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	08/01/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50105 Licensure Reference Number 175 NAC 12-006.05 (E) Based on interviews and record reviews, the facility failed to provide bathing preferences for 1 (Resident 27) of 1 sampled resident. The facility census was 75. Findings are: A. Record review of Resident 27's Admission Record dated 07/29/2024 revealed that Resident 27 originally admitted to the facility on [DATE]. Record review of Resident 27's Minimum Data Set (MDS -a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) dated 05/27/2024 revealed a Brief Interview for Mental Status (BIMS-a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) of 15, which indicated the resident had no mental status impairment. An interview on 07/29/2024 at 11:15 AM with Resident 27 indicated the staff would not allow a bed bath as a choice. A review of Resident 27's Care Plan revealed no reference for choice about bathing preferences. An interview on 07/31/24 at 07:50 AM with Medication Aide (MA)-N revealed the schedule for all resident baths and/or showers are in a book labeled Hall Bath Book, located at the nurse's station. According to MA-N, staff are to notify the resident they have a scheduled bath for the day and ask when they would like to have a bath or a shower. When the bath is completed, charting is done in Point of Care (POC) (the recording and documenting of patient information directly at the bedside or point of care.) and in the Hall Bath Book. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of 200 Hall Bath Book revealed Resident 27 is scheduled for bathing weekly on Monday and Thursday. The Hall Bath Book revealed charting in POC must be completed when the bath or shower is complete. If the scheduled bath or shower is refused, an alternate day should be offered and documented in the electronic medical record (EMR) (digital collection of medical information about a person that is stored on a computer) on the refusal and an alternate day scheduled. A record review of Resident 27's POC revealed a 30 day look back period, document dated 07/30/2024. The record revealed: -07/01/2024-refused -07/04/2024-shower to be offered on alternate day -07/08/2024-refused -07/11/2024-refused -07/15/2024-refused -07/18/2024-refused -07/22/2024-refused -07/25/2024-refused A review of nursing Progress Notes, dated 06/30/2024 through 07/30/2024 revealed a refusal for baths, and/or showers dated: -07/29/2024 at 6:09 PM stating: resident refused shower this shift. -07/22/2024 at 5:50 PM stating: resident refused to have a skin check and shower done today. -07/15/2024 at 5:52 PM stating: resident refused (gender) shower/bath and skin check. No other dates revealed refusals, reattempts or alternates rescheduled. Interview on 07/31/2024 at 3:22 PM with MA-N revealed if a resident refuses their baths the resident would be asked again within the day. MA-N revealed if the resident had a specific bath type preference, it is honored. Interview on 07/31/2024 at 3:26 PM with Licensed Practical Nurse (LPN)-O revealed Resident 27 refuses their shower and does ask for a bed bath. LPN-O revealed Resident 27 was denied a bed bath and facility staff informed Resident 27 [gender] needed a shower. LPN-O revealed if bed baths are honored the residents would not get clean. A review of policy titled, Bathing/Shower Policy with a revision dated 11/24/2020 revealed: Reporting: (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Notify the supervisor if the resident refuses the shower/tub bath. 2. Ask another staff member to attempt to bath/shower resident if the resident refuses, notify the social services as necessary. Ensure documentation is complete. 4. Report other information in accordance with facility policy and professional standards of practice. Preference: 1. Upon admission and at each care plan conference, shower preferences will be reviewed with resident and/or responsible party. Guidance: 1. If a resident refuses a bath because he or she prefers a shower or a different bathing method, such as in-bed bathing, prefers to bathe at a different time of day or on a different day, does not feel well that day, is uneasy about the aide assigned to help or is worried about falling, the resident's preferences must be accommodated.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49382 License Reference Numbers 175 NAC 12-006.19, NAC 1-006.02 Based on record reviews, observations and interviews, the facility failed to provide a clean, home like environment and to ensure equipment and building fixtures were in good, working order. This had the potential to effect all of the residents residing in the facility. The facility stated census was 75. Findings are: In an observation on 07/29/2024 at 3:13 PM the following was observed in the hall of the 200 wing: -From room [ROOM NUMBER] to room [ROOM NUMBER] the base board trim was missing causing exposed unfinished flaking drywall from the floor up the wall approximately 4 inches spanning the length of the hall. -The trim was missing from the floor of the doorway of rooms [ROOM NUMBERS] with gray black buildup of substance visible in the crack that is present. -The tile floor of the 200 hall from room [ROOM NUMBER] to room [ROOM NUMBER] was visibly scuffed and stained with black gray marks to the floor and yellow brown buildup along the edges of the floor near the base board trim. -The wooden handrail going down the hall 200 to 300 wings is rough and porous. It is visible where the varnish has come off the railing resulting in a change in coloration from light tan to a white gray in color of the areas where the varnish has come off. In an observation on 07/29/2024 at 3:15 PM in the 400 wing the following was observed: -In the commons sitting area the television present had a splintering crack to the lower left-hand corner of the television. This crack resulted in the left 4 inches of the television to not be working. Present were multiple-colored vertical lines and no television picture consistent with the rest of the television. -The trim is missing from the floor in the commons area from where the carpet stops, and the laminate flooring starts resulting in a 3/4 inch area of exposed underlayment with visible soiling with dirt and debris. -In the hallway of the 400-wing multiple large stains in the carpeting of the hallway. One area outside the doorway of the dining area at the end of the hall was the size of the doorway and brown, black in color. Multiple black, gray round spots varying in size were noted from the dinning room doorway up the hallway to the commons sitting area. The wallpaper at the end of the hall by the dinning room and the lounge area is pealing and seams are coming loose from the wall. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-In the hallway of the 400 wing between rooms [ROOM NUMBERS] there was an electrical panel in the wall. The spackling to the top half of the panel was crumbling and falling out of the wall exposing a large crack between the panel and the dry wall. The lower half of the electrical panel the wallpaper that was on the wall is warped and pealing up. -In the dinning room of the 400 wing in the corner of the ceiling above the closet and the door is stained with a reddish brown splattering. An electrical outlet that is in the ceiling is loose from the ceiling approximately 1/4 an inch. The window of the dinning area has a white gray film and 2 vertical lines of old tape to the outside of the window obstructing a clear view outdoors. In an interview on 08/01/2024 at 10:30 AM it was confirmed with the facility Maintenance Director (MAINT) the presence of the listed items made the facility an unsafe and un-homelike environment.

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F 0606 Level of Harm - Potential for minimal harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 41938 Licensure Reference Number 175NAC 12-006.04A(iii) Based on record review and interview the facility failed to ensure that background checks were completed prior to staff working in the facility for 1 of 5 sampled staff. This had the potential to expose all facility residents to potential abuse and neglect. The facility census was 75. Findings are: Record review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated April 2021 revealed that the facility will conduct employee background checks and not knowingly employ or otherwise engage any individual who has been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of resident or misappropriation of their property; or a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. Record review of the undated facility Hiring Process Checklist revealed that the facility will complete Nebraska state specific APS/CPS (Adult Protective Services/Child Protective Services) Registry Check (A check of the Central Registry containing records of all reports of adult or child abuse to see if the individual's name appears). Record review of the untitled and undated list of facility employees revealed that Medication Aide-E (MA-E) had a hire date of 5/9/24. Record review of the employee file for MA-E revealed that it contained the Nebraska Central Registry Check received by the facility that was dated 5/22/24 (13 days after the hire date of MA-E). Record review of the Timecard report for MA-E dated 4/28/24-5/25/24 revealed that MA-E attended orientation on 5/9/24 from 9:00 AM to 3:00 PM. The timecard revealed that MA-E worked in the facility on 5/17/24 from 5:54 AM to 6:09 PM; 5/20/24 from 5:57 AM to 6:08 PM; and 5/21/24 from 5:53 AM to 6:05 PM prior to the facility having the completed Nebraska Central Registry check for MA-E. Interview on 8/1/24 at 8:56 AM with the facility Human Resources (HR) revealed that HR provides the employee orientation and runs the Central Registry check on the day of orientation. HR confirmed that MA-E attended orientation on 5/9/24. HR confirmed that the facility did not have the completed Nebraska Central Registry check for MA-E prior to MA-E working with residents in the facility.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175 NAC 12-006.09(F)(i) Based on record review and interview the facility failed to ensure that a written summary of the baseline care plan (a written plan required to be developed within 48 hours of admission detailing the instructions needed to provide initial effective and person-centered quality care for a resident) was reviewed with the resident/resident representative and that the resident/resident representative was provided a copy of the written summary of the baseline care plan for 4 of 4 residents reviewed (Residents 22, 127, 23, and 13). This had the potential to prevent the resident/resident representative from identifying and communicating additional care required for the resident. The facility census was 75. Findings are: A. Record review of the facility policy titled Care Plans-Baseline dated March 2022 revealed that a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission. The baseline care plan includes instructions needed to provide effective, person-centered care of the residents. The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan (no later than 21 days after admission). A comprehensive care plan may be used in place of the baseline care plan providing the comprehensive care plan is developed within 48 hours of the resident's admission and meets the requirements of a comprehensive assessment. The resident and/or representative are provided a written summary of the baseline care plan. Provision of the summary to the resident and/or representative is documented in the medical record. Record review of the Admission Record dated 7/31/24 for Resident 22 revealed that Resident 22 admitted into the facility on [DATE]. Diagnoses included Hemiplegia and Hemiparesis (paralysis of one side of the body) following stroke, Pneumonia, and Parkinson's Disease. Record review of the medical record for Resident 22 revealed no identified baseline care plan for Resident 22. Record review of the medical record for Resident 22 revealed no documentation that the resident/resident representative were provided a written summary of a baseline care plan. Interview on 7/31/24 at 3:54 PM with the Director of Nursing Trainer (DONT) confirmed that the facility had no copy of a baseline care plan for Resident 22. DONT confirmed that the facility had no documentation that a written summary of a baseline care plan was reviewed with the resident/resident representative. DONT confirmed that the facility had no evidence that a copy of a written summary of a baseline care plan was provided to the resident/resident representative as required. B. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Admission Record dated 8/1/24 for Resident 127 revealed that Resident 127 admitted into the facility on [DATE]. Diagnoses included Encephalopathy (any brain disease that alters brain function or structure causing declining ability to reason and concentrate, memory loss, personality change, seizures, and twitching are common symptoms), Severe Malnutrition, and Acute Kidney Failure. Record review of the medical record for Resident 127 revealed no identified baseline care plan for Resident 127. Record review of the medical record for Resident 127 revealed no documentation that the resident/resident representative were provided a written summary of a baseline care plan. Interview on 7/31/24 at 3:54 PM with the Director of Nursing Trainer (DONT) confirmed that the facility had no copy of a baseline care plan for Resident 127. DONT confirmed that the facility had no documentation that a written summary of a baseline care plan was reviewed with the resident/resident representative. DONT confirmed that the facility had no evidence that a copy of a written summary of a baseline care plan was provided to the resident/resident representative as required. C. Record review of the Admission Record dated 7/30/24 for Resident 23 revealed that Resident 23 admitted into the facility on [DATE]. Diagnoses included Chronic Respiratory Failure, Severe Obesity, and Unsteadiness on their Feet. Record review of the medical record for Resident 23 revealed no identified baseline care plan for Resident 23. Record review of the medical record for Resident 23 revealed no documentation that the resident/resident representative were provided a written summary of a baseline care plan. Interview on 7/31/24 at 3:54 PM with the Director of Nursing Trainer (DONT) confirmed that the facility had no copy of a baseline care plan for Resident 23. DONT confirmed that the facility had no documentation that a written summary of a baseline care plan was reviewed with the resident/resident representative. DONT confirmed that the facility had no evidence that a copy of a written summary of a baseline care plan was provided to the resident/resident representative as required. D. Record review of the Admission Record dated 7/31/24 for Resident 13 revealed that Resident 13 admitted into the facility on [DATE]. Diagnoses included Malnutrition, Transient Ischemic Attacks (a short period of symptoms similar to those of a stroke that is caused by a brief blockage of blood flow to the brain), and Sleep Apnea. Record review of the medical record for Resident 13 revealed no identified baseline care plan for Resident 13. Record review of the medical record for Resident 13 revealed no documentation that the resident/resident representative were provided a written summary of a baseline care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 7/31/24 at 3:54 PM with the Director of Nursing Trainer (DONT) confirmed that the facility had no copy of a baseline care plan for Resident 13. DONT confirmed that the facility had no documentation that a written summary of a baseline care plan was reviewed with the resident/resident representative. DONT confirmed that the facility had no evidence that a copy of a written summary of a baseline care plan was provided to the resident/resident representative as required.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident’s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50105 Licensure Reference Number 175 NAC ,d+[DATE].09 Based on record reviews and interviews; the facility failed to follow the advance directive for Cardiopulmonary Resuscitation (CPR) (a lifesaving attempt combination of rescue breathing and chest compressions when someone's heart has stopped) or DNR (A type of advance directive in which a person states that health care providers should not perform cardiopulmonary resuscitation (restarting the heart) if his or her heart or breathing stops) for three residents (Residents 40, 32 and 46). The facility census was 75. The facility Administrator was notified on [DATE] at 9:00 PM of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE], as confirmed by surveyor onsite verification. Findings are: Record review of the facility policy titled Do Not Resuscitate Order with a revision date of [DATE]. The policy statement revealed, our facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a Do Not Resuscitate Order in effect. A. A review of Resident 40's admission record dated [DATE] revealed under advance directive as a DNR. A review of Resident 40's physician orders in the electronic medical record (EMR, a digital collection of medical information about a person that is stored on a computer), for the month of July showed, the resident was listed as a DNR with an order date of [DATE]. A review of Resident 40's medical record revealed an advance directive choice to attempt resuscitation/CPR and to provide full treatment dated [DATE]. The document was signed by the resident and the physician. During an interview on [DATE] at 2:25 PM the Unit Manager-M (UM-M) revealed when the resident needs emergency assistance, the crash cart is retrieved, and the code listing report is located on the crash cart revealing a code status for every resident. Record review of the code listing report found at the crash cart containing a list of all current residents and their current code status dated [DATE] revealed the code status listed for Resident 40 as DNR. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on [DATE] at 2:34 PM with UM-M further revealed, Resident 40's code status in the code listing report found at the crash cart and the code status found in the medical record were not accurate. Review of Resident 40's medical record, UM-M verified the advance directive found in the chart revealed a signed advance directive order for CPR, full treatment. UM-M reported to this surveyor, an interview with Resident 40 on [DATE] at 2:40 PM revealed the resident confirms an advance directive choice for CPR, full treatment. Licensed Practical Nurse-O (LPN-O) was interviewed on [DATE] at 3:32 PM revealing in an emergency, to locate a code status on an individual in an emergency, they look at the orders in the EMR. Registered Nurse-A (RN-A) was interviewed on [DATE] at 3:42 PM revealing in an emergency, to locate a code status on an individual, they look in the medical record. 41938 B. Record review of the Admission Record dated [DATE] for Resident 32 revealed that Resident 32 admitted into the facility on [DATE]. Diagnoses included Diabetes, Hypertension (high blood pressure), and Hyperlipidemia (high levels of fat particles (lipids) in the blood that increases the risk of stroke or heart attack). Record review of the Resuscitation Orders form for Resident 32 dated [DATE] revealed that the resident chose to have No CPR (DNR-Do Not Resuscitate) in the event of cardiac and/or Respiratory Arrest. The form was signed by the resident's physician on [DATE]. Record review Resident 32's Care Plan dated [DATE] revealed that in the event of no pulse and absence of respirations Resident 32 chooses to be a DNR (Do Not Resuscitate). Record review of the facility Code Book (a listing of residents and their code status) dated [DATE] located on the facility emergency crash carts (a self-contained, mobile unit that contains virtually all of the materials and devices necessary to perform CPR) revealed that it listed Resident 32 as a Full Code. (This did not reflect the wishes of Resident 32 to have No CPR). 49382 C. A review of an Admission Record dated [DATE] revealed the facility admitted Resident 46 on [DATE]. Record review of the Resuscitation Orders form for Resident 46 dated [DATE] revealed that the resident chose to have No CPR (DNR-Do Not Resuscitate) in the event of Cardiac and/or Respiratory Arrest. The form was signed by the resident's physician on [DATE]. Record review of the care plan dated [DATE] for Resident 46 revealed that in the event of no pulse and absence of respirations Resident 46 chooses to be a DNR (Do Not Resuscitate). (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility Code Book (a listing of residents and their code status) dated [DATE] located on the facility emergency crash carts (a self-contained, mobile unit that contains virtually all of the materials and devices necessary to perform CPR) revealed that it listed Resident 46 as a Full Code. (This did not reflect the wishes of Resident 46 to have No CPR). Record review of Abatement Statement for F678 Cardiopulmonary Resuscitation dated [DATE] submitted by the Nursing Home Administrator on [DATE] and approved on [DATE] at 11:10 PM revealed the following: Residents identified that were affected or were identified at risk of serious injury, harm, impairment, or death were: Resident 40, Resident 32, Resident 46 -All residents' signed code status forms will be audited starting [DATE] to ensure physician orders match resident preferences. -Code status spreadsheet will be updated starting [DATE] to reflect accurate and current code statuses for each resident. -Starting [DATE], Social Services will contact residents without current code status preferences and discuss resident or representative wishes related to code status. -Starting [DATE], the Admissions Department will verify and obtain code statuses prior to admission with responsible party. -Starting [DATE], current code status forms will be placed in the code status binder and placed inside crash cart. -Director of Nursing (DON) will start in-services on [DATE] regarding: -Code status policy -Code status spreadsheet -Code status form: DNR/Full Code/Do Not Hospitalize (DNH) -Identifying a resident's code status -Education will be provided to all staff currently on duty and prior to any staff coming off duty. -Resident profile and code status icon on PCC will be audited and updated with current resident wishes related to code status by Unit Managers or designee weekly or upon admission or re-admit. -Starting [DATE], Social Services will audit code status book weekly to ensure code statuses for residents are accurate. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Starting [DATE], Admissions Department will audit code status forms received and obtained from hospital records weekly for new residents. -Starting [DATE], new admissions will be reviewed during clinical meetings to discuss and determine resident code statuses. -Auditing results will be submitted to Quality Assurance and Performance Improvement (QAPI) (a data driven and proactive approach to quality improvement) and addressed as appropriate. At the time of the survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175 NAC 12-006.09(H) Based on observation, record review, and interview the facility failed to ensure that staff performed blood glucose testing (determining the amount of blood sugar in your blood) in a manner consistent with current professional standards to prevent errors for 5 of 7 residents (Residents 47, 40, 48, 21, and 1). The facility census was 75. Findings are: A. Record review of the facility procedure titled Measuring A Blood Glucose Using A Handheld Glucometer (a medical device used to measure and display the amount of sugar in the blood for residents with diabetes) dated 7/11/24 revealed the steps included: wipe the site with an antiseptic wipe. Insert the test strip into the machine (glucometer). Perform a capillary puncture (a skin prick) using a lancet (a small sterile blade used to obtain a small amount of blood for testing). Discard lancet immediately in a sharp's container. Wipe away the first drop of blood. Touch the drop of blood to the reagent (test) strip, allowing it to be taken up by the strip. Read the digital result. Provide the patient with a cotton ball or gauze to hold pressure to stop the bleeding. Record review of the Admission Record dated 8/1/24 for Resident 47 revealed Resident 47 admitted into the facility on [DATE]. Resident 47 had a diagnosis of Diabetes. Observation on 7/30/24 at 3:58 PM at the medication cart on the facility 200 hall revealed Medication Aide-I (MA-I) performed hand sanitization and put on gloves. MA-I obtained the glucometer, test strip, alcohol antiseptic prep pad, and lancet and went to the room of Resident 47. MA-I wiped the fingertip of the resident's left little finger with the alcohol prep pad. MA-I pricked the finger with the lancet and squeezed the finger to force a drop of blood to appear. MA-I applied the drop to the glucometer test strip. (MA-I did not wipe away the first drop of blood and obtain a second drop of blood to test as required). MA-I told the resident the blood sugar result of 130. MA-I applied a cotton ball to the fingertip. MA-I returned to the medication cart and revealed it is too early for Resident 47's insulin. Record review of the Medication Administration Record (MAR) (a legal record of the medications administered to a patient at a facility by a health care professional) dated 7/31/24 for Resident 47 revealed that Resident 47 had an order for sliding scale insulin (a progressive increase in the insulin dose based on the resident's blood sugar level that is based on pre-defined blood sugar ranges as ordered by the physician). The MAR revealed that MA-I documented the blood sugar reading of 130 for the 7/30/24 blood sugar ordered for 5:30 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 8/1/24 at 9:14 AM with the facility Director of Nursing (DON) confirmed that the expectation for obtaining blood sugar using the handheld glucometer is that staff follow the procedure. The DON confirmed that the expectation is that staff wipe away the first drop of blood and obtain a second drop of blood to be applied to the test strip. The DON confirmed that an inaccurate blood sugar reading may be obtained when the first drop of blood is tested . The DON confirmed that using the second drop of blood for testing ensures an accurate blood sugar reading. B. Record review of the Admission Record dated 7/31/24 for Resident 40 revealed that Resident 40 admitted into the facility on [DATE]. Resident 40 had a diagnosis of Diabetes. Observation on 7/30/24 at 4:02 PM at the medication cart on the 200 hall revealed that MA-I obtained supplies and went to the room of Resident 40. MA-I wiped the pad of the resident's left little finger with the alcohol prep pad. MA-I used the lancet to prick the finger pad. MA-I squeezed the finger and a drop of blood appeared. MA-I applied the drop of blood to the glucometer test strip. (MA-I did not wipe away the first drop of blood and obtain a second drop of blood to test as required). MA-I revealed a blood sugar result of 277. MA-I returned to the medication cart. Record review of the MAR dated 7/31/24 for Resident 40 revealed that Resident 40 had an order for sliding scale insulin. The MAR revealed that MA-I documented the blood sugar reading of 277 for the 7/30/24 blood sugar ordered for 4:30 PM. C. Record review of the Admission Record dated 8/1/24 for Resident 48 revealed that Resident 48 admitted into the facility on [DATE]. Resident 48 had a diagnosis of Diabetes. Observation on 7/30/24 at 4:12 PM at a medication cart on the 200 hall revealed that Medication Aide-J (MA-J) put on gloves and prepared supplies to check the blood sugar for Resident 48. MA-J went to the room of Resident 48 and wiped the pad of the resident's left little finger with the alcohol prep pad. MA-J pricked the finger with the lancet and squeezed until a drop of blood appeared. MA-J applied the drop to the glucometer test strip. (MA-J did not wipe away the first drop of blood and obtain a second drop of blood to test as required). MA-J revealed a blood sugar result of 153. MA-J returned to the medication cart and documented the blood sugar of 153. Record review of the MAR dated 7/31/24 for Resident 48 revealed that Resident 48 had an order for sliding scale insulin. The MAR revealed that MA-J documented the blood sugar reading of 153 for the 7/30/24 blood sugar ordered for 5:30 PM. Interview on 8/1/24 at 2:12 PM with MA-J revealed that MA-J was provided training on using the handheld glucometer last winter. MA-J revealed that the steps MA-J uses for obtaining a blood sugar are to identify which finger will be used and to wipe the finger with an alcohol wipe. MA-J revealed that they then poke the finger and apply the drop of blood to the test strip. MA-J revealed it is okay to use the first drop of blood. D. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Admission Record dated 8/1/24 for Resident 21 revealed that Resident 21 admitted into the facility on [DATE]. Resident 21 had a diagnosis of Diabetes. Observation on 7/30/24 at 4:15 PM at a medication cart on the 200 hall revealed that MA-J gathered supplies to check the blood sugar for Resident 21. MA-J put on gloves and wiped the resident's right ring finger. MA-J wiped the pad of the resident's finger with an alcohol prep pad. MA-J pricked the pad of the finger with the lancet and squeezed the finger to produce a drop of blood. MA-J applied the drop of blood to the glucometer test strip. (MA-J did not wipe away the first drop of blood and obtain a second drop of blood to test as required). MA-J placed a cotton ball on the resident's finger. MA-J revealed a blood sugar result of 141. Record review of the MAR dated 7/31/24 for Resident 21 revealed that Resident 21 had an order for blood glucose check before meals. The MAR revealed that MA-J documented the blood sugar reading of 141 for the 7/30/24 blood sugar check ordered for 5:30 PM. E. Record review of the Admission Record dated 8/1/24 for Resident 1 revealed that Resident 1 admitted into the facility on [DATE]. Resident 1 had a diagnosis of Diabetes. Observation on 7/31/24 at 4:21 PM in the room of Resident 1 revealed that Medication Aide-K (MA-K) put on gloves and placed a glucometer test strip in the glucometer. MA-K wiped the pad of the resident's right middle finger with an alcohol prep pad. MA-K pricked the finger with a lancet. A drop of blood appeared. MA-K applied the drop of blood to the test strip. (MA-K did not wipe away the first drop of blood and obtain a second drop of blood to test as required). MA-K revealed a blood sugar result of 163. Record review of the MAR dated 8/1/24 for Resident 1 revealed that Resident 1 had an order for sliding scale insulin. The MAR revealed that MA-K documented the blood sugar reading of 163 for the 7/31/24 blood sugar check ordered for 4:30 PM. Interview on 8/1/24 at 1:32 PM with MA-K revealed that the facility provided training on use of the handheld glucometer and thinks it was last fall. MA-K revealed that the process for obtaining a blood sugar using the glucometer included wiping the finger with the alcohol prep pad and poking the finger. MA-K revealed they apply the drop of blood to the glucometer test strip. MA-K confirmed that MA-K was not aware that the first drop of blood was to be wiped away and the second drop of blood was to be applied to the test strip.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49382 Licensure Reference Number 175 NAC 12-006.09(I)(i)(1) Based on observation, record review and interview the facility failed to investigate falls for causative factors and implement interventions by causative factors to prevent falls with injury for 1 Resident, (Resident #24) of 2 sampled residents. Facility stated census of 75. Findings are: Review of a facility policy titled Falls Management dated 05/2017 revealed the interdisciplinary team identifies and implements appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence. A review of an Admission Record dated 07/30/2024 revealed the facility admitted Resident #24 on 01/12/2024 with diagnoses that included Multiple Sclerosis (a disease of the central nervous system), generalized muscle weakness, seizure disorder (when nerve cells don't signal properly causing seizures), and dementia (an impaired ability to remember, think, or make decisions that interferes with doing everyday activities). Review of a facility supplied document titled with the facility name and Incidents by Incident type dated 07/29/2024 revealed Resident #24 had unwitnessed falls on 06/07/2024, 06/13/2024, 06/20/2024, 07/03/2024, 07/11/2024, and 07/21/2024. The Quarterly Minimum Data Set (MDS) (a mandatory comprehensive assessment tool that measures the health status of nursing home residents and is used for care planning) dated 07/19/2024, revealed Resident #24 had a Brief Interview for Mental Status (BIMS) (a brief screening tool that aids in detecting cognitive impairment) score of 4 indicating the resident was severely cognitively impaired. The resident was independent with eating, needed partial to moderate assistance with bed mobility and was dependent on staff assistance for toilet use and transfers. Resident #24 used a wheelchair for mobility propelled by staff and was frequently incontinent of bladder and continent of bowel. The resident was coded to have had two or more falls without injury in the last 90 days. Review of Resident #24's Care Plan with the following dates revealed the resident was at risk for falls with interventions listed as: -06/07/2024 A scoop mattress was placed on the resident's bed to alert the resident to the edge of their bed for safety. -07/21/2024 A fall mat is to be placed on the floor beside the resident's bed to prevent injuries when the resident places themselves on the floor during seizure and behavior activity episodes. Staff are to follow the provider recommendations and a medication review with medication changes occurred. The residents' room was moved closer to the nurse's station for closer observation. Record review of facility supplied Un-Witnessed Fall report dated revealed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-06/07/2024 Resident #24 was found sitting on the floor with their back against their bed. The resident confirmed that they had sled off the edge of the bed. There were no documented injuries to the resident. -07/21/2024 Resident #24 was found on the floor next to their bed. The resident received a hematoma and laceration requiring sutures in the local emergency room . In an observation on 07/29/2024 at 3:15 PM revealed Resident #24's bed had a regular flat mattress present. In an interview on 07/30/2024 at 10:15 AM with Medication Aide D (MA-D), MA-D revealed fall prevention interventions for Resident #24 was to keep the resident in close observation and redirect the resident when attempting to get out of their wheelchair. MA-D further reported Resident #24 was recently moved closer to the nurse's station for closer observation while in their room. In an observation on 07/31/2024 at 1:15 PM it was observed that Resident #24's bed was placed with the head of the bed against the wall with a fall mat placed on the floor to the left side of the bed and Resident #24 had a regular flat mattress present. In an interview on 07/31/2024 at 1:30 PM with Licensed Practical Nurse (LPN) B, LPN-B confirmed that Resident #24 mattress was a regular flat mattress. LPN-B denied knowing if the resident was to have a special or scoop mattress. In an interview on 07/31/2024 at 2:45 PM with the Assistant Director of Nursing (ADON), the ADON confirmed that the resident was to have a special scoop mattress to their bed as a fall prevention intervention.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175 NAC 12-006.12(A)(vi) Based on record review and interview the facility failed to ensure a monthly medication review (MRR) (a monthly review of a resident's medications by a licensed pharmacist to minimize or prevent adverse consequences or to prevent residents from receiving unnecessary drugs) was performed for 1 resident (Resident 37) of 5 residents reviewed. This had the potential for significant medication irregularities to go unidentified. The facility census was 75. Findings are: Record review of the Admission Record for Resident 37 dated 7/30/24 revealed that Resident 37 admitted into the facility on [DATE]. Diagnoses included Diabetes, hypertension (high blood pressure), and major depressive disorder. Record review of the Care Plan dated 7/30/24 for Resident 37 revealed that Resident 37 is on diuretic therapy (treatment with medicines that help reduce fluid buildup in the body. They are sometimes called water pills). The Care Plan revealed that the diuretic therapy may cause dizziness, hypotension (low blood pressure), fatigue, and increased risk for falls. The Care Plan revealed that Resident 37 has Diabetes. Interventions included diabetes medication as ordered by doctor. Monitor for side effects. The Care Plan revealed that Resident 37 has a potential behavior problem related to depression. Interventions included administer medications as ordered and monitor for side effects. The Care Plan revealed that the physician increased the resident's antipsychotic medication (a psychotropic medication used to manage psychotic disorders) due to increased anxiety on 12/12/23. The Care Plan revealed that Resident 37 has altered cardiovascular status (heart or blood vessel issues). Interventions included to give all cardiac medications as ordered and observe and document side effects. Report adverse reactions to the physician. Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) dated 5/23/24 for Resident 37 revealed that Resident 37 received insulin all 7 days of the 7 day lookback period. The MDS revealed that Resident 37 received antipsychotic, antianxiety, antidepressant, and antiplatelet (medications that prevent platelets in the blood from sticking together and forming blood clots) medications during the 7 day lookback period. Record review of the Monthly Regimen Reviews (monthly medication reviews) completed for Resident 37 revealed that MRRs were completed on: 7/31/23- with no changes required to the resident medications. 8/29/23- with note that the resident Medication Administration Record update recommended. 3/31/23- no recommendations. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/29/24- with note that Paxil (an antidepressant psychotropic medication) used for anxiety but not linked to a diagnosis code. 5/30/24- no recommendations. 6/30/24- consider gradual dose reduction for Paxil, aripiprazole (an antipsychotic medication used to treat schizophrenia, bipolar disorder, depression), lorazepam (a psychotropic medication used to treat anxiety), and mirtazapine (a psychotropic antidepressant). Record review of the medical record for Resident 37 revealed no MRRs for 9/2023, 10/2023, 11/2023, 12/2023, 1/2024, or 2/2024. Interview on 7/31/24 at 2:06 PM with the facility Infection Control Coordinator (ICC) revealed that the ICC is responsible for follow up on the resident MRRs. The ICC confirmed that an MRR is to be performed monthly for every resident.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 49382 Licensure Reference Number 175 NAC 12-006.09(H) Based on record review and interview the facility failed to ensure as needed antipsychotic medications were limited to 14 days of use and residents and or their representatives were informed of risks, benefits, purpose, and potential adverse consequences of antipsychotic medication use. This effected 1 of 2 sampled residents, Resident #24. Facility stated census of 75. Findings are: A review of a facility policy titled Antipsychotic Medication Use and dated 07/2022 revealed: -Residents and or resident representatives will be informed of the recommendation, risks, benefits, purpose, and potential adverse consequence of antipsychotic medication use. -As needed orders for antipsychotic medications will not be renewed beyond 14 days. The duration of the as needed order will be indicated in the order for the medication. A review of an Admission Record dated 07/30/2024 revealed the facility admitted Resident #24 on 01/12/2024 with diagnoses of Multiple Sclerosis (a disease of the central nervous system), generalized muscle weakness, seizure disorder (when nerve cells don't signal properly causing seizures), and dementia (an impaired ability to remember, think, or make decisions that interferes with doing everyday activities). The Quarterly Minimum Data Set (MDS) (a mandatory comprehensive assessment tool that measures the health status of nursing home residents and is used for care planning) dated 07/19/2024, revealed Resident #24 had a Brief Interview for Mental Status (BIMS) (a brief screening tool that aids in detecting cognitive impairment) score of 4 indicating the resident was severely cognitively impaired. The resident was coded as displaying inattention and disorganized thinking that fluctuated in frequency and severity and not displaying any behaviors. Resident #24 was independent with eating, needed partial to moderate assistance with bed mobility and was dependent on staff assistance for toilet use and transfers. Resident #24 used a wheelchair for mobility propelled by staff and was frequently incontinent of bladder and continent of bowel. The resident was coded to have received antipsychotic medication without a gradual dose reduction being attempted and no documentation that a gradual dose reduction was clinically contraindicated. Review of Resident #24's Care Plan revealed a focus listed as Behavior: the resident had a potential to be verbally and physically aggressive, wander and reject care. Interventions were listed to administer medications as ordered, give the resident as many choices a possible, allow time for the resident to express self and feelings, encourage the resident to participate in activities when restless or agitated, and the resident was to be seen by the in-house psychiatric provider. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #24's Behavior documentation record for the month of July 2024 revealed no documentation of the resident having behaviors. A review of Resident #24's Physician Orders for the month of July 2024 revealed the resident had orders to receive Seroquel, (an antipsychotic medication) 50 milligrams every morning and night and 25 milligrams in the afternoon, and Haloperidol (an antipsychotic medication) 1 milligram every 12 hours as needed. The Haloperidol as needed order did not have a 14-day discontinuation date. In an interview on 07/31/2024 at 2:45 PM with the Assistant Director of Nursing (ADON), the ADON confirmed that Resident #24's as needed Haloperidol did not have a discontinue date for the order and the order was indicated for indefinite use. The ADON stated the resident had not been seen by a psychiatric provider as stated as an intervention in the care plan and the resident and or their representative was not informed of the risks, benefits, purpose, and potential adverse consequences of antipsychotic medication use.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175 NAC 12-006.10(D) Based on observation, record review, and interview the facility failed to maintain a medication error rate of less than 5% with an observed medication error rate of 16% (25 medications administered with 4 errors). The facility census was 75. Findings are: A. Record review of the undated facility Insulin Administration for Qualified Medication Aide (QMA) (a Medication Aide) Competency Checklist revealed that the QMA must perform the procedure with 100% accuracy for competency. The steps for preparing an insulin pen and administering insulin revealed the staff is to check the Medication Administration Record (MAR) for the insulin order. Remove the (insulin) pen cap. Wipe the pen tip with an alcohol wipe. Remove the protective seal from a new needle and screw the needle in place. Dial a dose of 2 units to prime the pen. Hold the pen with the needle pointing straight up and tap lightly so the bubbles will rise to the top. Press the injection button all the way in and check to see that the insulin comes out of the needle (If no insulin comes out, repeat the test. If insulin still does not come out, get a new needle.) Check the order for the correct dose. Make sure the window shows 0 and then select the dose. Select the correct dose and dial until the number shows in the window. Take the medication and supplies to the resident. Record review of the Admission Record dated 7/31/24 for Resident 40 revealed that Resident 40 admitted into the facility on [DATE]. Resident 40 had a diagnosis of Diabetes. Observation on 7/30/24 at 4:02 PM at the medication cart on the 200 hall revealed that MA-I obtained supplies and went to the room of Resident 40. MA-I wiped the pad of the resident's left little finger with the alcohol prep pad. MA-I used the lancet to prick the finger pad. MA-I squeezed the finger and a drop of blood appeared. MA-I applied the drop of blood to the glucometer test strip. (MA-I did not wipe away the first drop of blood and obtain a second drop of blood to test as required). MA-I revealed a blood sugar result of 277. MA-I returned to the medication cart. MA-I entered the blood sugar result and verified Resident 40 was to receive 6 units of Lispro insulin (a type of fast acting insulin). MA-I obtained the insulin pen and set the dial to 2 units. MA-I pushed the plunger as MA-I held the tip of the pen downward and a drop of insulin appeared at the tip of the pen. (MA-I had not applied the needle and had not held the pen tip upward to prime the pen as required- a medication error). MA-I applied the needle and dialed the pen to a dose of 6 units. MA-I wiped the stomach of Resident 40 with an alcohol prep pad. MA-I tried to inject the insulin into the stomach of Resident 40, but the pen/needle would not click. MA-I returned to the medication cart and removed the needle and discarded it into the sharps container. MA-I applied a new needle. MA-I dialed the pen to 6 units and returned to the resident room. (MA-I did not prime the new needle). MA-I wiped a different area on the resident's stomach and injected the insulin and held the needle in place for 20 seconds at 4:08 PM. MA-I returned to the medication cart and documented the administration. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the MAR (a legal record of the medications administered to a patient at a facility by a health care professional) dated 7/31/24 for Resident 40 revealed that Resident 40 had an order for sliding scale insulin. The MAR revealed that MA-I documented that 6 units of insulin were administered to Resident 40 for the 7/30/24 4:30 PM sliding scale insulin order. Interview on 8/1/24 at 9:14 AM with the facility Director of Nursing (DON) confirmed that the expectation is that staff follow the facility procedure for insulin administration. The DON confirmed that the needle is to be applied to the insulin pen prior to priming the pen. The DON confirmed that once the needle is applied to the insulin pen the insulin pen is dialed to 2 units. The DON confirmed the insulin pen is then held with the tip of the needle up when priming the pen to remove any air and ensure the correct insulin dose will be administered. B. Record review of the Admission Record dated 8/1/24 for Resident 48 revealed that Resident 48 admitted into the facility on [DATE]. Resident 48 had a diagnosis of Diabetes. Observation on 7/30/24 at 4:35 PM at a medication cart on the 200 hall revealed that Medication Aide-J (MA-J) reviewed the insulin order for Resident 48. MA-J revealed the order for Resident 48 to receive 2 units of Lispro insulin. MA-J removed the cap from the insulin pen. MA-J applied a needle to the insulin pen and dialed the pen to 2 units. MA-J held the tip of the pen downward and pushed the plunger to prime the needle. (MA-J did not hold the tip of the pen/needle upward to prime the pen/needle as required-a medication error). MA-J dialed the insulin pen to the ordered dose of 2 units and went to the resident's room. MA-J wiped an area on the resident's upper right arm with an alcohol prep pad. MA-J and injected the insulin. MA-J held the needle in place for several seconds. MA-J returned to the medication cart and documented the administration. Record review of the MAR dated 7/31/24 for Resident 48 revealed that Resident 48 had an order for sliding scale insulin. The MAR revealed that MA-J documented the blood sugar reading of 153 for the 7/30/24 blood sugar ordered for 5:30 PM. Interview on 8/1/24 at 2:12 PM with MA-J revealed that MA-J was trained on use of insulin pens in December or January of last year (2023). MA-J revealed the steps for administering insulin with the insulin pen begin with removing the cap from the insulin pen. MA-J then places a needle on the pen and dials the pen to 2 units to prime. MA-J revealed that the insulin pen is held with the tip of the needle held down towards the trash can and the plunger is pushed so you can see insulin drip. MA-J revealed that MA-J then dials the ordered dose of insulin to administer to the resident. C. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Monument Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 111 West 36th Street Scottsbluff, NE 69361	

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 7/31/24 at 11:32 AM on the facility 200 hall revealed that Medication Aide-I (MA-I) revealed a blood sugar of 161 for Resident 16 meant Resident 16 was to receive 2 units of insulin. MA-I removed the insulin pen from the medication cart and removed the cap from the Lispro insulin pen. MA-I applied a needle to the insulin pen. MA-I dialed the insulin pen to 2 units. MA-I held the tip of the insulin pen downward and pushed the plunger to prime the pen. (MA-I did not hold the tip of the pen/needle upward to prime the pen/needle as required-a medication error). MA-I dialed the pen to the dose of 2 units and went to the room of Resident 16. MA-I wiped an area on the resident's stomach with an alcohol prep pad. MA-I placed the needle against the resident's stomach and injected the insulin and held the needle in place for 20 seconds. Record review of the MAR dated 8/1/24 for Resident 16 revealed that Resident 16 had an order for sliding scale insulin. The MAR revealed that MA-I documented that 2 units of insulin were administered to Resident 16 for the 7/31/24 11:30 AM sliding scale insulin order. D. Record review of the facility policy titled Installation of Eye Drops dated January 2014 revealed that the steps for the procedure included: Gently pull the lower eyelid down. Instruct the resident to look up. Drop the medication into the mid lower eyelid. Observation on 7/31/24 at 11:41 AM at the medication cart on the 200 hall revealed that Medication Aide-I (MA-I) performed med set up for Resident 40. MA-I reviewed the order for Resident 40 to receive Systane eye drop (a liquid medication used to treat dry eyes) one drop in each eye. MA-I entered the room of Resident 40. MA-I washed the hands and then applied gloves. Resident 40 sat in a wheelchair in the room. MA-I opened the bottle of Systane eye drops. MA-I squeezed the eye drop bottle and dropped 1 drop on the top of the right eyelid. (MA-I did not pull down on the lower eyelid to apply the drop into the lower eyelid as required) MA-I then pulled up on the top eyelid of the right eye and squeezed the eye drop bottle. A drop fell from the bottle onto the top of the closed bottom eyelid. The eye drop did not go into the eye (a medication error as the eye drop was not received in the eye). MA-I then moved their hands to the left eye of Resident 40. MA-I pulled up the top eyelid of the resident's left eye and applied a drop to the left eye. The drop landed on the eyeball. Record review of the MAR dated 7/31/24 for Resident 40 revealed that Resident 40 had an order for Systane eye drops to give 1 drop in each eye four times a day. The MAR revealed that MA-I documented that 1 drop was administered to each eye of Resident 40 for the 7/31/24 12:00 PM order. Interview on 8/1/24 at 9:14 AM with the facility Director of Nursing (DON) confirmed that the expectation for administering eye drops is that staff pull down on the lower eyelid and place the eye drop in the lower eyelid pocket for proper administration. The DON confirmed that staff should not pull up on the upper eyelid. The DON confirmed that the eye drop was not administered if it did not go into the eye.

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NAME OF PROVIDER OR SUPPLIER Monument Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 111 West 36th Street Scottsbluff, NE 69361	

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175 NAC 12-006.10D Based on observation, record review, and interview the facility failed to ensure that staff provided the ordered dose of insulin (a medication used to reduce the amount of blood sugar in the blood of residents with diabetes) to residents to prevent significant medication errors for 3 of 4 residents observed (Residents 40, 48, and 16). The facility census was 75. Findings are: A. Record review of the undated facility Insulin Administration for Qualified Medication Aide (QMA) (a Medication Aide) Competency Checklist revealed that the QMA must perform the procedure with 100% accuracy for competency. The steps for preparing an insulin pen and administering insulin revealed the staff is to check the Medication Administration Record (MAR) for the insulin order. Remove the (insulin) pen cap. Wipe the pen tip with an alcohol wipe. Remove the protective seal from a new needle and screw the needle in place. Dial a dose of 2 units to prime the pen. Hold the pen with the needle pointing straight up and tap lightly so the bubbles will rise to the top. Press the injection button all the way in and check to see that the insulin comes out of the needle (If no insulin comes out, repeat the test. If insulin still does not come out, get a new needle.) Check the order for the correct dose. Make sure the window shows 0 and then select the dose. Select the correct dose and dial until the number shows in the window. Take the medication and supplies to the resident. Record review of the Admission Record dated 7/31/24 for Resident 40 revealed that Resident 40 admitted into the facility on [DATE] and had a diagnosis of Diabetes. Observation on 7/30/24 at 4:02 PM at the medication cart on the 200 hall revealed that MA-I obtained supplies and went to the room of Resident 40. MA-I wiped the pad of the resident's left little finger with the alcohol prep pad. MA-I used the lancet to prick the finger pad. MA-I squeezed the finger and a drop of blood appeared. MA-I applied the drop of blood to the glucometer test strip. MA-I revealed a blood sugar result of 277. MA-I returned to the medication cart. MA-I entered the blood sugar result and verified Resident 40 was to receive 6 units of Lispro insulin (a type of fast acting insulin). MA-I obtained the insulin pen and set the dial to 2 units. MA-I pushed the plunger as MA-I held the top of the pen downward and a drop of insulin appeared at the top of the pen. (MA-I had not applied the needle and held the pen upward to prime the pen as required). MA-I applied the needle and dialed the pen to a dose of 6 units. MA-I wiped the stomach of Resident 40 with an alcohol prep pad. MA-I tried to inject the insulin into the stomach of Resident 40, but the pen/needle would not click. MA-I returned to the medication cart and removed the needle and discarded it into the sharps container. MA-I applied a new needle. MA-I dialed the pen to 6 units and returned to the resident room. (MA-I did not prime the new needle). MA-I wiped a different area on the resident's stomach and injected the insulin and held the needle in place for 20 seconds at 4:08 PM. MA-I returned to the medication cart and documented the administration. (continued on next page)

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Monument Rehabilitation and Care Center	111 West 36th Street Scottsbluff, NE 69361

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the MAR (a legal record of the medications administered to a patient at a facility by a health care professional) dated 7/31/24 for Resident 40 revealed that Resident 40 had an order for sliding scale insulin. The MAR revealed that MA-I documented that 6 units of insulin were administered to Resident 40 for the 7/30/24 4:30 PM sliding scale insulin order. Interview on 8/1/24 at 9:14 AM with the facility Director of Nursing (DON) confirmed that the expectation is that staff follow the facility procedure for insulin administration. The DON confirmed that the needle is to be applied to the insulin pen prior to priming the pen. The DON confirmed that once the needle is applied to the insulin pen the insulin pen is dialed to 2 units. The DON confirmed the insulin pen is then held with the tip of the needle up when priming the pen to remove any air and ensure the correct insulin dose will be administered. B. Record review of the Admission Record dated 8/1/24 for Resident 48 revealed that Resident 48 admitted into the facility on [DATE]. Resident 48 had a diagnosis of Diabetes. Observation on 7/30/24 at 4:35 PM at a medication cart on the 200 hall revealed that Medication Aide-J (MA-J) reviewed the insulin order for Resident 48. MA-J revealed the order for Resident 48 to receive 2 units of Lispro insulin. MA-J removed the cap from the insulin pen. MA-J applied a needle to the insulin pen and dialed the pen to 2 units. MA-J held the tip of the pen downward and pushed the plunger to prime the needle. (MA-J did not hold the tip of the pen/needle upward to prime the pen/needle as required). MA-J dialed the insulin pen to the ordered dose of 2 units and went to the resident's room. MA-J wiped an area on the resident's upper right arm with an alcohol prep pad. MA-J injected the insulin. MA-J held the needle in place for several seconds. MA-J returned to the medication cart and documented the administration. Record review of the MAR dated 7/31/24 for Resident 48 revealed that Resident 48 had an order for sliding scale insulin. The MAR revealed that MA-J documented that 2 units of insulin were administered to Resident 48 for the 7/30/24 5:30 PM sliding scale insulin order. Interview on 8/1/24 at 2:12 PM with MA-J revealed that MA-J was trained on use of insulin pens in December or January of last year (2023). MA-J revealed the steps for administering insulin with the insulin pen begin with removing the cap from the insulin pen. MA-J then places a needle on the pen and dials the pen to 2 units to prime. MA-J revealed that the insulin pen is held with the tip of the needle held down towards the trash can and the plunger is pushed so you can see insulin drip. MA-J revealed that MA-J then dials the ordered dose of insulin to administer to the resident. C. Record review of the Admission Record dated 7/29/24 for Resident 16 revealed that Resident 16 admitted into the facility on [DATE]. Resident 16 had a diagnosis of Diabetes. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 7/31/24 at 11:32 AM on the facility 200 hall revealed that Medication Aide-I (MA-I) revealed a blood sugar of 161 for Resident 16 meant Resident 16 was to receive 2 units of insulin. MA-I removed the insulin pen from the medication cart and removed the cap from the Lispro insulin pen. MA-I applied a needle to the insulin pen. MA-I dialed the insulin pen to 2 units. MA-I held the tip of the insulin pen downward and pushed the plunger to prime the pen. (MA-I did not hold the tip of the pen/needle upward to prime the pen/needle as required). MA-I dialed the pen to the dose of 2 units and went to the room of Resident 16. MA-I wiped an area on the resident's stomach with an alcohol prep pad. MA-I placed the needle against the resident's stomach and injected the insulin and held the needle in place for 20 seconds. Record review of the MAR dated 8/1/24 for Resident 16 revealed that Resident had an order for sliding scale insulin. The MAR revealed that MA-I documented that 2 units of insulin were administered to Resident 16 for the 7/31/24 11:30 AM sliding scale insulin order. Interview on 8/1/24 at 9:14 AM with the facility Director of Nursing (DON) confirmed that the expectation is that staff follow the facility procedure for insulin administration. The DON confirmed that the needle is to be applied to the insulin pen prior to priming the pen. The DON confirmed that once the needle is applied to the insulin pen the insulin pen is dialed to 2 units. The DON confirmed the insulin pen is then held with the tip of the needle up when priming the pen to remove any air and ensure the correct insulin dose will be administered.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50253 License Reference Number 175 NAC 12-006.19(A) Based on observations and interviews: the facility staff failed to ensure the facility dishwashing machine reached the required temperature to prevent to the potential for food borne illness. This had the potential to effect all residents who ate food from the kitchen. The facility staff identified a census of 75. Findings are: Observation on 08/01/24 at 10:00 AM of a Placard on the side of the [NAME] dishwasher indicated the minimum temperatures needed for the wash cycle was to 160 degrees Fahrenheit and the minimum for the rinse cycle was to be 180 degrees Fahrenheit. Observation on 8/01/2024 at 10:15 AM of the kitchen dishwasher revealed the wash cycle temperature was a 145 Degrees Fahrenheit (DF) and the rinse cycle was 163 DF. An interview was conducted on 8/01/2024 at 10:10 AM with Dietary Aide (DA) Q. During the interview DA-Q reported not knowing if the dishwasher was low or high temp and didn't know what temps needed to be reached to facilitate cleaning of the dishes. Interview on 08/01/24 at 10:13 AM with the DD. DD did not know what temperatures needed to be reached on the wash and the rinse cycles just knew they had to be hot. Nor did the DD know what the blinking light was on the dishwashing monitor. Interview on 8/1/24 at 10:15 AM with Dietary Aide - V (DA-V) who stated the blinking light meant that the machine was nearly out of dishwashing detergent. Confirmed the washer will stop completely when it runs out and needs refilled. Interview on 08/01/24 at 10:31 AM with Maintenance Personnel (MAINT) Stated the dishwasher was a high temp dishwasher and the temperature dishwasher.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175 NAC 12-006.04(A)(ii) Licensure Reference Number 175 NAC 1-005.06 (A)(D)(F) Based on record review and interview the facility failed to ensure that pre-employment health history screens were reviewed to prevent the potential for transmission of contagious disease for 5 of 5 staff; the facility failed to ensure multi-use equipment was sanitized between use and hand hygiene practices were followed between tray passes; and the facility failed to implement a facility water management plan for the prevention of waterborne illnesses. The facility census was 75. Findings are: A. Record review of the undated and untitled list of facility employees revealed that Medication Aide-E (MA-E) had a hire date of 5/9/24. Record review of the Employee Health Screening Post Conditional Offer dated 5/9/24 for MA-E revealed that it was signed by MA-E on 5/9/24. The line for the RN (Registered Nurse) Signature was blank. Interview on 8/1/24 at 8:56 AM with the facility Human Resources (HR) revealed that the facility Employee Health Screening form is in the orientation packet. HR revealed that the staff member fills out the health screening form and returns it to HR. HR confirmed that the health screening form is placed into the employee file and is not reviewed. HR confirmed that the Employee Health Screening form is not reviewed by nursing or anyone else to assess for potential communicable diseases. HR confirmed that the information on the form should be reviewed and accepted with a signature of an RN. B. Record review of the undated and untitled list of facility employees revealed that Maintenance Worker-H (MW-H) had a hire date of 5/9/24. Record review of the Employee Health Screening Post Conditional Offer dated 5/9/24 for MW-H revealed that it was signed by MW-H on 5/9/24. The line for the RN (Registered Nurse) Signature was blank. C. Record review of the undated and untitled list of facility employees revealed that Nurse Aide-F (NA-F) had a hire date of 5/30/24. Record review of the Employee Health Screening Post Conditional Offer dated 5/30/24 for NA-F revealed that it was signed by NA-F on 5/30/24. The line for the RN (Registered Nurse) Signature was blank. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	D. Record review of the undated and untitled list of facility employees revealed that Transportation Driver (TD) had a hire date of 6/13/24. Record review of the Employee Health Screening Post Conditional Offer dated 6/12/24 for TD revealed that it was signed by TD on 6/12/24. The line for the RN (Registered Nurse) Signature was blank. E. Record review of the undated and untitled list of facility employees revealed that Medication Aide-G (MA-G) had a hire date of 7/11/24. Record review of the Employee Health Screening Post Conditional Offer dated 7/11/24 for MA-G revealed that it was signed by MA-G on 7/11/24. The line for the RN (Registered Nurse) Signature was blank. 50105 F. On 07/31/2024 from 7:44 AM until 8:45 AM revealed Medication Assistant 9 MA)-N and MA-Y both entered room [ROOM NUMBER] to assist a resident out of the bed with a Hoyer lift. MA-N and MA-Y were observed leaving room [ROOM NUMBER] pushing the Hoyer lift into room [ROOM NUMBER] without sanitizing the hoyer lift before or after its use. The Hoyer lift was brought out of room [ROOM NUMBER] and parked for storage. MA-N and MA-Y did not sanitize the hoyer lift after using it in room [ROOM NUMBER]. MA-A N without sanitizing the same hoyer lift brought the hoyer lift into room [ROOM NUMBER]. Further review revealed MA-N completed using the hoyer left pushed out of room [ROOM NUMBER] and did not sanitize the hoyer lift. On 7/31-2024 at 8:45 AM an interview was conducted with MA-N. During the interview MA-N reported not being aware of who is responsible to sanitize the hoyer lift after use. An interview on 07/31/2024 at 10:32 AM with the Infection Control Coordinator (ICC) revealed that staff use a different sling for each resident who uses the Hoyer lift and sit to stand equipment. The ICC further revealed that cleaning multi-use equipment should be done in-between use by the nursing department. G. Record review of the facility Emergency Preparedness Plan revealed there was no information on the facility water management plan that included monitoring for and prevention of Legionella and any other water borne pathogen. An interview with the Maintenance Director revealed there is no water management plan available for the facility. The Maintenance Director confirmed there were no measures being taken to prevent the growth of Legionella. Further interview with the Maintenance Director revealed there is no monitoring processes in place when control limits are not met. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review revealed documentation and communication on all activities for a water management plan was not happening.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49382 Licensure Reference Number 175 NAC 12-009.04 Based on observation and interview the facility failed to maintain a pest free environment. This had the potential to effect all of the residents residing in the facility. The facility stated a census of 75. Findings are: Review of a facility policy labeled Maintenance Service dated 12/2009 revealed maintenance service shall be provided to all areas of the building, grounds, and equipment. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. In an observation on 07/29/2024 at 3:04 PM flying insects were observed to be gathering in the corner of a window located in the courtyard across the hall from room [ROOM NUMBER] and 122. A resident was observed to be sitting in their wheelchair in the gazebo in the courtyard area. A wasp nest was present to the upper right-hand corner of the window frame approximately the size of a soft ball with multiple wasps visibly crawling on the nest and flying to and from the nest. In an interview on 07/29/2024 at 3:20 PM with Registered Nurse A (RN-A), RN-A confirmed that residents go out to the courtyard across from room [ROOM NUMBER] and 122 to sit and enjoy the flowers and the weather. RN-A denies having problems with flying insects in the facility that they are aware of. In an interview on 08/01/2024 at 10:05 AM with the Maintenance Director (MD) the MD confirmed there was an active wasp's nest present to the upper right-hand corner of the window of the courtyard. The MD stated that the nest had been observed approximately a week ago and had not had the time to exterminate the wasps. The MD stated the exterminator comes monthly for pest and insect control and confirmed that the active wasp nest was a potential hazard to the residents wishing to go out into the court yard.