| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155152 | A. Building<br>B. Wing | 05/19/2025 |

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| Monticello Healthcare | 1120 N Main St<br>Monticello, IN 47960 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>43293<br><br>Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately completed related to insulin use for 1 of 18 MDS assessments reviewed. (Resident 52).<br><br>Finding includes:<br><br>The record for Resident 52 was reviewed on 5/15/25 at 9:38 a.m. Diagnoses included, but were not limited to, Parkinson's disease, diabetes, and schizophrenia.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 3/14/25, indicated the resident received insulin.<br><br>The Medication Administration Record (MAR) for March 2025 indicated the resident received Ozempic (semaglutide) (a medication for diabetes and weight loss) once a week.<br><br>The record lacked documentation the resident received insulin during the MDS assessment period.<br><br>During an interview on 5/15/25 at 11:30 a.m., the MDS Coordinator indicated she thought she should code that the resident received insulin because Ozempic lowers blood sugar. She indicated she would reach out to her consultant for supporting documentation/guidance. No further information was received.<br><br>During an interview on 5/16/25 at 2:27 p.m., the Director of Nursing (DON) indicated Ozempic should be coded as an injected medication, but not as insulin.<br><br>A policy titled, 5 Supportive Documentation Requirements Table, received as current on 5/16/25 at 3:31 p.m. from the Administrator, indicated, .Documentation must be consistent with physician orders and insulin administration records .<br><br>3.1-31(i) |

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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>32664<br><br>Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services related to the monitoring and assessment of skin discolorations for 1 of 7 residents reviewed for non-pressure related skin conditions. (Resident B)<br><br>Finding includes:<br><br>On 5/13/25 at 11:12 a.m., Resident B was observed sitting in a wheelchair in the dining area. The wheelchair had padding on the arms. A large dark purple discoloration was observed to the resident's left elbow.<br><br>On 5/14/25 at 10:26 a.m., Resident B was observed being wheeled out of her room in her wheelchair by her son. The dark purple discoloration was still observed to her left elbow.<br><br>Record review for Resident B was completed on 5/14/25 at 10:42 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, hypertension, dementia, diabetes mellitus, and respiratory failure.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 2/14/25, indicated the resident was cognitively impaired. The resident required a substantial maximal assistance for bathing, dressing, and transfers. The resident had a life expectancy of less than 6 months and was on hospice services.<br><br>A Care Plan, dated 9/3/24 and revised 3/11/25, indicated the resident was at risk for skin breakdown or further skin breakdown due to impaired mobility with increased weakness. An intervention included to assess and document skin condition weekly and as needed and to notify the physician of abnormal findings. Another intervention included to have padded arm rests to the wheelchair.<br><br>A Weekly Skin Assessment, dated 5/13/25, indicated the resident had no skin integrity alterations and bruising was not indicated.<br><br>The record lacked any documentation to indicate the resident's discoloration had been assessed or was being monitored.<br><br>During an interview on 5/14/25 at 10:50 a.m., LPN 1 indicated she was unaware of the resident's discoloration to her left elbow.<br><br>During an interview on 5/16/25 at 3:00 p.m., the Director of Nursing (DON) indicated there was no prior documentation the resident's discoloration had been assessed or was being monitored.<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 rashes. The licensed nurse is responsible for assessing all skin alterations by the direct caregivers on the shift reported .<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | This citation relates to Complaint IN00459697.<br><br>3.1-37(a) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>45666<br><br>Based on record review and interview, the facility failed to fully implement care-planned dietary interventions for a resident at risk for weight loss related to incomplete meal consumption logs and a lack of supplement/substitute documentation for 1 of 18 records reviewed. (Resident C)<br><br>Finding includes:<br><br>Resident C's record was reviewed on 5/15/25 at 12:52 p.m. Diagnoses included, but were not limited to, dementia, chronic obstructive pulmonary disease (COPD), and type 2 diabetes mellitus.<br><br>The Significant Change in Status Minimum Data Set (MDS) assessment, dated 4/15/25, indicated the resident was severely cognitively impaired. The resident required setup help for eating.<br><br>A Care Plan, dated 11/29/24, indicated the resident required assistance and/or monitoring for AM/PM care, nutrition, hydration, and elimination. Interventions included, but were not limited to, record breakfast, lunch, dinner, and fluid intake percentage.<br><br>A Care Plan, dated 12/3/24, indicated the resident was at nutritional risk related to COPD, diabetes mellitus, dementia, and chronic kidney disease. Interventions included, but were not limited to, honor preferences, monitor weight, offer substitution if resident consumes less than 50% of a meal, and provide diet as ordered.<br><br>A Registered Dietician Nutritional Review, dated 4/22/25 at 4:02 p.m., indicated the resident had an average meal consumption of 55% for three meals a day. The resident was able to communicate meal choices and feed himself. The resident weighed 145 pounds (lbs) on 4/22/25, 146 lbs on 4/14/25, and 148 lbs on 4/8/25. The resident's usual/desirable body weight range was 150-155 lbs. The Plan of Care/Interventions indicated the resident's weight had increased and he preferred to eat in his room but was encouraged to attend meals in the dining room. The Plan of Care was to be continued and to honor the resident's preferences.<br><br>The Intake: Breakfast, Lunch, Dinner, and Supplements Point of Care from 4/19/25 to 5/19/25 indicated the resident consumed between 1-50% of the following meals:<br><br>- breakfast: 4/19, 4/23, 4/24, 4/25, 4/29, 4/30, 5/9, 5/11, and 5/12/25<br><br>- lunch: 4/19, 4/20, 4/23, 4/24, 4/25, 4/26, 4/28, 4/29, 4/30, 5/2, 5/9, and 5/14/25<br><br>- dinner: 4/19, 4/22, 4/23, 4/24, 4/26, 4/27, 4/29, 4/30, 5/1, 5/2, 5/4, 5/5, 5/7, 5/9, and 5/14/25<br><br>There was no documentation of a supplement or substitute offered on the above dates.<br><br>There was no documentation of any intake for dinner on 4/25/25, breakfast on 4/28/25, dinner on 5/6/25, and lunch on 5/10/25.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/19/25 at 3:30 p.m., the Director of Nursing (DON) indicated the staff were to document substitutes given with the Supplement Point of Care documentation under the Intake section. Substitutes were always available and offered, however it was not documented. The resident had been gaining weight.<br><br>A policy titled, Delivery and Documentation of Meal Service and Between Meal Nourishments, indicated . Documentation The nursing Department will document foods/fluids consumed at each meal using percentage eaten and fluids consumed in ml's. The dining room assistant or licensed nurse offers a substitute in the event the resident's nutritional intake is 50% or less at any meal and document acceptance or refusal .<br><br>This citation relates to Complaint IN00459697.<br><br>3.1-50(a)(2) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>32664<br><br>Based on observation, record review, and interview, the facility failed to ensure a resident who required respiratory care received oxygen as ordered by the physician for 1 of 2 residents reviewed for respiratory care. (Resident B)<br><br>Finding includes:<br><br>On 5/13/25 at 10:58 a.m., Resident B was observed sitting in a wheelchair in the dining area. The resident was watching television with other residents. The resident had a portable oxygen attached to the back of her wheelchair. The oxygen was on the resident via a nasal cannula and set at 3 liters.<br><br>On 5/14/25 at 10:26 a.m., Resident B was observed being wheeled out of her room in her wheelchair by her son. The resident was awake and had oxygen on via a nasal cannula and set at 3 liters.<br><br>Record review for Resident B was completed on 5/14/25 at 10:42 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, hypertension, dementia, diabetes mellitus, and respiratory failure.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 2/14/25, indicated the resident was cognitively impaired. The resident required a substantial maximal assistance for bathing, dressing, and transfers. The resident had a life expectancy of less than 6 months and was on hospice services. The resident received oxygen therapy.<br><br>A Care Plan, dated 9/3/24 and revised 2/21/25, indicated the resident had potential for impaired gas exchange related to respiratory failure. The resident wore oxygen. An intervention included to administer oxygen as ordered by the physician.<br><br>The May 2025 Physician's Order Summary (POS) indicated an order for oxygen at 3 liters per nasal cannula while sleeping or napping, every shift.<br><br>During an interview on 5/14/25 at 10:50 a.m., LPN 1 indicated the resident needed to wear her oxygen at all times. She would have to clarify the order to only wear it while sleeping or napping with the physician.<br><br>During an interview on 5/16/25 at 3:00 p.m., the Director of Nursing (DON) indicated the order for the oxygen had been changed to continuously at 3 liters.<br><br>A facility policy, titled Oxygen-Liquid, received as current, indicated .Procedure 1. Verify physician orders. Know the flow rate and duration of use .<br><br>3.1-47(a)(6) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45666<br><br>Based on record review and interview, the facility failed to ensure there was adequate monitoring of vital signs per the physician's orders prior to the administration of a medication that alters the rate/rhythm of the heart for 1 of 5 residents reviewed for unnecessary medications. (Resident 22)<br><br>Finding includes:<br><br>Resident 22's record was reviewed on 5/14/25 at 2:09 p.m. Diagnoses included, but were not limited to, dementia, Parkinson's disease, and atrial fibrillation (irregular heart beat).<br><br>The Significant Change in Status Minimum Data Set (MDS) assessment, dated 4/20/25, indicated the resident was moderately cognitively impaired.<br><br>A Care Plan, dated 9/20/22, indicated the resident received digoxin (medication that alters the rate and rhythm of the heart). Interventions included, but were not limited to, administer medications as ordered, check pulse prior to administering medications, and observe for symptoms of toxicity.<br><br>A Physician's Order, dated 4/15/25, indicated digoxin 62.5 micrograms (mcg) one tablet at 6:00 a.m. daily. Hold the medication for pulse less than 60 beats per minute.<br><br>The April and May 2025 Medication Administration Record lacked any documentation of the resident's heart rate being monitored at the time of digoxin administration. The medication was marked as administered daily.<br><br>During an interview on 5/16/25 at 10:10 a.m., the Director of Nursing indicated the resident had been in the hospital and when she had readmitted on [DATE], the order was implemented, however it was not marked for the nursing staff to document the heart rate with each administration of the medication.<br><br>3.1-48(a)(3) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>32788<br><br>Based on observation, record review, and interview, the facility failed to ensure food was prepared by methods that conserve nutritive value related to not following instructions for puree food preparation. This had the potential to affect 5 residents who received a pureed diet from the kitchen.<br><br>Finding includes:<br><br>On 5/14/25 at 10:50 a.m., [NAME] 1 was observed preparing pureed food. She indicated she was going to puree chicken patties. She washed her hands and removed a pan of chicken patties from the oven. She placed 6 chicken patties in the blender and blended them. She stopped the blender, added two cups of water from the faucet, and blended again. She stopped the blender, stirred the contents with a spatula, added another cup of water, and blended longer. She stopped the blender, stirred the contents, added one scoop of thickener, and blended again. She stopped the blender, stirred the contents, checked the consistency using spoon tilt test (a test used to determine correct puree consistency), and resumed blending. She stopped the blender, stirred the contents, checked the consistency again, added one more scoop of thickener, and blended. She stopped the blender, stirred the contents, checked the consistency a final time, indicated she was done making the puree, and put the contents of the blender into a pan to be served.<br><br>During an interview on 5/14/25 at 11:03 a.m., [NAME] 1 indicated the kitchen staff used to have a book of pureed recipes, but they no longer had it.<br><br>During an interview on 5/14/25 at 11:04 a.m., the Dietary Manager indicated they no longer used pureed recipes. The corporation had gotten rid of the recipes, and they were now to follow the IDDSI (International Dysphagia Diet Standardization Initiative) guidelines. The pureed food just had to pass either the spoon tilt test or the fork drip test to be the correct consistency. There were no guidelines on how much liquid, what type of liquid, or how much thickener to add to a pureed food when preparing it. They started out by blending whatever food they were making and went from there to determine if they should add some liquid or thickener. They typically would not use water as the liquid but instead would use the broth of whatever item they were preparing, for example when preparing a chicken item they would use chicken broth.<br><br>During an interview on 5/14/25 at 3:40 p.m., the Administrator was made aware of the concern with the pureed preparation and had no further information to provide.<br><br>An IDDSI Notes document, undated and provided as current by the Administrator, indicated, .For pureed: Measure desired number of servings into food processor. Blend until smooth. Add broth or gravy with meats, and milk or water for other foods if product does not meet proper consistency per IDDSI guidelines. Commercial thickener should be added as necessary to achieve proper consistency .<br><br>3.1-21(a)(1) |