| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155152 | A. BUILDING 00<br>B. WING | 03/07/2024 |

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

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00423488.<br><br>Complaint IN00423488 - No deficiencies related to the allegations are cited.<br><br>Survey dates: March 3, 4, 5, 6, and 7, 2024.<br><br>Facility number: 000072<br>Provider number: 155152<br>AIM number: 100287440<br><br>Census Bed Type:<br>SNF/NF: 72<br>Total: 72<br><br>Census Payor Type:<br>Medicare: 5<br>Medicaid: 58<br>Other: 9<br>Total: 72<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on 3/11/24. | F 0000 | **The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.**<br>**Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after 3/23/24** | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Christopher Schiavone | Executive Director | 03/20/2024 |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>Based on observation, record review, and interview, the facility failed to ensure assessment and monitoring of skin discolorations, for 1 of 2 residents reviewed for non-pressure skin conditions. (Resident 50)<br><br>Finding includes:<br><br>On 3/3/24 at 3:25 p.m. Resident 50 was observed lying in bed. There were multiple dark purple discolorations to his right arm and a white bandage in place to his right elbow. The resident was wearing a short sleeve shirt and there were no protective sleeves in place.<br><br>On 3/5/24 at 10:21 a.m., Resident 50 was observed lying in bed. There were multiple dark purple discolorations to his right arm. The resident was wearing a short sleeve shirt and there were no protective sleeves in place.<br><br>On 3/6/24 at 12:31 p.m., Resident 50 was observed sitting up in bed eating lunch. There were multiple dark purple discolorations to his right arm. The resident was wearing a short sleeve shirt and there were no protective sleeves in place.<br><br>Record review for Resident 50 was completed on 3/4/24 at 12:57 p.m. Diagnoses included, but were not limited to, hypertension, vascular dementia, and cardiomyopathy.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 12/15/23, indicated the resident was moderately cognitively impaired, received antiplatelet medication, and required assistance from staff with ADLs (activities of daily living). | F 0684 | **F684 Quality of Care**<br>It is the practice of this facility to ensure that residents receive the treatment and care in accordance with professional standards of practice, comprehensive person-centered care, and the resident's choice.<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>Resident #50 has been assessed and MD/family have been notified of his bruises and geri sleeves/long sleeves are on<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**<br>All residents have the potential to be affected.<br>Audit of all residents that require geri sleeves have been assessed and geri sleeves are in place.<br>A full house skin sweep of all residents currently residing in the facility has been completed and any skin impairment has been identified and reviewed by the DNS/designee by 3/23/24.<br><br>**What measures will be put into** | 03/23/2024 |

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| | A Care Plan, updated 1/2/24, indicated the resident was at risk for bleeding and bruising due to taking an antiplatelet medication. Interventions included to observe for increased bleeding or bruising.<br><br>The Weekly Skin and Vital Sign Assessments, dated 2/20/24, 2/27/24, and 3/5/24, lacked any documentation of the discolored areas to the resident's right arm.<br><br>The Physician's Order Summary, dated 3/2024, indicated the resident was to wear geri sleeves (protective sleeves) or long sleeves and to monitor the skin to the upper extremities every shift. There were also orders for aspirin 81 mg (milligrams) daily and clopidogrel (Plavix, an antiplatelet medication) 75 mg daily.<br><br>The Medication Administration Record (MAR), dated 3/2024, indicated the resident received the aspirin and clopidogrel medications daily as ordered. The geri sleeves and skin monitoring were signed off every shift. There were no documented refusals or issues noted with the skin.<br><br>During an interview with the Assistant Director of Nursing (ADON) on 3/6/24 at 2:53 p.m., she indicated she would complete a skin assessment for the resident and document any discolorations.<br><br>A facility policy, titled "Skin Management Program", received as current, indicated "...6. Any skin alterations noted by direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include but not limited to bruises, open areas, redness, skin tears, blisters, and | | **place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>Nursing staff will be inserviced on geri sleeves/long sleeves and Skin Management Policy by DNS/designee by 3/23/24<br>DNS/designee will conduct rounds each day to ensure geri sleeves are in place per MD order and bruises have been identified and addressed.<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>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool " Quality of Care" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. | |

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| | rashes. The licensed nurse is responsible for assessing all skin alterations by the direct caregivers on the shift reported...Procedure for alterations in skin integrity...4. All newly identified areas after admission will be documented on the New Skin Event. 5. The wound nurse/designee will be notified of alterations in skin integrity...b)...ii) Wound management entries will be completed for non-ulcers (bruises, skin tear, abrasion, rashes). If no signs of complications or worsening in condition of skin alteration and doesn't meet the guideline for IDT weekly wound review the wound management entry can be closed after 72 hours..."<br><br>3.1-37(a) | | | |
| F 0921 SS=E Bldg. 00 | 483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions 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 ensure the residents' environment was in good repair related to broken and missing blind slats, chipped paint, marred walls, and loose stripping for 3 of 4 units observed. (Cottage, BCD, and West Units)<br><br>Findings include:<br><br>During the Environmental Tour, on 3/7/24 at 10:40 a.m., the following was observed:<br><br>1. Cottage<br><br>Room 153- Stripping surrounding the air conditioner was loose and hanging. Two | F 0921 | It is the practice of this facility to ensure we provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>Rooms 153, 156, 121, 128, 129, 130, and 142 have been repaired.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective** | 03/23/2024 |

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| | residents resided in the room.<br><br>Room 156- Slats missing from window blind, peeling paint and caulk above the window and marred walls in the bathroom. Two residents resided in the room.<br><br>2. BCD<br><br>Room 121- Slats were broken off the window blinds. One resident resided in the room.<br><br>Room 128- Marred walls with chipped paint next to bed by the door. Two residents resided in the room.<br><br>Room 129- Slats missing from window blind and chipped paint on the window trim. Two residents resided in the room.<br><br>Room 130- Slats broken on window blinds and marred door frame to the bathroom. Two residents resided in the room.<br><br>3. West<br><br>Room 142- Slats missing from the bathroom window blind. One resident resided in the room.<br><br>During an interview with the Maintenance Director at that time, he indicated the items were in need of repair and he would fix them.<br><br>3.1-19(f) | | **action(s) will be taken:**<br><br>All residents have the potential to be affected. Environmental audit of resident rooms will be completed by ED/designee on or before 3/23/24.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>All staff will be educated on completing maintenance work orders by 3/23/24. The Maintenance Director/designee will be assigned to check 1 unit each week to identify any potential concerns in the environment. ED/Designee will conduct rounds to ensure environment is clean and in good repair.<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>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool "Housekeeping (environmental cleanliness)" weekly for 4 weeks, | |

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| | | | monthly for 6 months and quarterly thereafter for at least 2 quarters. Findings will be submitted to the QAPI Committee for review and follow up. | |