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| 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 04/03/2025 |
| 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) |
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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51560</p> <p>Licensure Reference Number 175 NAC 12.006.09 (l)(i)(1)</p> <p>Based on record review and interview, the facility failed to notify the resident and/or the residents' representative of a new medication for one (Resident 5) of three sampled residents. The facility identified a census of 89.</p> <p>Findings are:</p> <p>A record review of an undated Change in A Resident's Condition or Status Policy revealed the following:</p> <p>A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting).</p> <p>Unless otherwise instructed by the resident, a nurse will notify the resident's representative when there is a significant change in the resident's physical, mental, or psychosocial status.</p> <p>A record review of Resident 5s' Admission Summary revealed an admitted [DATE] from a short-term general hospital.</p> <p>The summary revealed Resident 5s' pertinent diagnoses include:</p> <ul style="list-style-type: none"> -Wedge compression vertebral fracture T7-T8- (a bone fracture located in the mid vertebral spine). -Scoliosis- (an abnormal curvature of the spine). -Osteoarthritis- (chronic inflammation and deterioration of the cartilage between joints). -Depression- (a mood disorder characterized by a sustained feeling of sadness and loss of interest). <p>A record review of Resident 5s' Minimum Data Set (MDS- a federally mandated assessment tool for nursing homes) dated 01/14/2025 revealed the following:</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>-Section C revealed Resident 5 had a Brief Interview for Mental Status (BIMS- a standardized assessment tool used to screen for cognitive impairment in long-term care facilities) score of 11/15 indicating Resident 5 had mild cognitive impairment.</p> <p>-Section D revealed Resident 5 had a Patient Health Questionnaire 2 (PHQ-2to9 - brief screening tool for depression; used to assess the severity of depressive symptoms) score of 4/27 indicating that Resident 5 suffered from minimal symptoms of depression.</p> <p>-Section E revealed Resident 5 exhibited no potential indicators of experiencing hallucinations or delusions. Section E further revealed that Resident 5 exhibited behavioral symptoms not directed at occurred daily and significantly disrupted care of living environment.</p> <p>-Section GG revealed Resident 5 required maximal to total dependent assistance with dressing, undressing, bathing, and hygiene.</p> <p>A record review of physicians' orders revealed the following:</p> <p>-Risperidone (a type of antipsychotic medication that treats mental health conditions schizophrenia, bipolar disorder and some symptoms of autism) 0.25 milligrams (mg); give one tablet by mouth every 12 hours as needed (PRN) for behaviors. The order had no documented evidence of a stop date or duration and included instructions to follow up with Resident 5s' primary health care provider. The order had a start date of 1/12/25.</p> <p>A record review of a Progress Note for Resident 5 dated 1/12/25 at 5:41 PM revealed Resident 5 began yelling out about pain to their back, despite having both PRN and regularly scheduled pain medication given. The writer documented they entered the room and found Resident 5 sitting in wheelchair, appearing to be sleeping and offering no complaints. The writer documented they left the room and approximately 10 minutes later, Resident 5 began to yell out again, and stated ow, it hurts. The writer documented that they notified the on-call provider at that point due to nothing helping Resident 5 with pain and discomfort. The writer stated that Resident 5 had pain medication, was repositioned, was redirected, and still Resident 5 continued to yell out. The writer documented that the provider prescribed an order for Risperidone 0.25 mg, one tablet every 12 hours as needed. The provider then instructed the facility to follow up with Resident 5s' primary care physician. The writer documented that the medication was administered, and Resident 5 continued to yell out for approximately 30 minutes, then was calm and did not yell out in pain since. A record review of Progress Notes revealed no documented evidence of Resident 5 or their representative being notified of the newly prescribed medication.</p> <p>An interview on 4/2/25 at 12:30 PM with Resident 5's representative revealed they were not made aware that Resident 5 was placed on that medication until much later and stated they would have not agreed to it, had they been told. The representative revealed they requested it be discontinued immediately upon hearing that the medication was an antipsychotic.</p> <p>An interview on 4/2/25 at 3:15 PM with Licensed Practical Nurse-A revealed that to their understanding the facility expectation is to notify the resident representative with changes in condition, which would include the use of a PRN antipsychotic.</p> <p>(continued on next page)</p> | | |

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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>An interview on 4/2/25 at 9:30 AM with Unit Manager-D revealed staff are educated to notify resident representatives as soon as possible when there is a change in condition that requires intervention. The UM-D confirmed that there was no documented evidence of Resident 5's representative being notified of the new medication and that there should have been.</p> | | |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51560</p> <p>Licensure Reference Number 175 NAC 12.006.09 (F)</p> <p>Based on observation, record review, and interviews, the facility failed to have resident specific interventions in place to address or minimize the behaviors of one (Resident 1) of three sampled residents. The facility identified a census of 89.</p> <p>Findings are:</p> <p>A record review of Resident 1's Admission Summary revealed an admitted [DATE].</p> <p>A record review of Resident 1's pertinent diagnoses revealed the following:</p> <ul style="list-style-type: none"> -Dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a general term for a decline in mental ability, including memory, thinking, and reasoning, and is caused by damage to or changes in the brain). -Alzheimer's Disease (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior). - Depression (a common and serious medical illness that negatively affects how you feel, think, and act. It's characterized by persistent sadness, loss of interest in activities). <p>A record review of Resident 1's Quarterly Minimum Data Set (a federally mandated assessment tool used in long term care) dated 1/7/25 revealed the following:</p> <ul style="list-style-type: none"> -Section C revealed a Brief Interview for Mental Status (BIMS- an assessment tool used in long term care to assess cognition) score of 6/15- indicating that Resident 1 had moderate to severe cognitive impairment. -Section D revealed a Patient Health Questionnaire (PHQ 9- a screening tool to assess for symptoms and severity of depression) score of 6- indicating Resident 1 experienced minimal symptoms of depression. -Section E revealed that Resident 1 had no documented behaviors. <p>A record review of Resident 1's current Care Plan revealed the following:</p> <ul style="list-style-type: none"> -A focus area revealed: Resident 1 has the potential to be physically aggressive related to their diagnosis of dementia. The goal for that focus area revealed: Resident 1 will not harm self or others. <p>(continued on next page)</p> | | |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>-Interventions for that focus area revealed: Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. Assess and address for contributing sensory deficits. Psychiatric/Psychogeriatric consult as indicated.</p> <p>A record review of incident reports revealed a resident to resident altercation on 2/23/25 involving Resident 1 that occurred in Resident 1's room with their roommate. The incident report revealed:</p> <p>A nurse was called into Resident 1's room by other staff who stated Resident 1 had been punching their roommate. Staff immediately separated Resident 1 from the roommate and Resident 1 was asked to sit in the common room. When Resident 1 was approached by staff they made negative comments about the roommate continuously talking to Resident 1, which led to the altercation.</p> <p>A record review of a Physician Visit on 3/5/25 revealed that Resident 1's provider recommended to the facility that Resident 1 would do better without a roommate given recent altercation.</p> <p>A record review of Progress Notes revealed the following:</p> <p>-A Progress Note on 1/17/25 revealed Resident 1 was cussing at her roommate who was being disruptive yelling throughout the night.</p> <p>-A Progress Note on 1/19/25 revealed Resident 1 was yelling out directly at their roommate. Both residents were in their own beds at this time. Staff was in the room and ensured that residents remained separate.</p> <p>- A Behavior Note on 2/23/25 revealed Resident 1 was observed being aggressive with their room mate.</p> <p>- A Behavior Note On 2/25/25 revealed Resident 1 was agitated and aggressive concerning the administration of their medication.</p> <p>- A Behavior Note on 3/24/25 revealed Resident 1 became agitated and struck out at their table mate twice during lunch. Resident 1 refused re-direction.</p> <p>- A Behavior Note on 4/3/25 revealed Resident 1 refused to go in their room and continued to curse and push staff in the hallway. Resident 1 was allowed space while staff stayed close by to ensure Resident 1's safety as well as the safety of other residents.</p> <p>(continued on next page)</p> | | |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>An interview on 3/31/25 at 10:20 AM with Nurse Aide (NA)-E revealed that Resident 1 does have the potential to become violent with little to no warning. NA-E stated that too much stimulation was a significant triggering factor for Resident 1. The stimulation could come in the form of visual, verbal, or acoustic. Regarding resident to resident abuse, NA-E reported that they voiced concerns regarding the transfer of Resident 1's now roommate to Resident 1's room to the Social Services Director (SSD). NA-E stated that the resident being moved into Resident 1's room was being transferred to memory support due to their propensity for violence. NA-E stated they were concerned that placing them in a room together would likely result in an altercation. NA-E stated that their concerns were largely ignored, as the two residents were placed together. NA-E stated that the SSD told all the staff on shift that their hands were tied and that the corporate office doesn't care how many altercations there are as long as the beds are filled. NA-E reported the two residents often argued in their room and required staff intervention to diffuse and redirect. NA-E stated they have not been approached by management team regarding Resident 1's behavior to discuss interventions, triggers to behaviors, or to gain input from floor staff. NA-E stated they are unsure of where to look to locate the facilities documented interventions for Resident 1</p> <p>An interview on 3/31/25 at 10:15 AM with Registered Nurse (RN)-B revealed that Resident 1 required moderate supervision on days that were full of stimulation and had the potential for catastrophic reactions (a sudden, intense emotional outburst characterized by distress, agitation, and disorganized behavior, often triggered by an overwhelming situation, particularly in individuals with neurological impairments) and violence. On those days staff monitor Resident 1 very closely to mitigate and watch for situations that may trigger them. On those days, staff will attempt to re-direct resident to a quieter environment. RN-B stated they told the SSD that transferring the resident from another hall to a shared room with Resident 1 was a bad idea due to the fact that both residents had incidents of getting aggressive with other residents. RN-B confirmed that the SSD told all the staff on shift that their hands were tied and that the corporate office doesn't care how many altercations there are as long as the beds are filled. RN-B stated that they have not been approached by management team to discuss Resident 1's behaviors, triggers, potential interventions, or gain input from floor staff on what works and what doesn't work. RN-B stated memory support unit does not have a unit manager and that they often feel like they are forgotten back here. RN-B confirms Resident 1's Care Plan is not individualized to them and stated they do not get notifications from management team when new interventions have been documented.</p> <p>An interview on 4/3/25 at 10:00 AM with NA-F revealed that Resident 1 keeps to themselves most of the time and does not like a lot of noise or stimulation. NA-F stated that they voiced concerns to SSD regarding the transfer of resident from the 200 hall to a shared room with Resident 1 based on the history of aggression that both residents had. NA-F confirmed that the SSD told all the staff on shift that their hands were tied and that the corporate office doesn't care how many altercations there are as long as the beds are filled. NA-F stated they are unsure of where to look to locate the facilities documented interventions for Resident 1.</p> <p>An interview with the Nursing Home Administrator (NHA) on 4/2/25 at 3:45 PM revealed they were not aware of staff having concerns regarding Resident 1's behavior and potential to become more violent with new roommate. The NHA confirmed that the unit that Resident 1 resides does not have its own Unit Manager that its oversight is split between the two other Unit Managers in the building. The NHA confirmed that the Care Plan is designed to be individualized and that Resident 1's is not.</p> | | |

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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>51560</p> <p>Licensure Reference Number 175 NAC 12.006.09</p> <p>Based on interviews and record review, the facility failed to perform wound care as ordered for one (Resident 6) of three sampled residents. The facility identified a census of 89.</p> <p>Findings are:</p> <p>A record review of an undated Pressure Ulcers/Skin Breakdown Clinical Protocol Policy revealed the physician will authorize pertinent orders related to wound treatments, including wound cleansing, debridement approaches, dressings, and application of topical agents, if indicated.</p> <p>A record review of Resident 6's care plan revealed that Resident 6 has a chronic surgical wound to their right shoulder. Interventions for that focus area revealed that staff are to follow treatment orders as provided by the wound nurse/wound clinic.</p> <p>A record review of Resident 6's provider orders revealed a wound care order with a start date of 8/18/24 and read as follows:</p> <p>Wound care to the right shoulder- cleanse with normal saline, wound cleanser, and gauze. Do not allow site to close, apply no sting barrier film to peri-wound, apply dermablue/equivalent over wound opening; cover with silicon border dressing every day shift for wound care.</p> <p>A record review of Resident 6's Minimum Data Set (MDS- a federally mandated assessment tool for nursing homes) dated 02/28/2025 revealed the following:</p> <p>-Section C revealed Resident 6 had a Brief Interview for Mental Status (BIMS- a standardized assessment tool used to screen for cognitive impairment in long-term care facilities) score of 15/15 indicating Resident 6 had no documented cognitive impairment.</p> <p>-Section GG revealed Resident 6 ambulated with a walker or a wheelchair and required partial to moderate assistance with dressing, undressing, toileting, and hygiene.</p> <p>-Section M revealed Resident 6 had a chronic surgical wound to their right anterior shoulder.</p> <p>A record review of Resident 6s' pertinent diagnosis revealed the following:</p> <p>-Unspecified open wound to right shoulder- a surgical wound that is expected to remain open per physicians' orders.</p> <p>-Major depressive disorder without psychotic features-a recurrent, severe form of depression characterized by persistent sadness, loss of interest, and other symptoms, but without hallucinations or delusions.</p> <p>(continued on next page)</p> | | |

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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>-Bipolar disorder, Unspecified-a mental illness characterized by extreme shifts in mood, energy, and activity levels, ranging from periods of intense happiness and energy (mania or hypomania) to periods of deep sadness and low energy (depression).</p> <p>A record review of Resident 6s' Treatment Administration Record (TAR) for the month of March revealed documented evidence of dressing changes to Resident 6s' right shoulder being completed 20 of 31 days.</p> <p>An interview on 3/31/25 at 9:30 AM with Resident 6 revealed that Resident 6 feels well cared for. Resident 6 stated the wound on their right shoulder is supposed to have a dressing change every day but stated it isn't always done every day. Resident 6 revealed that it will sometimes go three days without being changed.</p> <p>An interview with Licensed Practical Nurse (LPN) A on 3/31/25 at 1:30 PM confirmed that there have been numerous times that they have performed addressing change to Resident 6s' right shoulder and found the old dressing to be dated two sometimes three days prior to that day. LPN-A revealed the dressing also at times does not have a date on it.</p> <p>An interview on 4/2/25 at 3:45 PM with the Director of Nursing (DON) confirmed that there was documented evidence on Resident 6s' TAR of dressing changes to right shoulder occurring a total of 20/31 days for March. The DON stated the facility expectation is that dressing changes will be completed as ordered and if the nurse on that shift is unable to complete the dressing, it should be passed on to the next shift for completion. The DON revealed that the facility had previously identified this as a facility-wide problem and revealed an education document that was given to Nursing staff regarding the importance of following the dressing change orders and frequency.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51560</p> <p>Licensure Reference Number 175 NAC 12.006.09 (F) (i) (5)</p> <p>Based on observation, record review, and interviews, the facility failed to protect other residents from one (Resident 1) of three sampled residents who displayed adverse behaviors. The facility identified a census of 89.</p> <p>Findings are:</p> <p>A record review of Resident 1's Admission Summary revealed an admitted [DATE].</p> <p>A record review of Resident 1's pertinent diagnoses revealed the following:</p> <ul style="list-style-type: none"> -Dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a general term for a decline in mental ability, including memory, thinking, and reasoning, and is caused by damage to or changes in the brain). -Alzheimer's Disease (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior). - Depression (a common and serious medical illness that negatively affects how you feel, think, and act. It's characterized by persistent sadness, loss of interest in activities). <p>A record review of Resident 1's Quarterly Minimum Data Set (a federally mandated assessment tool used in long term care) dated 1/7/25 revealed the following:</p> <ul style="list-style-type: none"> -Section C revealed a Brief Interview for Mental Status (BIMS- an assessment tool used in long term care to assess cognition) score of 6/15- indicating that Resident 1 had moderate to severe cognitive impairment. -Section D revealed a Patient Health Questionnaire (PHQ 9- a screening tool to assess for symptoms and severity of depression) score of 6- indicating Resident 1 experienced minimal symptoms of depression. -Section E revealed that Resident 1 had no documented behaviors. <p>A record review of Resident 1's current Care Plan revealed the following:</p> <p>A focus area revealed:</p> <ul style="list-style-type: none"> -Resident 1 has the potential to be physically aggressive related to their diagnosis of dementia. <p>(continued on next page)</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>The goal for that focus area revealed: Resident 1 will not harm self or others.</p> <p>Interventions for that focus area revealed:</p> <ul style="list-style-type: none"> -Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. -Assess and address for contributing sensory deficits. Psychiatric/Psychogeriatric consult as indicated. <p>A record review of incident reports revealed a resident to resident altercation on 2/23/25 involving Resident 1 that occurred in Resident 1's room with their roommate. The incident report revealed:</p> <p>A nurse was called into Resident 1's room by other staff who stated Resident 1 had been punching their roommate. Staff immediately separated Resident 1 from the roommate and Resident 1 was asked to sit in the common room. When Resident 1 was approached by staff they made negative comments about the roommate continuously talking to Resident 1, which led to the altercation.</p> <p>A record review of a Physician Visit on 3/5/25 revealed that Resident 1's provider recommended to the facility that Resident 1 would do better without a roommate given recent altercation.</p> <p>A record review of Progress Notes revealed the following:</p> <ul style="list-style-type: none"> -A Progress Note on 1/17/25 revealed Resident 1 was cussing at her roommate who was being disruptive yelling throughout the night. -A Progress Note on 1/19/25 revealed Resident 1 was yelling out directly at their roommate. Both residents were in their own beds at this time. Staff was in the room and ensured that residents remained separate. -A Behavior Note on 2/23/25 revealed Resident 1 was observed being aggressive with their room mate. -A Behavior Note On 2/25/25 revealed Resident 1 was agitated and aggressive concerning the administration of their medication. -A Behavior Note on 3/24/25 revealed Resident 1 became agitated and struck out at their table mate twice during lunch. Resident 1 refused re-direction. -A behavior Note on 4/2/25 revealed Resident 1 was visited by Psychiatric Provider who recommended Resident 1 be moved to a different room to lessen irritability. <p>An observation on 3/31/25 at 10:15 AM Resident 1 is observed to be sitting in commons area with other residents who are engaged in an activity with activity staff. Resident 1 is noted to be sitting away from the group against the wall with arms folded across chest. Resident 1 appears to be taking part in activity while maintaining distance from the group of people.</p> <p>(continued on next page)</p> |

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| 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>An interview on 3/31/25 at 10:20 AM with Nurse Aide (NA)-E revealed that Resident 1 does have the potential to become violent with little to no warning. NA-E stated that too much stimulation was a significant triggering factor for Resident 1. The stimulation could come in the form of visual, verbal, or acoustic. Regarding resident to resident abuse, NA-E reported that they voiced concerns regarding the transfer of Resident 1's now roommate to Resident 1's room to the Social Services Director (SSD). NA-E stated that the resident being moved into Resident 1's room was being transferred to memory support due to their propensity for violence. NA-E stated they were concerned that placing them in a room together would likely result in an altercation. NA-E stated that their concerns were largely ignored, as the two residents were placed together. NA-E stated that the SSD told all the staff on shift that their hands were tied and that the corporate office doesn't care how many altercations there are as long as the beds are filled. NA-E reported the two residents often argued in their room and required staff intervention to diffuse and redirect. NA-E stated they have not been approached by management team regarding Resident 1's behavior to discuss interventions, triggers to behaviors, or to gain input from floor staff.</p> <p>An interview on 3/31/25 at 10:15 AM with Registered Nurse (RN)-B revealed that Resident 1 required moderate supervision on days that were full of stimulation and had the potential for catastrophic reactions (a sudden, intense emotional outburst characterized by distress, agitation, and disorganized behavior, often triggered by an overwhelming situation, particularly in individuals with neurological impairments) and violence. On those days staff monitor Resident 1 very closely to mitigate and watch for situations that may trigger them. On those days, staff will attempt to re-direct resident to a quieter environment. RN-B stated they told the SSD that transferring the resident from another hall to a shared room with Resident 1 was a bad idea due to the fact that both residents had incidents of getting aggressive with other residents. RN-B confirmed that the SSD told all the staff on shift that their hands were tied and that the corporate office doesn't care how many altercations there are as long as the beds are filled. RN-B stated that they have not been approached by management team to discuss Resident 1's behaviors, triggers, potential interventions, or gain input from floor staff on what works and what doesn't work. RN-B stated memory support unit does not have a unit manager and that they often feel like they are forgotten back here.</p> <p>An interview on 4/3/25 at 10:00 AM with NA-F revealed that Resident 1 keeps to themselves most of the time and does not like a lot of noise or stimulation. NA-F stated that they voiced concerns to SSD regarding the transfer of resident from the 200 hall to a shared room with Resident 1 based on the history of aggression that both residents had. NA-F confirmed that the SSD told all the staff on shift that their hands were tied and that the corporate office doesn't care how many altercations there are as long as the beds are filled.</p> <p>An interview with the Nursing Home Administrator (NHA) on 4/2/25 at 3:45 PM revealed they were not aware of staff having concerns regarding Resident 1's behavior and potential to become more violent with new roommate. The NHA confirmed that the unit that Resident 1 resides does not have its own Unit Manager that its oversight is split between the two other Unit Managers in the building.</p> | | |

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| <p>F 0757</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51560</p> <p>Licensure Reference Number 175 NAC 12.006.09 (H)</p> <p>Based on observation, record review, and interviews; the facility failed to ensure that one (Resident 5) of three sampled residents were not over-medicated. The facility identified a census of 89.</p> <p>Findings are:</p> <p>A record review of an undated Psychotropic Medication Use Policy revealed the following:</p> <p>Residents receiving psychotropic medications are monitored for adverse consequences.</p> <p>If psychotropic medications are identified as possibly causing or contributing to adverse consequences, the prescriber will determine whether the medication(s) should be continued, and document the rationale for this decision. Situations which may prompt an evaluation or re-evaluation of the resident include:</p> <ul style="list-style-type: none"> -A clinically significant change in condition/status; -A new, persistent, or recurrent clinically significant symptom or problem; -A worsening of an existing problem or condition; -An unexplained decline in function or cognition. <p>A record review of physicians' orders revealed the following:</p> <ul style="list-style-type: none"> -Risperidone (a type of antipsychotic medication that treats mental health conditions schizophrenia, bipolar disorder and some symptoms of autism) 0.25 milligrams (mg); give one tablet by mouth every 12 hours as needed (PRN) for behaviors. The order had no documented evidence of a stop date or duration and included instructions to follow up with Resident 5s' primary health care provider. The order had a start date of 1/12/25. -Oxycodone (an opioid medication used for the treatment of pain) 10 mg; give one tablet by mouth every 12 hours for chronic pain requiring long term opioid treatment. This order had a start date of 1/10/25 -Oxycodone-Acetaminophen (an opioid combined with a non-opioid medication used to treat pain) 10-325 mg; give one tablet by mouth every 5 hours for chronic pain. The order had a start date of 1/10/25. -Buprenorphine HCl (a partial opioid used to treat pain with less side effects) 2 mg, Give 0.5 tablet under the tongue twice a day. This medication had a start date of 1/20/25, was administered the month of February as a scheduled medication, and replaced the scheduled Oxycodone 10 mg order in an effort to decrease side effects. <p>(continued on next page)</p> |

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| <p>F 0757</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>A review of a Federal Drug Administration (FDA) Drug Safety Communication released in 2016 revealed a Black Box Warning (the most serious level of warning the FDA can place on a prescription drug label, indicating a significant risk of serious, potentially life-threatening, adverse effects) had been issued related to the interaction between opioid medications and antipsychotic medications. The interaction was shown to cause increased respiratory depression (a condition where breathing becomes too slow or shallow, potentially leading to insufficient oxygen and carbon dioxide exchange) and increased sedation.</p> <p>A record review of Resident 5s' Admission Summary revealed an admitted [DATE] from a short-term general hospital.</p> <p>The summary revealed Resident 5s' pertinent diagnoses include:</p> <ul style="list-style-type: none"> -Wedge compression vertebral fracture T7-T8- (a bone fracture located in the mid vertebral spine). -Scoliosis- (an abnormal curvature of the spine). -Osteoarthritis- (chronic inflammation and deterioration of the cartilage between joints). -Depression- (a mood disorder characterized by a sustained feeling of sadness and loss of interest). <p>A record review of Resident 5s' Minimum Data Set (MDS- a federally mandated assessment tool for nursing homes) dated 01/14/2025 revealed the following:</p> <ul style="list-style-type: none"> -Section C revealed Resident 5 had a Brief Interview for Mental Status (BIMS- a standardized assessment tool used to screen for cognitive impairment in long-term care facilities) score of 11/15 indicating Resident 5 had mild cognitive impairment. -Section D revealed Resident 5 had a Patient Health Questionnaire 2 (PHQ-2to9 - brief screening tool for depression; used to assess the severity of depressive symptoms) score of 4/27 indicating that Resident 5 suffered from minimal symptoms of depression. -Section E revealed Resident 5 exhibited no potential indicators of experiencing hallucinations or delusions. Section E further revealed that Resident 5 exhibited behavioral symptoms not directed at occurred daily and significantly disrupted care of living environment. -Section GG revealed Resident 5 required maximal to total dependent assistance with dressing, undressing, bathing, and hygiene. -Section I revealed Resident 5 had a psychiatric diagnosis of depression. -Section J revealed Resident 5 received scheduled pain medication and PRN pain medication. The section further revealed that Resident 5 had not received non-medication intervention for pain. The Pain Assessment Interview revealed Resident 5 acknowledged the presence of pain rarely and revealed that pain rarely effected the ability to sleep. <p>(continued on next page)</p> | | |

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| <p>F 0757</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>A record review of a Progress Note for Resident 5 dated 1/10/15, Resident 5s' admission day, revealed Resident 5 was alert and oriented to person, place, time, and situation. Resident 5 was responsive to commands and questions. Resident 5 used a walker and staff assistance for transfers.</p> <p>A record review of a Progress Note for Resident 5 dated 1/12/25 at 5:41 PM revealed Resident 5 began yelling out about pain to their back, despite having both PRN and regularly scheduled pain medication given. The writer documented they entered the room and found Resident 5 sitting in wheelchair, appearing to be sleeping and offering no complaints. The writer documented they left the room and approximately 10 minutes later, Resident 5 began to yell out again, and stated ow, it hurts. The writer documented that they notified the on-call provider at that point due to nothing helping Resident 5 with pain and discomfort. The writer stated that Resident 5 had pain medication, was repositioned, was redirected, and still Resident 5 continued to yell out. The writer documented that the provider prescribed an order for Risperidone 0.25 mg, one tablet every 12 hours as needed. The provider then instructed the facility to follow up with Resident 5s' primary care physician. The writer documented that the medication was administered, and Resident 5 continued to yell out for approximately 30 minutes, then was calm and did not yell out in pain since.</p> <p>A record review of Resident 5s' Medication Administration Record from 1/12/25 to 1/31/25 revealed the as needed antipsychotic medication was administered 11 occasions in 20 days with no documented evidence regarding what behaviors were observed that indicated the use of the medication. A review of the follow-up documentation (documentation required when an as needed medication is administered, to determine its effectiveness) revealed the medication was documented as being effective, indicating that no further behaviors were observed.</p> <p>A record review of Resident 5s' Medication Administration Record from 1/12/25 to 1/28/25 revealed the opioid medication was administered 21 occasions in 16 days. The follow-up documentation revealed the medication was effective in treating Resident 5s' pain.</p> <p>A record review of A record review of Resident 5s' Medication Administration Record from 2/11/25 to 2/28/25 revealed the antipsychotic medication was administered 12 occasions in 18 days. A review of the follow-up documentation revealed three occasions that the medication was documented as ineffective.</p> <p>A record review of Resident 5s' Medication Administration Record from 2/11/25 to 2/28/25 revealed the Buprenorphine medication was administered daily, as ordered.</p> <p>A record review of Resident 5s' Medication Administration Record from 3/1/25 to 3/20/25 revealed the antipsychotic medication was administered 8 occasions in 20 days.</p> <p>A record review of Resident 5s' Medication Administration Record from 3/1/25 to 3/31/25 revealed the opioid medication was administered every day, three times a day, as ordered by the provider.</p> <p>A record review of Resident 5s' Progress Notes from 1/12/25 to 3/24/25 revealed the following documentation:</p> <p>(continued on next page)</p> | | |

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| <p>F 0757</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>-On 1/20/25, a Progress Note revealed Resident 5 was seen at a pain clinic where the Provider documented that Resident 5 was too heavily medicated and discontinued Resident 5s' routinely scheduled Oxycodone, but left the PRN oxycodone order in place. In addition, an order for Buprenorphine HCl (a partial opioid used to treat pain with less side effects) 2 mg, Give 0.5 tablet under the tongue twice a day was initiated</p> <p>-On 1/23/25, Resident 5 was evaluated by their primary care physician. The progress note further stated that Resident 5 has had a decline in cognition and physical ability. There was no documented evidence of the provider addressing the need for continuation of the antipsychotic medication or acknowledging a potential interaction between pain medication regimen and antipsychotic medication.</p> <p>-On 1/24/25, Resident 5s' representative voiced concern over Resident 5s' decline to which the facility told them labs were drawn and results were pending.</p> <p>-On 1/25/25, a Progress Note stated Resident 5 continues to decline with mentation and physical ability. Resident 5 has trouble feeding self, transfers, working with Physical Therapy, communicating issues (eating, using restroom, pain, and hold a conversation). The writer further stated that a phone call was placed to a physician in regard to the decline, as, when Resident 5 was admitted, they were alert and oriented to person, place, time, and situation. Now Resident 5 is oriented to self only. The physician gave orders to send Resident 5 to the Emergency Department.</p> <p>-Resident 5 returned from the Emergency Department after a chest x-ray, brain scan, and lab work with no issues noted, per writer.</p> <p>-On 1/28/25 a Care Conference Note revealed that Resident 5s' representatives had concerns with Resident 5s' mentation and stated that Resident 5 is not confused at baseline. Resident 5s' representatives requested to have their medications reviewed. No documented evidence of a follow-up is noted in the Progress Notes regarding this request.</p> <p>-On 1/28/25 a Progress Note regarding a telephone call with the pain clinic regarding Resident 5 revealed an order to discontinue all orders for the oxycodone.</p> <p>-On 2/3/25 a Progress Note at 1:37 AM revealed that Resident 5 was screaming out in pain and pointed to [gender] upper left side and stated it radiated around [gender] back. Resident 5 was transported to the Emergency Department per an order from the Nurse Practitioner on-call. Resident was discharged from the hospital after having their pain treated with opioid medication.</p> <p>-On 2/3/25 a Progress note at 5:59 PM revealed Resident 5 was again sent to the Emergency Department regarding uncontrolled pain.</p> <p>-On 2/10/25 Resident 5 was discharged from the hospital with no new orders, per writer. Writer further revealed that per the hospital nurse nothing new was found during the hospitalization.</p> <p>-On 2/10/25 a Progress Note revealed Resident 5 had a fall in their room, per writer.</p> <p>-On 2/13/25 a Progress Note revealed Resident 5 was administered the as needed antipsychotic medication due to sporadic yelling during the night. Writer stated the medication was effective.</p> <p>(continued on next page)</p> | | |

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| F 0757 Level of Harm - Actual harm Residents Affected - Few | <p>-On 2/18/25 a Progress Note revealed that the in-house Nurse Practitioner saw Resident 5 and instructed the facility to follow up with primary provider and pain management provider. There was no documented evidence of the provider addressing the need for continuation of the antipsychotic medication or acknowledging a potential interaction between pain medication regimen and antipsychotic medication.</p> <p>-On 2/25/25 a Progress Note revealed the Director of Nursing (DON) left a message for Resident 5s' primary care provider regarding risperidone order stating Resident 5 currently has a PRN order for risperidone and utilizes it daily. The DON is requesting that it be scheduled as a routine medication.</p> <p>-On 2/28/25 a Progress Note revealed Resident 5 returned from the pain clinic with orders to discontinue the pain medication- Buprenorphine 2 mg and issued an order to re-start the Oxycodone-Acetaminophen 10-325 mg three times at day, scheduled.</p> <p>-On 3/21/25 a Progress Note revealed a call to Resident 5s' primary care provider revealing that Resident 5s' representatives would like the antipsychotic medication Risperidone discontinued. The note further stated that Resident 5 has an appointment with the physician 3/24/25 and that it would be addressed at that time.</p> <p>-On 3/24/25 a Progress Note revealed Resident 5 was evaluated by the Primary Care Provider who stated Resident 5 was not doing well. Has many issues. The Physician discontinued the antipsychotic and the buprenorphine. Resident 5 remained on the PRN oxycodone.</p> <p>An interview on 4/2/25 at 12:10 PM with Physical Therapy Director (PTD) revealed that Resident 5 was discharged from therapy on 3/13/25 related to inconsistencies with therapy. The PTD further describes Resident 5s' inconsistencies as They were alert, oriented, and able to follow commands one day; then would be nearly completely nonverbal the next day. This made any progress with therapy very difficult to achieve.</p> <p>An interview on 4/2/25 at 10:45 AM with Nurse Aide (NA)-G revealed that they have worked with Resident 5 since their admission to the facility. NA-G stated there was period of time after Resident was admitted that their cognition and physical abilities appeared to have declined. NA-G further revealed that within the last week they had noted an improvement in Resident 5's cognition and stated Resident 5 seems more with it, knows more about what they want, and are able to tell me.</p> <p>An interview on 4/2/25 at 12:30 PM with Resident 5's representative revealed they were not made aware that Resident 5 was placed on that medication until much later and stated they would have not agreed to it, had they been told. The representative revealed they voiced concern about Resident 5's decline on numerous occasions and knew that something was off. The representative revealed they requested it be discontinued immediately upon hearing that the medication was an antipsychotic. Resident 5's representative stated they visit Resident 5 up to three times a day and have noticed an improvement in Resident 5's cognition and physical abilities.</p> <p>(continued on next page)</p> | | |

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| <p>F 0757</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>An interview on 3/31/25 at 10:30 AM with Unit Manager (UM)-D revealed that new education has been provided to staff on using the on-call provider for the management of behaviors. UM-D revealed they thought each time a provider signed the order summary that the provider was essentially renewing the PRN order. UM-D confirmed that there were many missed opportunities to evaluate the potential of Resident 5 being over-medicated or a potential interaction between opioids and antipsychotics.</p> |