STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165279	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/12/2025
NAME OF PROVIDER OR SUPPLIER Monticello Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Pinehaven Drive Monticello, IA 52310	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, record review, resident and staff interviews the facility failed to prevent a resident to resident altercation, involving Resident #1 and Resident #2, for 1 out of 2 incidents reviewed. The facility identified a census of 48 residents. Findings include: The Minimum Data Set(MDS) assessment tool, dated 8/21/25, listed diagnoses for Resident # 2 which included anemia, hypertension (high blood pressure), arthritis and Non-Alzheimer's Dementia, anxiety and post traumatic stress disorder. The MDS stated the resident was independent for transferring and listed the resident's Brief Interview for Mental Status(BIMS) score as 6 out of 15, indicating severe cognitive impairment. The Minimum Data Set(MDS) assessment tool, dated 8/8/25, listed diagnoses for Resident #1 which included hypertension, renal insuffieciency and diabetes. The MDS revealed the resident's Brief Interview for Mental Status(BIMS) score was15 out of 15, which indicated no cognitive impairment. An incident report dated 6/27/25 at 5:15 PM revealed Resident #2 elbowed another resident in the stomach. No injuries reported and the residents immediately separated.An incident report dated 9/22/25 at 8:40 AM revealed Resident #2 shoved another resident in her room. No injuries reported from the incident and the residents were immediately separated. Review of Resident #1's Progress Note dated 10/2/25 at 11:55 AM, date of incident not included, revealed Resident #1 had been slapped by Resident #2, Resident #1 had swung their left arm back at Resident #2, and Resident #1 didn't know where she had hit Resident #2. An incident report dated 10/2/25 at 11:50 AM revealed Resident #2 slapped Resident #1 in Resident #1's room. Resident #2 was standing slightly behind the other resident's right wheelchair handle. The nurse separated the residents immediately. No injury observed on either resident. Resident #1 stated she trespassed and pointing to Resident #2 stated she slapped me and pointed to her right cheek, she admitted she slapped her back. Resident #2 denied she slapped Resident #1.The Care Plan initiated on 6/27/25 and revised on 7/3/25 revealed Resident #2 has physical behavioral symptoms towards others (for example: hitting, kicking, pushing and scratching) The interventions directed 15 minute checks initiated on 10/2/25. Another intervention initiated on 9/23/25 directed staff when resident becomes physically abusive, keep distance between the resident and others (for example: staff, other residents and visitors). On 10/23/25 at 1:10 PM Resident #1 stated Resident #2 came into their room and [Resident #1] was in their wheelchair, and [Resident #2] ordered me out of my room. [Resident #1] said this was their room and [Resident #2] said no it wasn't it, was hers, and [Resident #2] slapped [Resident #1] on the right side of [Resident #1's] face. [Resident #2] was agitated because she thought it was her and [Resident #2] knew I (Resident #1) couldn't fight back. Resident #1 explained Resident #2 had come into Resident #1's room before but had never hit them.On 10/27/25 at 10:45 AM Resident #2 observed lying in her bed partially asleep. No one was in the room with her. On 10/27/25 at 2:00 pm Staff E, Certified Nursing Assistant (CNA) stated Resident #2 has declined and she doesn't usually know where she is mentally or physically. She needs to be redirected or an argument might break out. If an argument breaks out we separate them (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and chart the behaviors. Resident #2 doesn't have 1 on 1 supervision. We just try to keep track of her, the best we can do is redirect her. We lay her down and not a minute later she will be right back up. Sometimes activities will help but she doesn't sit still for them or anything else. On 10/30/25 at 9:15 AM Staff A, Licensed Practical Nurse (LPN) stated they were the nurse for the incident with Resident #1 and Resident #2 on 10/2/25. [Staff A] heard loud voices, walked in the room, and the residents were arguing. Resident #1 stated Resident #2 slapped her. Staff A explained Resident #2 was very confused, was declining, and was more agitated. She got irritated much faster.On 11/12/25 at 12:26 PM the Director of Nursing (DON) stated they did have Resident #2 on 15 minute checks after each of the resident to resident incidents but they were discontinued after moving Resident #2 to a different hall. The DON explained felt that had separated the residents and did not need the 15 minute checks any longer, resident interviews were done, and no one had concerns with safety issues for other residents. On 11/12/25 at 4:08 PM the Administrator stated had moved Resident #2 to the opposite side of the building after this incident with Resident #1. The plan was for the residents involved to be separated. Resident #2 had not had any slapping incidents prior to the one with Resident #1, that was one of the reasons we are attempting to find alternate placement was her behaviors were progressing. Per the Administrator, did not think at that time Resident #2 needed one on one since it was the first slapping incident, we felt moving her room location would be sufficient. This was the first physical alteration and she had not had any issues prior to that. The facility provided a policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated July 2024. The policy directed in the section of Prevention of Abuse: The facility will identify, through ongoing assessment, high-risk situations where abuse, neglect or misappropriation of resident property may occur and provide appropriate intervention in such occasions. Situations that may indicate a higher risk for abuse to occur include, but are not limited to, verbally/physically/sexually aggressive behavior, wandering into other resident's rooms or rummaging through their property, the presence of history of aggressive/violent/self-injurious behaviors, communication deficits, or those residents most dependent upon staff for their care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff and resident interviews the facility failed to provide adequate supervision to prevent resident to resident behaviors (Resident # 2, Resident #4, Resident #6, Resident #8, Resident #9). The facility identified a census of 48 residents. Findings include:1.) The Minimum Data Set(MDS) assessment tool, dated 8/21/25, listed diagnoses for Resident #2 which included anemia, hypertension (high blood pressure), arthritis and Non-Alzheimer's Dementia, anxiety and post traumatic stress disorder. The MDS stated the resident was independent for transferring and listed the resident's Brief Interview for Mental Status(BIMS) score as 6 out of 15, which indicated severe cognitive impairment. An incident report from 10/27/25 at 7:00 PM revealed Resident #4 found lying in the hall outside her room and Resident #2 walking away yelling profanities at her. Resident #4 stated this lady attacked me and started yelling at me and I yelled back. Review of Resident #4's Progress Note 10/27/25 at 7:00 PM revealed Resident #2 struck Resident #4 left lower jaw. No injuries noted. The care plan with a revision date 7/3/25 revealed Resident #2 has physical behavioral symptoms toward others (for example: hitting, kicking, pushing and scratching) the following interventions were implemented on the dates indicated:-7/3/25 when a resident becomes physically abusive, move to a quiet, calm environment.- 9/23/25 the intervention when a resident becomes physically abusive, keep distance between the resident and others (e.g. staff, other residents, visitors).- 10/2/25 directed 15 minute checks.On 11/12/25 at 12:26 PM the Director of Nursing stated on 10/27/25 the incident with Resident #4 happened and Resident #2 was walking the hallway. Resident #4 came out of her room to put her food tray in the hallway. Resident #4 does not like people around her room or people next to her room. Resident #4 shoved Resident #2 and she called her a name and then slapped her across the face. Resident #4 denied any injury, she slapped me just once. The facility then placed Resident #2 immediately on 1:1 supervision by staff and placed Resident #4 on 15 minute checks. The facility provided a policy titled Management of Inappropriate Resident Behavior: Resident to Resident Aggression dated 2/6/17. The policy directed if aggressive behavior is witnessed or reported, intervene immediately and separate the residents involved. The policy failed to direct further interventions to prevent further incidents. 2.)The MDS assessment dated [DATE] for Resident #8 revealed the resident was independent with transfers and ambulation. The MDS listed the resident's BIMS score was 9 out of 15, which indicated moderate cognitive impairment. Review of Resident #8's Care Plan revealed the resident had impaired cognition related to cerebrovascular accident (CVA). The intervention initiated 11/3/25 and revision on 11/7/25 directed staff there is to be no sexual contact with Resident #9. The care plan did not have interventions to prevent further sexual contact with other residents. a. The incident report dated 11/2/25 at 4:15 PM revealed Resident #8 sitting with a female resident watching television and holding hands. Nurse observed Resident #8 groping female resident's breast. Resident #8 then was observed by other staff and residents, again touching the female's breast and putting her hand in his groin. Residents were separated at this time and manager on call notified. Review of an incident report for the same date and time identified the female resident as Resident #9. b. An incident report on 11/7/25 at 5:00 PM revealed Resident #6 was sitting in the dining room with Resident #8 a male resident had his hand between her legs and was rubbing her legs. Resident #6 stated she attempted to push his hand away but he was not moving it. Resident #6 stated that he did not hurt her but he is just a very persistent guy. She stated that she did not like this behavior. Review of the MDS for Resident #6 dated 10/13/25 indicated a BIMS score of 14 out of 15, which indicated intact cognition. Observation on 11/10/25 at 11:30 AM revealed Resident #8 lying on the bed in his (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room and watched television. Staff E, CNA sat in a recliner in room, he states Resident #8 was a 1:1 (one to one supervision) and they had been providing supervision. Resident stated he has been here for a while, and they were keeping an eye on his diabetes was the reason staff was with him. Staff E, CNA stated if the resident did get up and wanted to walk around the facility, he would go with him.On 11/12/25 at 10:00 AM Resident #6 stated the following regarding the incident from 11/7/25 with Resident #8: She did recall him putting his hand on her left knee and he was rubbing her knee and moving his hand up further on her thigh and she pushed him away and said stop it and he did. Staff did come and separate them. She did not like it and told him that. She did feel safe in the facility and staff removed him immediately. On 11/12/25 at 10:28 AM Staff D, Registered Nurse (RN) stated they was the nurse on duty on 11/7/25 for the incident with Resident #6 and Resident #8. [Staff D] was at the nurses station doing something and Resident #10 reported she had seen Resident #8 with his hand down Resident #6 pants. [Staff D] went out there immediately to separate them and he was not touching her. [Staff D] clarified it with Resident #10 and she verified his hand was on top of her pants and on her thigh. Then [Staff D] talked to Resident #8 and he got defensive and said he didn't do anything. [Staff D] then spoke to Resident #6 and asked her where his hands were. She said it was on top of pants and she said she brushed his hand away and he would not move his hand he started to move his hand up and I told him no and he would not listen. Resident #8 had been on 1:1 supervision since the incident happened. On 11/12/25 11:48 AM Resident #10 stated she did witness Resident #8 touch Resident #6 he had his hand on her thigh and was rubbing it. It was on top of her pants. It just did not seem appropriate. [Resident #10] went to the nurse and let her know and then she immediately went to the residents and staff assisted both of them back to their room. [Resident #10] had been a resident here for a while and had never seen anything like that. [Resident #10] felt safe in the facility. On 11/12/25 at 2:49 PM Staff H, CNA explained worked on the night of 11/7/25 on the [redacted] hall and that was where Resident #8's room was located. Staff H explained at the beginning of the shift we let people know where residents are and [Staff H] did not hear anything about him having any particular incidents prior. He would occasionally walk down the hall and hold hands but not that he had an incident of touching any residents inappropriately. [Staff H] was on break at the time of the incident about 4:10 PM, got back at 4:40 PM, and they told [Staff H] had to do 1:1 with Resident #8 until 9:00 PM when another CNA took over. On 11/12/25 at 3:45 PM the Director of Nursing stated after the incident with Resident #9 and Resident #8 did not do 15 minute checks, they completed the sexual relationship tool, did that for any sort of relationship, would do it for both residents. Resident #8 answered appropriately and was able to give consent but Resident #9 was not. Then, notified the family and then kept those two residents separated. To prevent it from happening with other female residents facility educated the staff of what had happened and how to intervene, and discussed what they should be doing. On 11/12/25 at 3:59 PM the Administrator stated after the first incident with Resident #8 the residents were separated, staff did intervene, and educated staff to separate immediately. Facility had a policy for Sexual Relationship for cognitively impaired residents and staff should follow the policy.The facility provided a policy titled Sexual Relationships for Residents with Cognitive Impairment revised 10/24/22. It revealed the purpose to protect individuals with cognitive impairment who are unable to provide consent to an unwanted sexual relationship. The policy clarified the definition of cognitive impairment for purposes of this policy would consider residents with a BIMS score of 12 or below as cognitively impaired.