STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285095	A. Building B. Wing	08/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monument Rehabilitation and Care Center	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)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Number of residents sampled: Number of residents cited: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, record review, interview, and facility policy review, the facility failed to implement an adequate pain management program by accurately assessing, monitoring, and treating pain, which affected 1 (Resident #90) of 3 residents reviewed for pain management. The failure resulted in Resident #90 experiencing uncontrolled pain. Findings included: A facility policy titled, Pain Assessment and Management, revised 10/2022, indicated, The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. The policy revealed, 1. The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. 2. 'Pain management' is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. 3. Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain; b. Recognizing the presence of pain; c. Identifying the characteristics of pain; d. Addressing the underlying causes of pain; e. Developing and implementing approaches to pain management; f. Identifying and using specific strategies for different levels and sources of pain; g. Monitoring for the effectiveness of interventions; and h. Modifying approaches as necessary. The policy also indicated, Recognizing Pain included 1. Observe the resident (during rest and movement) for physiological and behavioral (non-verbal) signs of pain; and 5. Review the medication administration record to determine how often the individual requests and receives PRN [pro re nata; as needed] pain medication, and to what extent the administered medications relieve the resident's pain. The policy revealed, Assessing Pain included 1. Assess the resident at admission and during ongoing assessments to help identify the resident who is experiencing pain or for whom pain may be anticipated during specific procedures, care, or treatment; and 4. Assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level. The policy continued, 5. During the pain assessment gather the following information as indicated from the resident (or legal representative), which included c. Characteristics of pain; d. Impact of pain on quality of life; f. Factors and strategies that reduce pain; and h. Physical and psychosocial issues (physical examination of the site of the pain, movement, or activity that causes the pain, as well as any discussion with resident about any psychological or psychosocial concerns that may be causing or exacerbating pain). The Implementing Pain Management Strategies included 1. Establish a treatment regimen that is specific to the resident based on consideration of the following: a. The resident's medical condition; b. Current medication regimen; c. History of addiction or opioid use disorder; d. Nature, severity, and cause of the pain; e. Course of the illness; and f. Treatment goals. The policy continued, 2. Non-pharmacological interventions may be appropriate alone or in conjunction with medications. The policy revealed, 5. The following are considered when establishing the medication regimen: a. Starting with lower doses and titrating upward as necessary; b. Administering medication around the clock rather than PRN; c. Combining long-acting medications with PRNs for breakthrough pain; d. Combining non-narcotic analgesics with narcotic (opioid) analgesics; and e. Reducing or preventing anticipated adverse consequences of medications. The policy revealed, Monitoring and Modifying Approaches included 5. Contact the prescriber immediately if the resident's pain or medication side effects are not adequately controlled, and 6. If pain has not been adequately controlled, the multidisciplinary team, including the physician, shall reconsider approaches and make adjustments as indicated. The policy revealed, Report the following information to the physician or practitioner, which included 4. Prolonged, unrelieved pain despite care plan interventions. An admission Record indicated the facility admitted Resident #90 on 08/05/2025. According to the admission Record, the resident had a medical history that included diagnoses of primary osteoarthritis of the left shoulder, the presence of a left artificial shoulder joint, aftercare following joint replacement surgery, pain in the left shoulder, low back pain, and chronic pain. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/11/2025, revealed Resident #90 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident received or was offered PRN medication during the assessment timeframe. Resident #90's Care Plan Report included a focus area initiated 08/07/2025, that indicated the resident was at risk for pain related to the primary diagnosis of osteoarthritis and left shoulder surgery. Interventions initiated on 08/07/2025 directed staff to administer medications as ordered and to reposition the resident. The Care Plan