

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/16/2024
NAME OF PROVIDER OR SUPPLIER  Monticello Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  1120 N Main St Monticello, IN 47960	

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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>20580</p> <p>Based on observation, record review, and interview, the facility failed to ensure medications were stored in accordance with professional standards related to medications for multiple residents stored in the cabinet without the resident's name, medication name, prescribed dose, strength, and expiration date for 1 of 2 medication rooms observed. (Residents D, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, and Z)</p> <p>Finding includes:</p> <p>During an observation of the BCD Unit Medication room on 10/15/24 at 4:35 p.m., there were multiple paper medication cups stored with medication in the cups. The medication cups had another paper medication cup covering the medications. The medication cups used to cover the medications had initials and a 5, 6, or 7 written on them.</p> <p>During an interview at the time of the observation, LPN 1 indicated the medications in the medication cups were for the 5 p.m., 6 p.m., and 7 p.m. medication passes for Residents D, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, and Z. The medications should not have been set up and stored prior to the medication administration.</p> <p>During an interview on 10/15/24 at 4:40 p.m., the Director of Nursing indicated the medications were not to be set up and stored in the medication room prior to the medication administration times.</p> <p>A facility procedure for medication administration, dated 7/2023 and received as current from the Administrator, indicated medications were to be prepared for one resident at a time.</p> <p>A facility policy for storage of medications, dated 8/2024 and received from the Administrator as current, indicated the facility was to ensure the medications for each resident were stored in containers they were originally received in.</p> <p>This citation relates to Complaints IN00443901 and IN00444365.</p> <p>3.1-25(j)</p>

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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