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	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monument Healthcare and Nursing 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(S) Based on observation, interview, and record review; the facility failed to contain 4 (Residents 3, 6, 7, and 8) of 4 sampled residents' catheter bags within a dignity bag while in view of others. The facility identified a census of 82. Findings Are: A record review of facility policy Dignity with a revision date of February 2021 revealed demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents by helping the resident keep urinary catheter bags covered. A.A record review of Resident 3's admission Record dated 6/8/2026 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 3's Order Summary Report dated 6/8/2026 revealed the resident had an order to monitor their foley catheter (a tube placed into the bladder to drain urine) output every shift, with a start date of 5/6/2026. An observation on 6/8/2026 at 8:42 AM revealed Resident 3 sitting in their wheelchair in the Golden Moments Activities room with other residents. Resident 3 had a catheter bag hooked to the underside of their wheelchair; there was no cover on the catheter bag and urine was visible within the bag from the hallway outside the room. An observation on 6/8/2026 at 10:00 AM revealed Resident 3 remained in the same room in their wheelchair with other residents listening to music. Their catheter bag continued to be hooked to the underside of their wheelchair with no cover on it and urine visible in it from the hallway. An observation on 6/8/2026 at 12:00 PM revealed Resident 3 sitting in their wheelchair at a table in the dining room with other residents. Their catheter bag continued to be hooked to the underside of their wheelchair with no cover on it and urine visible in it from several feet away. An observation on 6/9/2026 at 8:05 AM revealed Resident 3 sitting in their wheelchair at a table in the dining room with other residents. Their catheter bag was hooked to the underside of their wheelchair with no cover on it and urine visible in it from several feet away. An interview on 6/9/2026 at 8:15 AM with the facility Administrator confirmed Resident 3's urinary catheter bag was not contained within a dignity bag, and the urine was visible to others in the dining room. Administrator confirmed the catheter bag should have been concealed within a dignity bag. B.A record review of Resident 6's admission Record dated 6/8/2026 revealed the resident was admitted to the facility on [DATE] with a diagnosis of neuromuscular dysfunction of the bladder (nerve damage interrupts the communication between the brain and bladder causing the bladder unable to contract and release urine properly). A record review of Resident 6's undated Care Plan revealed the resident had an indwelling foley catheter related to their neurogenic bladder. An observation on 6/8/2026 at 8:49 AM revealed Resident 6 laying in their bed with their room door open. Their catheter bag was hooked onto the metal frame of the bed and did not have a cover on it. There was urine visible in the bag from the hallway. An observation on 6/8/2026 at 10:53 AM revealed Resident 6 laying in their bed talking with a staff person who was standing next to the bed. Their catheter bag remained hooked onto the metal frame of their bed without a cover on it and urine was visible within the bag from the hallway. An observation on 6/8/2026 at 12:57 AM revealed Resident 6 laying in their bed with the door to their room open. Their catheter bag remained in the same position as prior observations. C.A record review of Resident 7's admission Record dated 6/8/2026 revealed (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
	285095	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monument Healthcare and Nursing 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident was admitted to the facility on [DATE] with diagnoses of neuromuscular dysfunction of the bladder and retention of urine. A record review of Resident 7's undated Care Plan revealed the resident had an indwelling foley catheter related to neuromuscular bladder disfunction and urinary retention. An observation on 6/8/2026 at 8:54 AM revealed Resident 7 laying in their bed with the door to their room open. Their catheter bag was hooked onto the metal frame of the bed and did not have a cover on it. There was urine visible in the bag from the hallway. An observation on 6/8/2026 at 10:59 AM revealed Resident 7 laying in their bed with the door to their room open. Their catheter bag remained hooked onto the metal frame of the bed and did not have a cover on it. There was urine visible in the bag from the hallway. An observation on 6/8/2026 at 12:03 PM revealed Resident 7 sitting in their wheelchair at a table in the dining room with other residents. Resident 7's catheter bag was hooked to the underside of their wheelchair without a cover on it and there was urine in the bag visible from several feet away. An observation on 6/9/2026 at 7:37 AM revealed Resident 7 laying in their bed with the light off and the door to the hallway open. Their catheter bag was hooked onto the metal frame of the bed and did not have a cover on it. There was urine visible in the bag from the hallway. D.A record review of Resident 8's admission Record dated 6/8/2026 revealed the resident was admitted to the facility on [DATE] with a diagnosis of retention of urine. A record review of Resident 8's undated Care Plan revealed the resident had an indwelling foley catheter related to urinary retention. An observation on 6/8/2026 at 8:44 AM revealed Resident 8 had been sitting at a table in the dining room with other residents. Resident 8's catheter bag was hooked to the underside of their wheelchair without a cover on it and there was urine in the bag visible from several feet away. At this time, nursing staff approached Resident 8 and pushed them in their wheelchair to their room. An observation on 6/8/2026 at 10:02 AM revealed Resident 8 was being pushed out of their room and down the hallway by facility therapy staff. Their catheter bag remained hooked to the underside of their wheelchair without a cover on it and with urine visible from several feet away. An observation on 6/8/2026 at 12:50 PM revealed Resident 8 being pushed in their wheelchair from the dining room and through the hallway by nursing staff. Their catheter bag remained hooked to the underside of their wheelchair without a cover on it and with urine visible from several feet away. An observation on 6/9/2026 at 8:01 AM revealed Resident 8 sitting in their wheelchair at a table in the dining room with other residents. The resident's catheter bag was hooked to the underside of their wheelchair without a cover on it and there was urine in the bag visible from several feet away. An interview on 6/9/2026 at 8:15 AM with the facility Administrator confirmed Resident 8's urinary catheter bag was not contained within a dignity bag, and the urine was visible to others in the dining room. Administrator confirmed the catheter bag should have been concealed within a dignity bag.