

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285095	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024
NAME OF PROVIDER OR SUPPLIER Monument Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 111 West 36th Street Scottsbluff, NE 69361	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263</p> <p>Licensure Reference Number 175 NAC 12-006.09</p> <p>Based on observation, interview, and record review; the facility failed to perform wound care according to the provider's order for 1 (Resident 7) of 3 sampled residents. The facility census was 83.</p> <p>Findings Are:</p> <p>A record review of Resident 7's admission record revealed the resident was admitted to the facility on [DATE] and had a diagnosis of an open wound to their right shoulder which was added on 4/18/2022.</p> <p>A record review of Resident 7's physician's order revealed the following wound care order with a start date of 8/18/24:</p> <p>-Wound care to right shoulder: cleanse with Normal Saline (NS)/wound cleanser and gauze, do not allow site to close, apply No-Sting barrier film to peri-wound, apply Dermablue/equivalent over wound opening, and cover with a silicone border dressing. The order was to be completed daily on the day shift and as needed for drainage or dislodgement.</p> <p>An observation on 12/16/24 at 12:32 PM revealed Registered Nurse (RN)-A preparing to perform wound care on Resident 7. RN-A performed Hand Hygiene (HH) via Alcohol Based Hand Rub (ABHR) and obtained wound care supplies from a treatment cart located at the nurse's station. RN-A walked to a cart that was down the hallway and put on a mask, gown, and gloves from the cart, returned to treatment cart and prepared the wound dressing for Resident 7. RN-A carried the prepared wound dressing to Resident 7's room, entered the room and sat the dressing directly on Resident 7's overbed table without first establishing a clean field. RN-A took Resident 7's old dressing off of their right shoulder and threw the dressing in the trash, along with their gloves. RN-A obtained new, non-sterile gloves from a box in Resident 7's bathroom and put them on. RN-A realized they had left part of their wound care supplies at the treatment cart, so they opened Resident 7's room door, had another staff bring the gauze that was soaked in wound cleanser to the room, and then closed the room door with their elbow. RN-A used the soaked gauze to cleanse Resident 7's open wound on their right shoulder and then threw the gauze away. RN-A picked up the new dressing from Resident 7's overbed table and applied it to Resident 7's right shoulder wound without using any No-Sting barrier film as ordered.</p> <p>(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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 12/16/24 at 2:34 PM with RN-A confirmed RN-A did not use the No-Sting barrier film per the physician's order.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263</p> <p>Licensure Reference Number 175 NAC 12-006.18(D).</p> <p>Based on observation, interview, and record review; the facility failed to prevent the potential for cross contamination during wound care for 1 (Resident 7) of 3 sampled residents. The facility census was 83.</p> <p>Findings Are:</p> <p>A record review of facility policy Wound Care dated October 2010 revealed in the section Steps in the Procedure, staff were to use a disposable cloth to establish clean field on resident's overbed table and were to place all items to be used during procedure on the clean field. The policy stated staff were to wash and dry their hands after placing supplies on the overbed table, after removing the soiled dressing from the resident, and after the completion of performing the wound care. The policy also revealed staff were to wear sterile gloves when physically touching the wound or holding a moist surface over the wound.</p> <p>A record review of Resident 7's admission record revealed the resident was admitted to the facility on [DATE] and had a diagnosis of an open wound to their right shoulder which was added on 4/18/2022.</p> <p>A record review of Resident 7's physician's order revealed the following wound care order with a start date of 8/18/24:</p> <p>-Wound care to right shoulder: cleanse with Normal Saline (NS)/wound cleanser and gauze, do not allow site to close, apply No-Sting barrier film to peri-wound, apply Dermablue/equivalent over wound opening, and cover with a silicone border dressing. The order was to be completed daily on the day shift and as needed for drainage or dislodgement.</p> <p>An observation on 12/16/24 at 12:32 PM revealed Registered Nurse (RN)-A preparing to perform wound care on Resident 7. RN-A performed Hand Hygiene (HH) via Alcohol Based Hand Rub (ABHR) and obtained wound care supplies from a treatment cart located at the nurse's station. RN-A walked to a cart that was down the hallway and put on a mask, gown, and gloves from the cart, returned to treatment cart and prepared the wound dressing for Resident 7. RN-A carried the prepared wound dressing to Resident 7's room, entered the room and sat the dressing directly on Resident 7's overbed table without first establishing a clean field. RN-A took Resident 7's old dressing off of their right shoulder and threw the dressing in the trash, along with their gloves. RN-A obtained new, non-sterile gloves from a box in Resident 7's bathroom and put them on. RN-A realized they had left part of their wound care supplies at the treatment cart, so they opened Resident 7's room door, had another staff bring the gauze that was soaked in wound cleanser to the room, and then closed the room door with their elbow. RN-A used the soaked gauze to cleanse Resident 7's open wound on their right shoulder and then threw the gauze away. RN-A then picked up the new dressing from Resident 7's overbed table and applied it to Resident 7's right shoulder wound, removed their gloves, gown and mask, threw them away and exited Resident 7's room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 12/16/24 at 2:34 PM with RN-A confirmed the RN did not use the no sting per the physician's order, did not put a barrier down on Resident 1's overbed table before placing the clean dressing on the table, and did not perform hand hygiene as required.</p>