| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165279 | A. Building<br>B. Wing | 06/24/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Monticello Nursing & Rehab Center | 500 Pinehaven Drive<br>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 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident, and staff interviews the facility failed to keep a resident free from physical restraints during a period of behaviors. A staff member used her body to force a resident to ambulate to her room for 1 out of 1 residents reviewed with behaviors (Resident #1). The facility reported a census of 43 residents. Findings include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS showed Resident #1 rejected care on one to three days during the observation period, and these behaviors worsened compared to previous evaluations. Resident #1 didn't require assistance with toilet transfers, sit-to-stand transfers, and walking. Active diagnoses for Resident #1 included hypertension (high blood pressure), arthritis (joint inflammation), and chronic obstructive pulmonary disorder (COPD; long-term lung disease). Review of Resident #1's care plan initiated 5/21/26 revealed Resident #1 didn't maintain a calm status and experienced behavioral episodes including paranoia (unfounded suspicion), negative statements, medication and care refusals, attempts to leave the building, calling the police, hallucinations (false sensory perceptions), and delusions (false beliefs). Care plan interventions directed staff to reassure Resident #1 if Resident #1 resisted everyday tasks, then leave and try again five to ten minutes later. Another intervention instructed staff to protect the rights and safety of other residents by speaking calmly, diverting attention, or removing Resident #1 to an alternate location. A nurse's progress notes from 5/30/26 at 1:01 AM revealed Resident #1 walked over to the fire alarm and pulled it. Resident #1 then walked down the hallway, entered multiple resident rooms, and screamed for help. Resident #1 didn't stop there; Resident #1 walked down a different hallway screaming for help, ripped a telephone off the wall, and destroyed it. Resident #1 pulled the fire alarm a second time, grabbed a fire extinguisher, and aimed it at other residents and staff. Resident #1 then sat on the floor and refused all assistance to get up. Staff notified Resident #1's Power of Attorney Representative and hospice (end-of-life care) of these behaviors. Review of the hospice notes from 5/30/26 at 12:27 AM revealed Staff A, Licensed Practical Nurse (LPN), notified hospice of Resident #1's aggression and agitation. This review failed to reveal any orders for staff to physically restrain Resident #1, and the records didn't contain such authorizations. A written statement dated 6/2/26 at 10:54 AM from Staff B, Certified Nursing Assistant (CNA), revealed that staff members performed every possible action that night. Resident #1 exited the room, grabbed the walkie-talkie belonging to Staff A, and placed it against Staff B's neck. Resident #1 acted as if the device served as a taser, and this incident occurred in the circle area. Staff didn't make eye contact, hoping Resident #1 wouldn't react. Resident #1 claimed Staff B laced Resident #1's coffee. Resident #1 then walked over, pulled the fire alarm near the front door, proceeded down the 500 hallway, and screamed for everyone to wake up and see the facility's activities. Resident #1 entered resident rooms and turned on lights before moving down the 100 hallway. Resident #1 ripped a telephone and a thermostat off the wall and whipped them around. Staff B and Staff C, CNA, tried to assist, and Staff B attempted to guide Resident #1 to Resident #1's room while Staff A and Staff C positioned themselves in the circle area to contact family members.<br>(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 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #1 placed full body weight on Staff B during this guidance and tried to drop to the ground. Staff B wrapped an arm around Resident #1's backside, held Resident #1's wrist, and secured Resident #1's waist with the other hand. This hold kept Resident #1 steady to prevent a fall through a gentle wrist grasp. Staff B finally escorted Resident #1 into the room and onto the bed, but Resident #1 didn't stay in bed and returned to the hallway. Staff B asked Staff A about available as-needed medication, and Staff B obtained permission from Staff A to hug Resident #1 to help calm Resident #1. This interaction occurred on the 100 hallway after Resident #1 dismantled the fixtures and threw the fire extinguisher. Staff didn't have other options remaining at that point. The hug didn't succeed as a distraction because Resident #1 dropped to the floor during the encounter while Staff A simultaneously applied topical medication to Resident #1's back. A written statement from Staff C on 6/2/26 at 11:39 AM regarding the incident with Resident #1 on 5/30/26 revealed Staff B held an arm around Resident #1's back with a hand on the other side and instructed Resident #1 to return to the room. Staff C didn't view this action as a problem. Resident #1 resisted and fought during the encounter, but Staff B executed a necessary action because Resident #1 entered other residents' rooms. Staff C didn't believe Staff B acted aggressively. Staff B maintained this hold from the 500 hallway to the 100 hallway and into the room. Resident #1 attempted to hit and kick Staff A and Staff B during the escort back to the room. Review of the facility investigation revealed that on 5/29/26 at approximately 11:45 PM, Resident #1 exited the room and approached the common area where Staff A, Staff C, and agency Staff B gathered. According to video evidence, Resident #1 took Staff A's walkie-talkie from the table and poked both Staff B and Staff C in the back of the neck. Staff reported that they avoided eye contact to de-escalate the situation and minimize further agitation. Resident #1 then moved toward the front entrance, triggered a wander guard alarm, and pulled the fire alarm near the front door. Following this, Resident #1 proceeded down the 500 hallway and verbally called out for help. Staff A and Staff B attempted to calm Resident #1 while Staff C reset the fire alarm panel. Staff B and Staff C both reported that Resident #1 struck Staff C during the de-escalation attempt, though Staff C didn't include this detail in a separate statement. Resident #1 continued to the 100 hallway and activated a second fire alarm. Resident #2, Resident #3, Resident #4, and Resident #5 stood at their doorways during this time. In an attempt to redirect Resident #1, Staff B approached from behind, placed one arm around Resident #1's back to hold Resident #1's wrist, and held Resident #1's waist with the other hand. Staff B then escorted Resident #1 back to the room and assisted Resident #1 into bed. Resident #1 immediately got up, returned to the 100 hallway, and removed the telephone and a thermostat cover from the wall. At this point, Resident #2 and Resident #3 remained in the hallway. Resident #1 then retrieved a fire extinguisher from the wall mount. Video evidence confirmed that Resident #1 handled the extinguisher and attempted an underhanded throw, but it fell directly in front of Resident #1's feet. The canister didn't strike any staff or residents. Staff B then requested permission from Staff A to hug Resident #1 while Staff A applied topical cream to Resident #1's back. Video evidence confirmed that during this interaction, Staff B held Resident #1 by the wrist and waist and didn't release Resident #1. Resident #1 didn't consent to this physical contact and couldn't disengage. During this interaction, Resident #1 lowered herself to the floor and refused to stand. Resident #1 remained on the floor until Resident #1's son arrived on site. Staff contacted hospice during this time. At 11:57 PM, the facility's alarm monitoring company contacted the Administrator and provided notification of the fire alarm activation. The Administrator immediately contacted the facility, and Staff A answered and reported that staff actively managed the situation. At 5:54 AM, the Administrator received a call from the on-call nurse, Staff G, Registered Nurse (RN), who reported that during the overnight incident, Resident #1 entered resident rooms and pointed the fire extinguisher at Resident #2 and Resident #3. Upon receiving this information, the Administrator immediately filed a self-report and initiated a formal investigation. On 6/22/26 at 11:28 AM Resident #1 sat in a recliner chair in the room. Resident #1 maintained an alert and pleasant status and responded to questions appropriately. Resident #1 stated that memory remained regarding pulling the<br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | fire alarm because staff members chased Resident #1. Resident #1 recalled three people present before the alarm activation but didn't remember the reason for pulling it. Resident #1 felt angry at that time, which occurred shortly after arrival when no one provided advance notice of the institutional transfer. Resident #1 revealed a dislike for losing independence. Resident #1 believed facility staff caused confusion. Resident #1 acknowledged probably threatening to strike others but didn't remember executing any hits. Resident #1 didn't recall if anyone struck Resident #1 but knew that staff grabbed for Resident #1. Resident #1 admitted feeling scared during the encounter when staff arrived and grabbed Resident #1. Resident #1 didn't think staff caused injury, noting that pain would've increased the anger. Resident #1 concluded that the staff grabbed Resident #1 but didn't act roughly or cause harm. On 6/23/26 at 8:50 AM Staff B confirmed working the night of the 5/30/26 incident with Resident #1. Staff A revealed that staff only supervised until Resident #1's son arrived. Resident #1 actively tried to go down on the ground, and Staff B tried to guide Resident #1 down. Staff B didn't touch Resident #1 otherwise and didn't hold Resident #1 at all. Resident #1 displayed a large amount of aggression at that time. Staff B didn't utilize a full restraint on Resident #1. Every action aimed to prevent a fall because Staff B didn't want Resident #1 to suffer an injury. Staff A and Staff B walked with Resident #1 a few times and tried to speak with Resident #1, but Resident #1 didn't demonstrate any reasoning capacity at all. On 6/23/26 at 1:32 PM Staff C revealed that regarding Resident #1's behaviors on 5/30/26, staff members tried talking to Resident #1 and asking about the problem. Staff C didn't exactly remember Resident #1's statements. Staff C confirmed that Staff B walked Resident #1 back to the room while holding onto Resident #1, and Staff C witnessed this guidance back to the room. Staff C revealed that facility rules didn't allow staff to use physical restraints at any time. Staff C didn't want involvement in the situation because staff members felt helpless in that moment. Resident #1 displayed behavioral symptoms, and Staff C believed that staff reactions increased Resident #1's agitation; therefore, Staff C wanted to leave Resident #1 alone so Resident #1 might calm down before staff reapproached. On 6/23/26 at 1:24 PM Staff D, CNA, revealed that when a resident displayed behaviors, Staff D attempted to remain calm and speak politely and respectfully. Successful approaches depended on the specific behavior. For example, if a resident exhibited extreme agitation by screaming, throwing items, or pulling a fire alarm, maintaining distance and using a calm voice worked best. Staff D used relaxing body language and tried to speak in a respectful manner. Staff D allowed residents space as long as they didn't cause harm to themselves or others. Staff D indicated that physical restraints didn't represent an appropriate response at any time, and staff should always pursue a hands-off approach. If residents calmed down, staff might touch a shoulder or hand, ask questions about personal topics like family or work history, and introduce alternate subjects. On 6/23/26 at 2:17 PM Staff E, LPN, confirmed that Resident #1 displayed paranoid behaviors. Staff E stated that whenever a resident exhibited such actions, Staff E attempted redirection. Staff E explained that talking about family or personal relationships helped redirect Resident #1. Staff E reassured Resident #1 and allowed space so Resident #1 didn't maintain the agitation. Staff E noted that staff shouldn't physically restrain a resident at any time unless that individual physically harmed someone, and then staff would only separate the individuals rather than apply a physical restraint. On 6/24/26 at 9:24 AM Staff F, CNA, revealed that handling agitated behaviors required stopping, assessing the situation, ensuring safety, and de-escalating the crisis. Staff F attempted to identify the resident's underlying problem and hoped that coworkers didn't delay in assisting. Staff F explained that separating the resident from the agitation source worked best. Staff F indicated that immediate danger to oneself or others represented the only time physical force became necessary, and staff shouldn't use force without immediate harm threats. Leaving the resident alone, providing space, and removing other residents didn't fail as the best options. On 6/24/26 at 9:41 AM Staff G, RN, expressed disagreement with the handled intervention. Regarding a fire alarm activation, Staff G responded immediately by standing with Resident #1, talking to Resident #1, and attempting to block the fire alarm to calm Resident #1 without physical touch while<br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | maintaining safety. Staff G explained that initiating a conversation to understand the behavior's cause prevents escalation. Staff G utilized a calm, reassuring voice without raising the tone. Staff G stated that physical force or touch didn't represent acceptable actions with a resident. If situations escalated, staff notified the healthcare provider and transferred the resident to the hospital. Staff G indicated that staff shouldn't hold or hug a resident to administer medication. Staff G expressed belief in resident rights, noting that the facility didn't exist to force interventions on individuals. On 6/24/26 at 9:55 AM the Director of Nursing (DON) confirmed the 5/30/26 incident regarding Resident #1's behaviors. The DON revealed initially thinking Resident #1 posed a risk to others, but that didn't reflect reality. Although staff members claimed they felt fearful, they didn't separate Resident #1 from other residents. The DON noted that staff didn't use available distraction and verbal redirection techniques. Staff could've contacted family members who expressed a willingness to come, and the family ultimately arrived once Resident #1 sat on the floor and refused to get up. Resident #1 typically cooperated with staff and responded well to family reassurance. The DON would've distracted Resident #1 with familiar topics like family and sewing. The DON believed staff ignored Resident #1 initially, which didn't represent appropriate care. The DON questioned if an early acknowledgement might've changed the outcome, or if Resident #1 sought coffee or alternate items that staff didn't offer to prevent escalation. Once the situation escalated, the DON disagreed with the physical holding executed by the staff, emphasizing that the facility didn't utilize hands-on restraints. The DON felt that staff physically restrained Resident #1 while walking Resident #1 up the hallway. The DON stated that if she worked at that time, she would've intervened, instructed staff to remove their hands, and notified a supervisor. The DON emphasized the duty to protect residents and expressed anger over the staff's actions, noting that staff didn't serve as the residents' voice. The DON stated that other staff should've intervened to separate the residents from harm, and she wouldn't tolerate such behavior because she wanted staff who protect residents. The DON concluded that physical restraints didn't represent an acceptable practice under any circumstances. The Restraint Free Environment policy dated [Undated] directed that a physical restraint refers to any manual method, physical or mechanical device, material, or equipment attached or adjacent to a resident's body that the individual cannot remove easily, restricting freedom of movement or normal access to one's body. The policy instructed that physical restraints include holding down a resident in response to a behavioral symptom or during care provision if the resident resists or refuses care. Compliance guidelines specified that residents maintain the right to respect and dignity, including freedom from any physical or chemical restraint imposed for discipline or staff convenience rather than medical necessity. The policy allowed brief physical restraints in emergency care situations to permit ordered, medically necessary treatments, unless the resident previously refused the treatment. Finally, the policy directed that falls didn't constitute self-injurious behavior or medical symptoms that warrant physical restraints. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and policy interview the facility administered a antipsychotic medication without a physician's order for 1 out of 1 residents reviewed with agitation and behaviors (Resident #1). The facility reported a census of 43 residents. Findings include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS Assessment showed Resident #1 exhibited behavioral symptoms including rejection of care on 1 to 3 days during the observation period, which worsened compared to prior assessments. The MDS Assessment indicated Resident #1 maintained independence with toilet transfer, sit to stand transfer, and ambulation (walking). The MDS Assessment listed diagnoses of hypertension (high blood pressure), arthritis (joint inflammation), and chronic obstructive pulmonary disease (COPD; chronic lung disease). The MDS Assessment indicated Resident #1 hadn't received antipsychotic (hallucination treatment) medication since admission/entry. Resident #1's May 2026 Electronic Medication Administration Record (EMAR) revealed a physician order for Haloperidol (antipsychotic medication) in Pentravan Cream (cream used to help absorb medication) 5 milligram (mg)/milliliter (ml) (2mg/0.4ml) to apply to the skin topically four times a day for agitation to give 2mg = 0.4ml, 4 times daily. Staff signed out the medication as administered on 5/29/26 at 7:00 AM, 11:00 AM, 3:00 PM, and 8:00 PM. The EMAR lacked an as-needed order for the medication. Staff didn't sign out the medication as administered again until 5/30/26 at 7:00 AM. Review of the Nurse Progress Note dated 5/26/26 at 10:02 AM revealed the nurse spoke with the hospice (end-of-life care) nurse and received an order to discontinue the as-needed haloperidol cream and schedule it. The new order directed staff to apply Haloperidol in Pentravan Cream 5mg/ml (2mg/0.4ml) to the skin topically four times a day for agitation to give 2mg = 0.4ml, 4 times daily. Review of the Physician Order Summary Report revealed an order for Haloperidol in Pentravan Cream 5mg/ml (2mg/0.4ml) to apply to the skin topically four times a day for agitation to give 2mg = 0.4ml, 4 times daily that became active on 5/26/26. Review of the Care Plan dated 5/30/26 failed to address the use of antipsychotic medications. Review of the facility Self-Report dated 6/3/26 regarding an incident on 5/29/26 revealed that during an incident with Resident #1, Staff B, Certified Nursing Assistant (CNA), requested permission from Staff A, Licensed Practical Nurse (LPN), to hug Resident #1 while Staff A applied topical cream to Resident #1's back. Review of the written statement from Staff A dated 6/2/26 at 10:45 AM revealed Resident #1 awoke and walked down the hallway. Resident #1 exhibited a negative mood, walked down the 500 hallway, turned lights on, and screamed for help. Resident #1 pulled the fire alarm, walked down the 100 hallway, and pulled the fire alarm there. Staff C, CNA, reported that Resident #1 grabbed a fire extinguisher. Staff A walked down the hallway and found the fire extinguisher already away from Resident #1. Staff A denied placing hands on Resident #1 and noted only applying cream to Resident #1's back. On 6/23/26 at 2:17 PM Staff E, LPN, revealed the order for Haldol (antipsychotic medication) for Resident #1 shifted from an as-needed basis to a scheduled basis. Staff E expressed uncertainty regarding subsequent events after Resident #1 changed rooms and hallways. Staff E explained that a nurse should never administer a medication without a physician order and noted checking the computer to find orders because the EMAR contains the physician orders. On 6/23/26 at 3:35 PM the Director of Nursing (DON) confirmed the facility lacked an as-needed order for the topical Haldol that Staff A administered to Resident #1 on 5/29/26. The Director of Nursing confirmed Staff A administered Haldol during behavioral episodes on 5/29/26 to Resident #1. The Director of Nursing confirmed this administration constituted a chemical restraint (medication control) because the nurse administered the medication without an order. The Director of Nursing stated an expectation that staff obtain an order prior to administering any medication. The Director of Nursing also noted this action provided<br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | grounds for termination because management refuses to retain a nurse who administers medication without an order. On 6/24/26 at 9:41 AM Staff G, Registered Nurse (RN), revealed every medication administration requires an order, noting that even Tylenol requires approval from a medical doctor. Staff G stated that administering an antipsychotic medication remains unacceptable even during behavioral episodes. Staff G reported checking the EMAR or the orders tab on the Electronic Health Record (EHR) and explained that if an order lacks documentation, administration can't occur. Staff G stated a nurse must call the provider to obtain a physician order under those circumstances. On 6/24/26 at 9:55 AM the Director of Nursing revealed that giving medication without a physician order remains entirely inappropriate. The Director of Nursing stated that Staff A should've requested a medication order when calling the provider, informed the Resident #1 Representative about the order, and requested consent. In the case of Resident #1, the Resident #1 Representative would've consented because they desired whatever measures maintained the safety of Resident #1 at the facility. The Director of Nursing stated an expectation that staff refrain from giving medication before obtaining an order, even when pulling items from the pharmacy emergency kit. The Use of Psychotropic Medication(s) policy dated undated instructed that chemical restraints refer to any drug utilized for discipline or staff convenience that lacks medical necessity to treat symptoms. The policy directed that although a psychotropic (mind-altering) medication may have approval to treat certain symptoms, staff must attempt nonpharmacological (non-drug) interventions unless clinical contraindications exist because they present fewer dangers to a resident's health and safety. The policy explanation and compliance guidelines directed that staff use psychotropic medications only when a practitioner determines the medication is appropriate to treat a specific, diagnosed, and documented condition and demonstrates a benefit through monitoring and documentation of the resident's response. |