires in an electrical junction box with a cover. NFPA 70, National Electrical Code, 1999 Edition, 1999 Edition, Article 370-28(c) requires exposed electrical wires be confined within a junction box with a cover compatible with the box. This deficient practice could affect 24 residents on 100 hall as well as visitors and staff. Findings include: Based on observations on 05/26/16 at 3:31 p.m. with the Maintenance Supervisor, a total of nine electrical wires were exposed within two electrical junction boxes without a cover in the closet of the Laundry room. Based on interview concurrent with the observations it was acknowledged by the Maintenance Supervisor, the electrical wires described were exposed and not protected within the junction boxes with a cover. 3.1-19(b)			