DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/26/2025 FORM APPROVED OMB NO. 0938-0391

				ER/SUPPLIER/CLIA (CATION NUMBER: A. BUILDING 01, 02		(X3) DATE SURVEY COMPLETED	
		155152	B. WING _		06	5/25/2025	
NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP COI 1120 N MAIN ST MONTICELLO, IN 47960	•		
PREFIX (EACH D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
{K 000} INITIAL COM	INITIAL COMMENTS			{K 000}			
Recertification conducted or 06/25/25. Review Date: Facility Number: Facility Number: Monticello Hewith Requirer Medicare/Mew Life Safety fron National Fire Life Safety Conducted or 06/25/25. Review Date:	Paper compliance to the Life Safety Code Recertification and State Licensure Survey conducted on 06/11/25 was completed on 06/25/25. Review Date: 06/25/25 Facility Number: 000072 Provider Number: 155152 AIM Number: 100287440 Monticello Healthcare was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. INITIAL COMMENTS Paper compliance to the Life Safety Code Recertification and State Licensure Survey conducted on 06/11/25 was completed on 06/25/25. Review Date: 06/25/25		{K 00	00}			
Provider Num	Facility Number: 000072 Provider Number: 155152 AIM Number: 100287440						
with Requirer Medicare/Me Life Safety fro National Fire Life Safety C	ments for F dicaid, 42 om Fire an Protection ode (LSC)	vas found in compliance Participation in CFR Subpart 483.90(a), d the 2012 Edition of the Association (NFPA) 101, , Chapter 19, Existing		TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 000072

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02		(X3) DATE SURVEY COMPLETED		
		155152	B. WING			R 06/25/2025	
NAME OF PROVIDER OR SUPPLIER				Г	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	25/2025
					1120 N MAIN ST		
MONTICELLO HEALTHCARE					MONTICELLO, IN 47960		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF		PROVIDER'S PLAN OF CORRECTION	CORRECTION (X5)	
PREFIX			PREFI		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG			TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
{K 000}	OO} Continued From page 1			000	0}		
	Health Care Occupancies and 410 IAC 16.2.				1		
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