

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  03/25/2026
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, staff and resident interviews, and facility policy review the facility failed to ensure a resident remained free from verbal mistreatment by staff for one of three residents reviewed (Resident #1). The facility reported a census of 51 residents. The facility corrected the deficient practice per past noncompliance through the following actions: -An all-staff meeting was held on 3/1/2026. Abuse training completed and abuse policy signed by all attendees.-Two additional all-staff meetings were held on 3/2/2026. All attendees completed abuse training and signed the abuse policy. -All alert and oriented residents were interviewed regarding their safety. -Incident review by Quality Assurance Performance Improvement (QAPI) meeting on 3/10/2026. Findings include: Resident #1 admitted to the facility on [DATE] and passed away on 3/10/2026 with hospice services in place. The MDS (Minimum Data Set) dated 1/8/2026 revealed the resident had severe cognitive impairment, had physical, verbal and other behaviors directed towards others, relied on staff assistance to transfer from one surface to another and used a wheel chair for mobility. The resident's diagnoses included Alzheimer's Disease and cancer. He sustained a fall since the prior assessment that resulted in injury, not major. Resident #1's Care Plan, initiated 10/25/2025, revealed the resident had physical behaviors and mood problems related to his Alzheimer's Disease. It directed staff to redirect his behaviors and if resistive, leave alone and try again after a few minutes. Reward verbally all positive behavior and administer medication as ordered. The resident's progress notes included: The General Progress Note dated 3/01/2026 at 12:49 p.m., written by Staff F, Registered Nurse (RN), revealed Staff F was notified by a CNA (Certified Nursing Assistant) that another CNA yelled at Resident #1. This happened when resident was getting dressed for lunch and resident rolled towards CNA, and went to punch him and jabbed him in the eye. CNA at this time turned away from resident and turned back towards resident and grabbed him by the shoulders and telling him to shut the f**k up He also stated If you weren't a resident I would beat the s**t out of you. Both CNA's exited the room together. CNA immediately reported the incident. Staff F immediately called on call and reported the incident. At this time, CNA was sent home. Incident was also reported to the administrator and also to the Staff B. When Staff F entered the room the resident started smiling and talking and denied any pain or discomfort. A full body skin assessment done and no evidence of any injury at this time. Vitals- Blood Pressure 126/70, Oxygen Saturation 95%, Respirations 18, Pulse 72, Temp 97.2 degrees. Resident was then transferred Ax3 (assist of three) with Hoyer (mechanical lift) into his wheelchair for lunch. The Incident Note dated 3/01/2026 at 8:17 p.m., written by Staff M, LPN (Licensed Practical Nurse), revealed, Resident up in wheelchair for supper without complaint. Visited with this resident in his room. Asked how his day was today. His response was good you say . Asked if he had the convertible out today and he laughed. Resident shows no signs of distraught or concern. No injury noted. The facility investigation included the following: An allegation of abuse was reported, with abuse type documented as staff to resident. The incident occurred approximately on 3/1/2026 at 11:45 a.m. in Room [Number Redacted] Law Enforcement was notified. The Incident Summary section revealed while Staff K, CNA assisted Resident #1, the resident punched Staff K in the face. Staff L, CNA, also (continued on next page)</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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No other residents or staff complained about Staff K. Staff F spoke to his roommate and he was very hesitant to say anything about Staff K because he did not want to get him in trouble. Staff A called Staff F right after the incident occurred and then he came in. Staff F notified the family. On 3/24/2026 at 8:40 a.m., Staff K, CNA was interviewed via telephone. Staff K reported working two years full time days at the facility, and had a couple of write ups during that time. One was not having a second person present during a two person resident transfer. The second one was about 6 months ago when he took a resident outside to smoke. A resident communicated to staff that they were allowed to go out to the parking lot to smoke, which was not the case. He received a write up for it. Regarding Resident #1, just prior to lunch time he went into his room with Staff L. The resident required two staff with cares at all times because of his combative behaviors. Staff L started providing cares for the roommate and then came to help him with Resident #1. The curtain was closed and he stood on the curtain side. He assisted the resident to roll onto his side so Staff L could provide incontinence cares. Staff K attempted to keep the residents swinging arms free from Staff L. The resident jabbed him in the eye. Staff K admitted he yelled a couple of profanities, not directed towards the resident. The resident started laughing and Staff L said 'it is not funny', and he said 'it is funny'. Staff K explained [Staff K] said no, it is not f funny. Staff K denied grabbing the resident's shoulders. He denied yelling at the resident, but said it was not f ing funny. After Staff K got himself sorted and made sure he did not have damage to his eyes, they continued cares. Staff L asked him if he was okay or if he needed to step out. He said they needed to get done so they could get the resident to lunch. They finished cares, put his pants on and a sling under him. Staff L made a report to Staff F, and he was sent home. He had gone into another resident's room to provide cares and when he came out he was sent home without writing a statement. Staff A called me that day while driving and he returned the call the following day. Staff K heard it had been reported that he grabbed Resident #1 by the shoulders and yelled at him. Staff K told Staff A that was not what happened. Staff A informed him there had been an allegation of abuse and the police may contact him. The police never contacted him. A few days later Staff A informed Staff K of his termination. He had no prior allegations or concerns of mistreatment. On 3/24/2026 at 1:05 p.m., interview with Staff L, CNA revealed the following: When the incident occurred with Resident #1, Staff L and Staff K were in the resident's room, room [Number Redacted]. They entered at the same time before lunch. Staff L assisted Resident #5 while in bed. Staff K assisted Resident #1, also in bed. The curtain was closed between the two beds. Staff L heard Resident #1 began cussing. He could get combative, kick and hit at times. She went to help Staff K. She stood on the wall side of the bed and Staff K stood on the curtain side. She rolled the resident towards Staff K and the resident jabbed him in the eye. Staff K turned away for a second and she asked him if he was okay. Staff K said that he hit him in the eye and he muttered, If you weren't a resident, I would beat the s**t out of you. The resident started laughing, Staff K grabbed his shoulders and said shut the f**k up. He screamed it two times. She told Staff K they needed to go. Staff K exited the room and she followed. She told him she had eye drops in her purse that he could use. Staff L reported it to Staff F, the charge nurse. The resident laughed and said that is awesome when Staff K said he got hit in the eye. Staff L reported working with Staff K prior to that, quite a few times. They both worked the weekend package for [length of time redacted], and she worked with (continued on next page)</p>		

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It was a Sunday and we were called in if we were available for the mandatory education. On 3/25/2026 at 8:20 a.m., Staff I, RN explained staff were re- educated after the incident with Resident #1 about the abuse policy. No resident ever voiced a concern and staff ever complained about Staff K. Resident #1 had very poor cognition. On 3/25/2026 at 9:00 a.m., Staff J, CNA explained the following via phone: Staff J worked at the facility for three years, currently on night shift. Staff all knew that Resident #1 would grab and curse. Staff J worked with Staff K, she trained him. Staff J had no issues with Staff K, he seemed to be a pretty good aide. Staff received training on the abuse policy, they had to sign it and complete abuse training. On 3/25/2026 at 10:10 a.m., Staff A, Administrator explained the following: Resident #1 was in room [Number Redacted], at the end of the hall until he passed on 3/10/2026. He received a call on Sunday, March 1, around 11:30 am. An incident occurred between Resident #1 and Staff K. Staff L had been working with Resident #5. Staff K had been focused on Resident #1. The resident had a history of being aggressive. According to Staff L, the resident hit Staff K very hard in the eye, and Staff K aggressively shook the resident's shoulders and said shut the f . up, and if you weren't a resident I would f .ing kill you. The resident laughed and Staff K repeated shut the f . up. Staff L stated they both exited the room at the same time, the residents were safe when they exited and she went to Staff F, the charge nurse. Staff F called him and Staff B. Staff K was asked to leave at that point. That was the last he had been in the building. Staff A came in, filed a self report, started interviews and did staff education. He proceeded to do more staff education the next day at 2 and 4 p.m. The education included the facility abuse policy. Staff F did evaluate the resident and found no signs of injury. Resident #5, his roommate also confirmed that Staff K yelled profanity at the resident. The curtain in the room was open. Staff K denied putting his hands on the resident, but did admit to yelling at him. He apologized and said he should not have done it. Staff and residents were interviewed. Staff A concluded it was verifiable that Staff K did verbally and physically abuse the resident and he was terminated. Staff B sat in on the call. Staff K worked at the facility for over a year and there had not been any concerns regarding the way he treated residents. Staff A notified the police right after he did the self report, and they did not come to the facility. Resident #1 had severe dementia and had no recall. We did discuss it in depth in QAPI (Quality Assurance Performance Improvement). Staff A felt staff responded appropriately, Staff L made it a point to leave the room after Staff K. She did not leave him alone in the room. They discussed what happened, the steps we took, the intervention regarding the training we did and how we cannot have that occur among our staff. Interview with Resident #5 (roommate) on 3/23/2026 at approximately 2 p.m. revealed the following: Resident reclined in bed, alert, pleasant and verbal. Resident #5 queried if recalled an incident with your roommate and a staff? He poked a staff in the eye and the staff got mad. Do you recall the staff's name? [Name Redacted], [First Name Matching Staff K Redacted], something like that. Was the curtain open? I can't remember, but I could hear, he called him f .er and that is all. He did not hit him or hurt him. I can't really blame him, it probably hurt him The resident reported no concerns with staff treatment, he was doing the best he could with his diagnosis of ALS. He appreciated the help from staff. The facility policy updated 3/18/2026 titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy revealed, All Residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not (continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>required to treat the resident's medical symptoms. This includes prohibiting nursing facility staff from taking acts that result in personal degradation* including the taking or using photographs or recordings in any manner that would demean or humiliate a resident, and prohibits using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep, or distribute photographs and/or recordings on social media or through multimedia messages. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The policy further revealed, It shall be the policy of this facility to implement written procedures that prohibit abuse, neglect, exploitation, and misappropriation of resident property. These procedures shall include the screening and training of employees, protection of Residents and the prevention, identification, investigation, and timely reporting of abuse, neglect, mistreatment, and misappropriation of property, without fear of recrimination or intimidation.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, clinical record review, and staff and resident interviews, the facility failed to ensure adequate supervision was provided for a resident with a history of falls for one of three residents reviewed (Resident #2). The facility reported a census of 51 residents. The facility corrected the deficient practice per past noncompliance through the following actions: -Staff education initiated on 3/10/2026 regarding importance of proper rounding and resident monitoring. Education continued on 3/11/2026, and ongoing until all Certified Nursing Assistants (CNAs) and nurses have completed and signed the education form. -Alert and oriented residents were interviewed regarding their safety and well-being. -Incident was added to the Quality Assurance and Performance Improvement (QAPI) agenda. Findings include: The MDS (Minimum Data Set) an assessment tool dated 3/5/2026 revealed Resident #2 had diagnoses including Alzheimer's Disease, Hypertension, Traumatic Brain Injury and Seizure Disorder. The resident transferred from one surface to another and ambulated without assistance, and had physical behaviors. The resident had two or more falls with injury, not major, since the prior assessment. The resident's Care Plan revealed the resident ambulated independently with or without a cane (date initiated 3/9/2026), and had a fall risk related to poor safety awareness and impaired balance (date initiated 3/9/2026). Interventions dated 3/9/2026 revealed, in part, to ensure he had the call light within reach, wore appropriate foot wear, and to leave the bathroom door ajar with the light on. On 3/10/2026, the Care Plan directed staff to remove the bedside table and provide an extra table without wheels. The Care Plan focus area dated 3/9/2026 reported the resident received anti-platelet medication putting him at risk for bleeding. On 3/9/2026, the Care Plan instructed staff to encourage the resident to keep the door open at night as resident allows to allow for more frequent staff checks. The Care Plan, with revision date 3/9/2026, also indicated the resident had behaviors directed towards others. The Care Plan focus area dated 3/23/2026 revealed the resident was at risk for making false accusations. In a Progress Note dated 3/10/2026 at 1:43 p.m., Staff D, RN (Registered Nurse) documented staff notified her that Resident #2 had blood on his lips. Staff D found the resident with a swollen bottom right lip with redness that measured 2x2 cm (centimeters), and an opening on the inside of the lip. The resident also had abrasions on the anterior right arm that measured 2x14 cm., and right shin that measured 2x0.7 cm. with scant blood. Staff D cleansed the areas and left them open to air. The resident complained of pain in the lip and arm, and Staff D administered Tylenol as scheduled and a cool cloth. The resident denied difficulty drinking. Staff D assessed the resident and found his range of motion and neurological examination within normal limits. The resident denied falling and indicated someone came into his room and picked a fight with him. Staff D notified Staff B, DON (Director of Nursing) and the Physician Assistant. In a Progress Note dated 3/10/2026 at 11:39 a.m., Staff B noted the Physician Assistant saw the resident during rounds. Staff requested a psychiatry referral due to the resident's continued behaviors and increased paranoia. An Incident Report at 6:25 a.m. reported the same information documented in the progress note. An Incident Report dated 1/13/2026 revealed the resident fell outside of his room in the hall. He walked out with his cane and cursed at staff complaining he had no underwear. He threw his cane back into his room, lost his balance and fell. He sustained a 1.4 x 3.5 cm abrasion to his right knee. The resident stood up unassisted, and staff showed the resident where he had his underwear in his room. An Incident Report dated 2/8/2026 at 2:40 a.m. revealed staff heard a loud bang and found the resident seated on the floor in his room near the bathroom door. The resident reported no injury, had no idea how it happened and he used his cane. The facility self report included: On 3/10/2026 at approximately 6:15 a.m., Staff C entered Resident #2's room during rounds and discovered the resident had a bloody lip and marks on his arms. The resident reported a female employee came into the room and assaulted him. Staff C notified Staff D, charge nurse immediately. Staff D assessed the resident and notified Staff A, Administrator and Staff B, DON. Staff E, ADON (Assistant Director of (continued on next page)</p>		

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Camera footage confirmed that no one entered or exited the resident's room between 9:36 p.m. on March 9, and the time Staff C entered the room the following morning. Additionally, Staff A confirmed through staffing records that there were no male C.N.A.'s working the night of the incident, further contradicting the resident's account. Observation on 3/23/2026 at approximately 8:10 a.m. revealed the resident's bedroom door shut with sign with instructions to knock before entering. Staff F, RN reported the resident keeps his door shut at all times and eats in his room. Observation on 3/23/2026 at 9:20 a.m. revealed the resident in bed. Staff E encouraged the resident to sit up and eat breakfast. Staff E reported staff encouraged him to come out for activities and meals, however he typically only came out of the room for baths. The cane and call light were within reach, and he wore gripper socks. The resident reported nobody had ever mistreated him, he felt safe, and staff treated him okay. At 11:30 a.m. the resident continued to lay in bed, alert and verbal, though difficult to understand stating he had cotton mouth. The resident requested ice for his water. When asked what happened to his closet door, he indicated he got into a fight with the maintenance man. Staff G entered the room and the resident made inappropriate comments directed towards her. Staff G reported the resident refuses to sit in the recliner for meals, and prefers to sit at the edge of the bed. On 3/25/2026 at approximately 10 o'clock a.m. the resident shouted in his room for someone to shut his door. Staff interviews revealed the following: On 3/25/2026 at 9:45 a.m., Staff A, Administrator reported on March 10, the aide found Resident #2 with blood on his lip and some abrasions on his arms. The facility had cameras in the hall. When he reviewed the footage, it showed on 3/9/2026 at 9:36 p.m., Staff N entered the resident's room. Nobody entered the room until the next morning, 3/10/2026 at 6:15 a.m. They provided education on the importance of rounding, and the lack of rounding was unacceptable. The cameras failed to capture the resident's call light in the hall. The agency aide working during the night did not round on him. Staff B spoke to her and she did not have anything to say. She went to the door and listened but did not go in. That was a big thing with the training. The resident hates it when people opened up his door during the night but it had to happen. The resident had no recall of falling, but there was blood at the base of the night stand and on the floor next to it. He did not have to go to the emergency room. The physician was in the building that day and he saw him. Staff B, DON had shown up twice on third shift to check on things, and she said it had gotten better. On March 10, the resident said a female employee came in and beat him up. Staff A, Administrator explained he spoke to him (resident) immediately when Staff A got to work and he (resident) told me it was a male employee who beat him up. Staff A further explained he filed the report and started the investigation. On March 18, Staff H, Maintenance was in his room, and looked into fixing the closet door which has been off since August. The resident told Staff H the reason he did not have a door was because someone beat him up, he fell into the door, that is why it broke, and that person took the door. After he reported that, Staff H notified Staff A. Staff A went immediately into his room and he told him that Staff H beat him up and took the door. Staff A reminded him that he fell into the door in August and that is why they had to take it. Staff H did not work at the facility at that time. Because he thought that, Staff A filed a self-report (reported the incident to the State Agency). Staff H was told not to go into his room, and they moved the maintenance office to the [redacted] hall next to the dietary supervisor and housekeeping supervisor. The facility has investigated four abuse allegations from the resident, and all were unverifiable. They updated his care plan, and take everything he said and investigate it. At every QAPI, Quality Assurance and (continued on next page)</p>		

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  03/25/2026
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Performance Improvement, they address every self-report from the previous month. On 3/23/2026 at 12:20 p.m., Staff E, ADON, explained Resident #2 stayed in his room most of the time, and explained he had inappropriate behaviors. That morning Staff D, charge nurse told Staff E that the resident had a bloody lip and some marks on his arm, and said someone came into his room during the night and beat him up. Staff E went into his room and saw he did have a bloody lip and marks on his arms. He said it was a woman and then changed it to a man. He said he did not know if it was someone who worked at the facility, and that it happened in the middle of the night. Staff E explained had cameras on every hall. Staff A, Administrator clarified with the cameras that nobody went into his room during the night. He does make false allegations and yells at the aides. He has his meal tray on his night stand. There was blood on the leg of the tray table so it was removed after the fall on 3/10/2026. With the blood on the tray table and on the night stand, Staff E explained knew he had a fall and he got himself up. He never had his call light on that night. He was able to use his call light and did. Staff was supposed to check on each resident at least every two hours. Staff E explained followed up with staff education. Staff B spoke to the night shift staff. One of the aides said she did not go into his room because he yelled at them when they did. They were educated and told that they just needed to lay eyes on the residents. On 3/23/2026 at 1:40 p.m., Staff B, DON, explained Resident #2 was on the list to be seen by telehealth psychiatry when they got family consent. He had a history of false allegations with hallucinations. The primary physician felt it was appropriate for him to see psychiatry. After the two recent incidents occurred, staff called the DON and the Administrator. Staff E went in to assess the resident after he stated someone came in and beat him up. We reviewed the camera footage and saw staff went in the night before around 9:30 p.m. and then at 6:15 the following morning. Staff B reviewed with staff the importance of rounding and educated staff. The aide who worked the night before said he would get mad at them if they went in, and that they answered his call light when he needed something. Staff B told staff they had to lay eyes on him to be sure he was safe. He got angry if someone opened the door, however we still need to. The resident used his call light or comes to out to the hall and yells. When they have tried to make him an assist of one he was noncompliant and refused to cooperate with therapy. He said someone beat him up but Staff B explained analysis revealed he fell, due to the blood on the tray night stand and no camera footage of anyone entering his room. The Physician Assistant was at the facility, he checked the resident, and he felt it resulted most likely from a fall. The resident has made other false allegations in the past and he is care planned for it. He does not leave his room unless he is looking for something, and comes out and yells for someone to come help. If he gets angry he gets shaky if staff try to help him. If staff try to put a gait belt on him, he gets upset. He is inappropriate and then he will say I am not a liar, I would not say that. On 3/25 at approximately 2 p.m., Staff B revealed the night shift received an employee education acknowledgement that they had to sign, and it is in the employee file. She also posted the education in the communication book and in the employee break room for all staff to view when they arrive to work. On 3/24/2026 at 8:22 a.m., Staff F, RN explained the resident was known to make false allegations and he preferred females. He was more likely to make an allegation about a male. Staff were educated after his fall. Per Staff F, were to do one hour rounding. Eyes need to be laid on him, especially at night. Staff F explained he did not come out of his room unless he wanted something. He would go to his doorway and yell for staff. He did use his call light. On 3/24/2026 at 1:30 p.m., Staff D, RN explained Staff C, CNA let Staff D know that she went into Resident #2's room in the morning and he had blood on his lip, and a swollen upper lip. The resident said someone came in and picked a fight with him, and that it was a male. Staff D checked him out, he had a couple of other abrasion type marks on his arm and shin. Staff D did neurological checks over the course of the day. The resident did not really say anything more. He did not recall that he slipped and fell. He had gripper socks on but Staff D replaced them with a new pair. In the past he has that someone attacked him. Staff were educated and instructed to make sure they check on residents even if they did not need to be changed. Just to be sure they were all okay. The resident did use his call light if he wanted (continued on next page)</p>		

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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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>something or he yelled. He insisted his door stayed closed and there was a sign on his door that told people to knock first. On 3/24/2026 at 1:45 p.m., Staff C, CNA explained on March 10, around 6:10 a.m. Staff C entered Resident #2's room to assist him with morning cares, like she did every morning. He did not have his call light on. Staff C asked him if he was ready to get up and get washed up. He was laying down in bed and she saw he had smeared blood on his chin. She reported it to Staff D. The resident said she came and beat me up. He had a tendency of making false allegations. Per Staff C, he broke his fan and now he was saying someone stole it, but we are trying to get him a new one. She was not told anything in report. His cane was by his chair and he had gripper socks on. His tray table was next to his bed. Staff C heard there was blood on the floor by the tray table, and they removed it. The resident now had a night stand in its place. After that incident with the resident, they received education regarding the need to check the residents on hourly rounds. They recently had abuse re-education as well. On 3/25/2026 at 8:10 a.m. Staff N, CNA explained the following via phone: Staff N worked from 6 p.m. - 10 p.m. as the medication aide on March 9, 2026. Staff N went into the resident's room around 9:30 p.m. to administer his bedtime medication. He was at the sink brushing his teeth, and then he got into bed and showed her what he was watching on TV. He can and does put his call light on. He would come to the bedroom door and yells when he wanted something. He was able to make his needs known. They were educated about doing hourly rounds and pamphlets were placed in the break room. Staff N explained had to do a walk through and check on the residents. On 3/25/2026 at 8:20 a.m., Staff I, RN explained the following via phone: Staff I worked from 10 p.m. on March 9 until 6:00 a.m. on March 10. The facility staffed one nurse and two aides on the night shift. Staff I reported she did not go into Resident #2's room during the shift. The resident typically put his call light on if he wanted something. She thought an aide went into his room, but the cameras showed otherwise. They received education about the need to check every resident every hour, open the doors, and lay eyes on them. On 3/25/2026 at 9:00 a.m., Staff J, CNA explained the following via phone: Staff J currently worked on the night shift from 10 p.m. - 6 a.m. That evening, March 9th on the night shift, she worked as well as an agency aide. The agency aide was assigned to the [redacted] and [redacted] hall. The resident normally put his call light on. The agency aide had worked at the facility in the past and normally did a pretty good job. Staff received education regarding the need to do hourly rounds.</p>		