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

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Monument Healthcare and Nursing Center | 111 West 36th Street<br>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.

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|---|---|
| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Dispose of garbage and refuse properly.<br><br>Number of residents sampled:<br><br>Number of residents cited:<br><br>Based on observation and interview, the facility failed to ensure garbage and refuse were stored in a covered receptacle. In addition, the facility failed to ensure malodorous trash bags, debris, and supplies were not on the ground around the garbage and refuse receptacle. These failures created the potential for pest activity and had the potential to affect all residents residing in the facility. Findings included: A concurrent observation and interview on 08/14/2025 at 5:00 PM with the Dietary Manager (DM) revealed the garbage and refuse receptacle located outside and behind the facility was uncovered and filled with garbage/refuse. Two large malodorous trash bags, garbage/debris (used gloves, an opened pudding cup, paper, paper cups, and bags), 18 metal poles, and wood fencing supplies were observed on the ground around the garbage and refuse receptacle. The DM stated the metal poles had been on the ground for about a month and were part of a fencing project that the maintenance department was working on. The DM confirmed that the garbage and refuse receptacle was uncovered; he further stated the receptacle had been uncovered for the past year. The DM stated that staff who could not lift the trash bags into the receptacle left the trash bags on the ground and either he or maintenance staff put the trash bags in the receptacle during rounds. During an interview on 08/14/2025 at 5:30 PM, the Director of Maintenance (DOM) stated that he monitored the grounds around the garbage and refuse receptacle once a day in the morning. The DOM stated that if trash bags were observed on the ground during his rounds, he put them inside the receptacle. The DOM confirmed that the garbage and refuse receptacle did not have a lid or cover. He stated that the trash receptacle was a rented unit the facility used since their trash compactor broke about a year prior, and the rental company did not have another trash compactor to provide or a trash receptacle with a lid. ^ During a phone interview on 08/15/2025 at 10:34 AM, Administrative Clerk (AC) I for the rental company stated that the company could provide another trash compactor that the facility could rent, but before the trash compactor could be provided to the facility, the facility needed to complete repairs to the enclosure where the compactor would be stored and repair the fence. AC I stated that the facility was made aware about a year prior that the repairs had to be completed before a trash compactor could be provided. AC I further stated that the facility could purchase a tarp to cover the trash receptacle until they were able to rent the trash compactor and open the door on the back to put the trash inside the receptacle. During an interview on 08/15/2025 at 10:42 AM, the Director of Nursing (DON) stated that she expected the facility to purchase a tarp or something similar to cover the trash receptacle and use the door of the dumpster to put trash in instead of throwing trash over the top. The DON further stated the facility should make the necessary repairs so that the facility could get their compactor replaced. During an interview on 08/15/2025 at 11:55 AM, the Administrator (ADM) stated that she was not aware that repairs were needed to allow the facility to get a trash compactor. She stated that she expected the maintenance department to make the repairs to accommodate the trash compactor, maintain the trash receptacle covered with a tarp, and the grounds around the trash receptacle should be maintained clean. |

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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:<br><br>Number of residents cited:<br><br>Based on observation, interview, and facility document and policy review, the facility failed to ensure: 1. cold foods were maintained at 41 degrees Fahrenheit (F) or below during meal service; 2. cartons of milk were labeled with an expiration date; 3. food items were labeled with use-by-dates (UBDs); 4. expired food items were discarded; and 5. frozen food items were stored in sealed containers and off the freezer floor. These failures had the potential to affect all residents receiving meals from the dietary department. Findings included: A facility policy titled, Refrigerators and Freezers, revised November 2022, indicated, 7. All food is appropriately dated to ensure proper rotation by expiration dates. ?Received' dates (dates of delivery are marked on cases and on individual items removed from cases for storage. ?Use by' dates are completed with expiration dates on all prepared foods in refrigerators. Expiration dates on unopened food are observed and ?use by' dates are indicated once food is opened. 9. Supervisors are responsible for ensuring food items in panty, refrigerators and freezers are not past ?use by' or expiration dates. Supervisors should contact vendors or manufacturers when expiration dates are in question or to decipher codes on packaging. A facility policy titled, Food Receiving and Storage, revised November 2022, indicated, Policy Interpretation and Implementation, 3. Potentially Hazardous Food, (PHF) or Time/Temperature Control for Safety (TCS) Food, means food that requires time/temperature control for safety to limit the growth of pathogens (i.e. bacterial or viral organisms capable of causing a disease or toxin formation. Refrigerated/Frozen Storage, 1. All foods stored in the refrigerator or freezer are covered, labeled and dated (?use by') date. 2. PHF/TCS foods are stored at or below 41 degrees F, unless otherwise specified by law. 7. Refrigerated foods are labeled, dated and monitored so they are used by their ?use by' date, frozen or discarded. 1. During a concurrent interview and observation of the lunch meal tray line on 08/13/2025 at 11:45 AM with Dietary [NAME] J, a large plastic container of Italian salad with dressing was observed on the tray line. Temperature monitoring was completed by Dietary [NAME] J at the request of the surveyor. The salad temperature was 44.7 degrees F. Dietary [NAME] J stated the salad was on the tray line for approximately 10 minutes, but he had not checked the temperature of the salad prior to the start of the lunch tray line. Dietary [NAME] J stated the salad temperature should be 40 degrees F or less. Dietary [NAME] J stated that a cold salad was served at lunch once per month and stored in a large tub on the tray line but was not stored in a manner to keep the salad at the proper temperature. During an interview on 08/13/2025 at 1:01 PM, the Dietary Manager (DM) stated he expected cold foods to be maintained at a temperature of 41 degrees F or below and that the cooks were trained to put cold food on ice during the tray line. The DM stated that he noticed the salad on the lunch tray line on 08/13/2025 was not on ice, but he did not instruct his staff to put the salad on ice. During an interview on 08/14/2025 at 11:17 AM, the Administrator (ADM) stated that she expected cold foods to remain 41 degrees F or below for meal service. During an interview on 08/14/2025 at 11:55 AM, Registered Dietitian (RD) H stated that she completed onsite facility sanitation inspections once per month. RD H stated she had previously identified concerns with cold foods not stored on the tray line in a manner to keep cold foods at the appropriate temperature, and she recommended to the facility to keep cold foods iced or stored on ice sheets. During an interview on 08/14/2025 at 4:02 PM, the Director of Nursing (DON) stated she expected cold items on the tray line to be kept on ice during the tray line service. 2. During a concurrent interview with the Dietary Manager (DM) and an observation of the walk-in refrigerator on 08/11/2025 at 9:39 AM, 25<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | eight-ounce cartons of two percent milk were observed not labeled with a date of storage, UBD, or expiration date by the facility or manufacturer. The DM stated that the facility's milk vendor delivered milk on Mondays and Thursdays, but he did not notice the cartons of milk did not have a manufacturer expiration date stamps. The DM stated the milk vendor had delivered cartons of milk before that did not have a manufacturer expiration date stamp. He further stated he did not contact the milk vendor to clarify the expiration date for the cartons of milk that were delivered without a manufacturer date stamp. An invoice dated 08/11/2025 revealed 100 cartons of two percent milk were delivered to the facility on [DATE]. During an interview on 08/14/2025 at 11:55 AM, Registered Dietitian (RD) H stated that she completed onsite facility sanitation inspections once per month. RD H stated she had not identified a concern related to cartons of milk delivered to the facility without a manufacturer date stamp, but that the expectation would be for all foods to have a date of storage and UBD. During an interview on 08/14/2025 at 4:02 PM, the Director of Nursing (DON) stated that if milk was delivered without an expiration date, she expected the facility to not serve the milk and either discard the milk or clarify the expiration date with the manufacturer. 3. During a concurrent observation of the walk-in refrigerator and an interview with the Dietary Manager (DM) on 08/11/2025 at 9:39 AM, the following items were observed not labeled with UBDs: a container of approximately three quarts of tomato sauce, a container with approximately 32 ounces of butterscotch pudding, a bag of approximately 12 ounces of cooked roast beef, a bag of three biscuits, a bag of approximately eight cooked hamburger patties, a bag of approximately nine cooked breaded chicken patties, and a pan of approximately seven uncooked hamburger patties. The DM stated each item should be labeled with a UBD. During an interview on 08/11/2025 at 9:45 AM, Dietary [NAME] J stated he usually monitored the walk-in refrigerator once a week. Dietary [NAME] J stated staff were supposed to record the UBD of each food item. During an interview on 08/11/2025 at 9:48 AM, Dietary [NAME] K stated each food item should be labeled with an expiration date. During an interview on 08/11/2025 at 9:50 AM, Dietary Director Assistant (DDA) L stated each food item should be labeled with an expiration date. During an interview on 08/14/2025 at 11:17 AM, the Administrator (ADM) stated that she expected the DM to make sure there was an expiration date on each food item. The ADM stated she expected the staff to record a UBD on all cold storage items and to monitor the cold storage units daily to ensure items were properly labeled, stored, and all expired foods removed. 4. During a concurrent observation of the walk-in refrigerator and an interview with the Dietary Manager (DM) on 08/11/2025 at 9:39 AM, the following items were observed stored beyond their UBDs: a pan of approximately three pounds of cooked apples labeled with a UBD of 08/08/2025 and two bags containing approximately fifteen cooked turkey patties each labeled with UBDs of 08/10/2025. The DM stated staff should check refrigerators daily for expired food, and leftover food should be discarded after three days or according to the UBD. During an interview on 08/11/2025 at 9:45 AM, Dietary [NAME] J stated he usually monitored the walk-in refrigerator once a week. He stated that he worked on Monday, Tuesday, Wednesday, Friday, and Saturday of the prior week but did not check the walk-in refrigerator for expired food items. He stated that he discarded outdated foods when he checked the walk-in refrigerator, but he did not check for outdated food items every time he worked. During an interview on 08/11/2025 at 9:48 AM, Dietary [NAME] K stated that he checked the walk-in refrigerator for expired foods when he was in the walk-in refrigerator. He stated the last time he checked the walk-in refrigerator for expired food was on 08/10/2025. He stated he looked around in the walk-in refrigerator, but he did not look at everything. Dietary [NAME] K stated each food item should be labeled with an expiration date. During an interview on 08/11/2025 at 9:50 AM, Dietary Director Assistant (DDA) L stated she tried to check for expired foods in the walk-in refrigerator daily. She stated that she removed some expired food items on 08/10/2025, but she did not get to check everything in the walk-in refrigerator. During an interview on 08/14/2025 at 11:17 AM, the Administrator (ADM) stated she expected the staff to record a UBD on all cold storage items and to monitor the cold storage units daily to ensure items were properly labeled, stored, and all expired<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | foods removed. 5. During a concurrent interview and observation of the freezer on 08/11/2025 at 10:00 AM with the Dietary Manager (DM), one case of dinner rolls was stored with the box open (exposing the dinner rolls to air). In addition, multiple boxes of food were observed stored on the floor of the freezer, including two cases of pulled pork, two cases of chicken breasts, and one case of peas and pearl onions. The DM stated the dinner rolls should have been stored in a closed container. The DM further stated that the items stored on the floor were delivered to the facility four days prior and remained on the floor because staff had not had a chance to put all the food items away. The DM stated he should have made sure staff went to the freezer to put the items away. During an interview on 08/14/2025 at 11:17 AM, the Administrator (ADM) stated she expected frozen foods to be put away appropriately upon delivery and all frozen items to be sealed. During an interview on 08/14/2025 at 11:55 AM, Registered Dietitian (RD) H stated all cold/frozen foods were to be stored in closed containers and should not be stored on the floor of the refrigerator or freezer. During an interview on 08/14/2025 at 4:02 PM, the Director of Nursing (DON) stated she expected food items to be stored in closed containers and not left on the floor. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Number of residents sampled:<br><br>Number of residents cited:<br><br>Based on interview, record review, and facility policy review, the facility failed to provide a written notice of bed hold policies upon transferring a resident to a hospital and failed to send a copy of a notification of transfer/discharge to the Ombudsman for 1 (Resident #86) of 1 resident reviewed for hospitalizations. Findings included: A facility policy titled, Bed-Holds and Returns, revised 10/2022, indicated, Residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies. The policy revealed, 1. All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice: a. notice 1: well in advance of any transfer (e.g. [exempli gratia; for example] in the admission packet); and b. notice 2: at the time of transfer (or, if the transfer was emergency, within 24 hours). An admission Record revealed the facility admitted Resident #86 on 05/30/2025. According to the admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease, pneumonia, acute and chronic respiratory failure with hypoxia (low levels of oxygen in the body's tissues), acute and subacute infective endocarditis (an infection of the inner surface of the heart), and pleural effusion (a collection of fluid around the lungs). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/04/2025, revealed Resident #86 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #86's Progress Notes revealed a Change of Condition note, dated 06/08/2025, that indicated the resident was assessed and had diminished wheezes, and indicated that the resident was sent to the emergency room for further evaluation. Resident #86's medical record revealed no documentation that a written notification of the bed hold policy had been provided to the resident or the resident's representative at the time of or following the resident's transfer on 06/08/2025. There was also no evidence that the Ombudsman had been provided with a copy of a notification of transfer/discharge for the resident. During an interview on 08/16/2025 at 8:59 AM, Licensed Practical Nurse (LPN) Q stated nursing staff issued notifications of the bed hold policies when a resident went out of the facility. They stated that if a resident was unable to sign the notification, they contacted the resident's Power of Attorney (POA) and asked them if they wanted a bed hold for the resident, and then they (LPN Q) let the unit manager know to complete the paperwork and document it in a progress note. During an interview on 08/16/2025 at 10:27 AM, Unit Nurse Manager (UNM) U stated the nurse sending a resident to the hospital asked the resident if they wanted a bed hold and had them sign the notification if they were able. They stated that if a resident refused to sign a notice of bed hold policies, then it should be documented on the notification of bed hold policies form.ˆ During an interview on 08/15/2025 at 1:38 PM, the Administrator stated they did not have any notification of bed hold policies or documentation of notification of bed hold policies from when Resident #86 went out to the hospital. The Administrator stated the Social Service Director (SSD) was responsible for the notification of bed hold policies and stated that it usually was completed verbally and then documented. The Administrator stated they did not have documentation that the Ombudsman was notified of Resident #86's discharge and stated that it had not been done. The Administrator stated the SSD was responsible for sending that information. During a telephone interview on 08/16/2025 at 9:16 AM, the SSD stated that they did not notify the Ombudsman when a resident was sent to the hospital. During an interview on 08/16/2025 at 10:57 AM, the Administrator stated nursing staff<br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | should get the notification of bed hold. The Administrator stated that when the nurse called the family to notify them of the transfer, the nurse asked them at that time if they wanted a bed hold, and it was documented in the progress notes. They stated they did not know why Resident #86 did not have a record of notification of bed hold policies. The Administrator stated there should have been one, and it should have been documented. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, the facility failed to accurately code the Minimum Data Set (MDS) for 5 (Residents #2, #5, #35, #37 and #76) of 8 residents reviewed for Preadmission Screening and Record Review (PASRR) requirements, smoking, unnecessary medications, or speech/communication concerns.<br><br>Findings included:<br><br>The Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2024, revealed, A1500: Preadmission Screening and Resident Review (PASRR) included Coding Instructions, which included, Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. The manual revealed, B0600: Speech Clarity included Coding Instructions, which revealed, Code 0, clear speech: if the resident usually utters distinct, intelligible words, Code 1, unclear speech: if the resident usually utters slurred or mumbled words, or Code 2, no speech: if there is an absence of spoken words. The manual revealed, J1300: Current Tobacco Use included Coding Instructions, which included, Code 0, no: if there are no indications that the resident used any form of tobacco, or Code 1, yes: if the resident or any other source indicates that the resident used tobacco in some form during the look-back period. The manual revealed, N0450: Antipsychotic Medication Review included Coding Instructions for N0450A, which included, Code 1, yes: if antipsychotics were received on a routine basis only, Code 2, yes: if antipsychotics were received on a PRN [pro re nata; as needed] basis only, or Code 2, yes: if antipsychotics were received on a routine and PRN basis.<br><br>1. An admission Record indicated the facility admitted Resident #76 on 02/23/2023. According to the admission Record, the resident had a medical history that included diagnoses of unspecified schizophrenia, schizoaffective disorder, anxiety disorder, borderline personally disorder, major depressive disorder, and unspecified psychosis not due to a substance or known physiological condition.<br><br>An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/20/2025, indicated Resident #76 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Section A1500 of the MDS indicated Resident #76 was not considered by the state Level II PASRR process to have a serious mental illness. The MDS revealed J1300 indicated Resident #76 did not use tobacco during the assessment timeframe. N0450A indicated the resident did not receive antipsychotic medication during the assessment timeframe.<br><br>Resident #76's Care Plan Report revealed a focus area initiated 07/12/2023, that indicated Resident #76 was a smoker. The Care Plan Report also included a focus area initiated on 04/13/2023, that indicated the resident used psychotropic medications.<br><br>Resident #76's PASRR Level II determination letter, dated 02/17/2023, indicated Resident #76 had a serious mental illness, and recommended nursing home placement with psychiatric medication management and social and recreational activities.<br><br>Resident #76's February 2025 Medication Administration Record revealed staff the resident received<br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | olanzapine (an antipsychotic) on 02/14/2025 (during the assessment timeframe).<br><br>Resident #76's Resident Smoking Agreement, dated 06/23/2025, revealed Resident #76 was determined to be safe to smoke.<br><br>An untitled and undated facility document provided by facility staff as a list of residents who smoked revealed Resident #76's name on the list.<br><br>During an interview on 08/13/2025 at 8:54 AM, Resident #76 stated they smoked cigarettes two to three times a day.<br><br>During an interview on 08/14/2025 at 2:57 PM, the MDS Coordinator stated the resident's MDS would accurately reflect the resident's status and care. The MDS Coordinator stated Resident #76's 02/20/2025 annual MDS, Section A1500 PASRR was incorrect and should have been marked yes, as the resident had a positive Level II PASRR. The MDS Coordinator stated Section J1300 was incorrect and should have been marked yes, as the resident was an active smoker. The MDS Coordinator stated they were both errors and needed to be modified to accurately reflect the resident's status.<br><br>During an interview on 08/15/2025 at 4:06 PM, the MDS Coordinator stated Resident #76's Section N, related to the use of antipsychotic medication, was incorrect and should have been marked yes to indicate the resident received antipsychotic medication. The MDS Coordinator stated the facility did not have a policy for accuracy of MDS assessments; the facility followed the Resident Assessment Instrument (RAI) manual.<br><br>During an interview on 08/15/2025 at 12:09 PM, the Director of Nursing (DON) stated the expectation was for MDS assessments to accurately reflect a resident's plan of care. The DON stated Resident #76's PASRR status, tobacco use, and their use of antipsychotic medication were all marked incorrectly and needed to be corrected.<br><br>During an interview on 08/15/2025 at 10:38 AM, the Administrator (ADM) stated the expectation was for the MDS Coordinator to look at the resident's electronic medical record (EMR) and use it to accurately reflect the PASRR, smoking, and medication status in the MDS. The ADM stated Resident #76's 02/20/2025 annual MDS was incorrect for the resident's PASRR status, smoking status, and their use of antipsychotic medication and required modification to correct them.<br><br>2. An admission Record indicated the facility admitted Resident #5 on 05/23/2025. According to the admission Record, the resident had a medical history that included diagnoses of unspecified bipolar disorder and encounter for orthopedic aftercare following surgical amputation.<br><br>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/28/2025, indicated Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. A1500 of the MDS indicated Resident #5 was not considered by the state Level II PASRR process to have a serious mental illness.<br><br>Resident #5's PASRR Level II determination letter, dated 05/21/2025, indicated the resident had a serious mental illness, and recommendations included nursing home placement with psychiatric medication management, supportive counseling, and individual therapy.<br><br>Resident #5's Care Plan Report included a focus area initiated 05/24/2025, that indicated Resident #5<br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | had a PASRR Level II completed on 05/21/2025 and met the state definition for having a mental illness.<br><br>During an interview on 08/14/2025 at 3:02 PM, the MDS Coordinator stated Resident #5's 05/28/2025 admission MDS, Section 1500 PASRR was incorrect and should have been marked yes, as the resident had a positive Level II PASRR. The MDS Coordinator stated it needed to be corrected.<br><br>During an interview on 08/15/2025 at 10:38 AM, the Administrator (ADM) stated the expectation was for the MDS Coordinator to look at the resident's electronic medical record (EMR) and use it to accurately reflect the PASRR status in the MDS. The ADM stated Resident #5's 05/28/2025 admission MDS PASRR Section A1500 was incorrect and needed to be modified.<br><br>During an interview on 08/15/2025 at 12:09 PM, the Director of Nursing (DON) stated the expectation was for MDS assessments to accurately reflect a resident's plan of care. The DON stated Resident #5's PASRR section was coded incorrectly and needed to be corrected.<br><br>3. An admission Record indicated the facility admitted Resident #35 on 01/04/2012. According to the admission Record, the resident had a medical history that included a diagnosis of bipolar disorder.<br><br>Resident #35's Notice of PASRR Level II Outcome, dated 07/15/2019, indicated Resident #35 was approved for PASRR Level II determination and did not require specialized services. The document indicated that if the resident was currently in a Medicaid-certified facility, the facility would need to document the PASRR condition in the Minimum Data Set (MDS) assessment record. The document indicated that the facility should mark yes for question A1500 on the MDS.<br><br>Resident #35's significant change MDS, with an Assessment Reference Date (ARD) of 08/24/2024, revealed the facility documented No to the question in section A1500, Is the resident currently considered by the state level II process to have a serious mental illness and/or intellectual disability or a related condition?<br><br>During a telephone interview on 08/14/2025 at 2:55 PM, the MDS Coordinator stated that she completed section A1500 of the significant change MDS dated [DATE] for Resident #35. The MDS Coordinator stated to complete that section, she looked in the miscellaneous section of the medical record and reviewed the PASRR to see if the resident had a Level I or Level II PASRR. During the interview, the MDS Coordinator reviewed Resident #35's PASRR and stated she marked No for section A1500 in error. She stated Resident #35 did have an approved PASRR Level II determination, and she should have marked this section Yes.<br><br>During an interview on 08/15/2025 at 10:22 AM, the Director of Nursing (DON) stated she expected staff to review the medical record to identify whether a PASRR had been completed, and if the resident had an approved PASRR Level II, the MDS should be coded accordingly. The DON stated she expected the facility to refer to the Resident Assessment Instrument (RAI) manual to ensure MDS assessments were completed accurately.<br><br>^<br><br>During an interview on 08/14/2025 at 4:32 PM, the Administrator stated the facility did not have a PASRR policy but stated she also expected the MDS Coordinator to follow the RAI manual when completing an MDS assessment.<br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 4. An admission Record revealed the facility admitted Resident #2 on 06/10/2024. According to the admission Record, the resident had a medical history that included diagnoses of schizophrenia, unspecified, post-traumatic stress disorder (PTSD), unspecified, mental disorder, not otherwise specified, and generalized anxiety disorder.<br><br>An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/18/2025, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident was not currently considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability or a related condition. The MDS indicated active diagnoses for psychiatric/mood disorder included anxiety disorder, schizophrenia, and PTSD.<br><br>Resident #2's Care Plan Report included a focus area initiated 05/14/2025 that indicated the resident had a mood problem related to amnesia, schizophrenia, anxiety, and PTSD medications. Interventions directed staff to monitor mood and behaviors (initiated 05/14/2025).<br><br>Resident #2's Nebraska PASRR Level II Summary of Findings Report, Level II determination date of 05/29/2024, revealed the resident met the federal definition of serious mental illness.<br><br>During a telephone interview on 08/15/2025 at 4:09 PM, MDS Coordinator (MDS) G stated Resident #2's MDS assessment was inaccurate. MDS G reviewed the PASRR Level II and stated the resident had a serious mental illness and the MDS assessment should have been marked yes.<br><br>^<br><br>During an interview on 08/15/2025 at 4:29 PM, Director of Nursing (DON) B stated Resident #2 had schizophrenia, PTSD, mental disorder, and anxiety. DON B stated the MDS assessment with an ARD of 06/18/2025 was not correct and it should have been marked yes for a serious mental illness or condition. DON B's expectation was the MDS assessment needed to be accurate for staff to be able to provide the residents with appropriate care and assistance.<br><br>^<br><br>During an interview on 08/15/2025 at 5:04 PM, Administrator (ADM) A stated Resident #2 had a serious mental illness with a diagnosis of schizophrenia. ADM A stated the MDS assessment with an ARD of 06/18/2025 was not correct and should have been marked yes for a serious mental illness. ADM A stated the ADM's expectation was that the ADM and MDS G worked together for the PASRR section of the MDS to ensure it was coded correctly. ADM A stated the facility did not have a policy for accuracy of the MDS; they followed the Resident Assessment Instrument (RAI) manual.<br><br>^<br><br>5. An admission Record revealed the facility admitted Resident #37 on 07/23/2003 and readmitted on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of cerebral palsy and dysphagia.<br><br>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/04/2024, revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident had unclear speech – slurred or (continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | mumbled words.<br><br>An annual MDS, with an ARD of 03/06/2025, revealed Resident #37 had a BIMS score of 14, which indicated the resident had intact cognition. The MDS indicated the resident had unclear speech – slurred or mumbled words.<br><br>A quarterly MDS, with an ARD of 06/06/2025, revealed Resident #37 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had clear speech – distinct intelligible words.<br><br>Resident #37's Care Plan Report included a focus area revised 03/18/2025 that indicated the resident had impaired communication due to unclear speech related to cerebral palsy with severe spasticity, mild intellectual disabilities, hearing deficits, and used hearing aids. Speech was unclear at times and staff needed to listen very close at times or have the resident repeat more slowly. Interventions directed staff to listen carefully and validate verbal and non-verbal expressions (initiated 02/10/2017).<br><br>^<br><br>During a telephone interview on 08/15/2025 at 4:04 PM, MDS Coordinator (MDS) G stated Resident #37's previous MDS assessments indicated the resident did not have clear speech and it was MDS G's error for the assessment of 06/06/2025 indicating the resident had clear speech.^<br><br>^<br><br>During an interview on 08/15/2025 at 4:36 PM, Director of Nursing (DON) B stated Resident #37's speech was difficult to understand. DON B referred to the resident's MDS assessment of 06/06/2025 and stated it was not accurate; the resident did not have clear speech.<br><br>^<br><br>During an interview on 08/15/2025 at 5:07 PM, Administrator (ADM) A stated Resident #37's speech was difficult to understand. ADM A referred to the resident's MDS assessment of 06/06/2025 and stated it was not accurate because Resident #37 had unclear speech, and it was coded as clear speech. ADM A stated the ADM's expectation was that MDS G had accurate information for coding and the staff that completed that portion of the MDS assessment had accurate information. ADM A stated MDS G completed the speech section of the MDS for Resident #37. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>Number of residents sampled:<br><br>Number of residents cited:<br><br>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<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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 Report revealed no other non-pharmacological interventions to address the resident's pain. Resident #90's hospital Post Acute Care Transition Report, dated 08/05/2025, revealed Active Medications included the following: -Acetaminophen (an analgesic) 500 milligrams (mg), two tablets (1,000 mg) by mouth every six hours PRN, with a maximum of 4,000 mg a day. -Hydrocodone-acetaminophen (a narcotic analgesic combination) 5-325mg, two tablets by mouth every four hours PRN for acute pain. Resident #90's hospital Post Acute Care Transition Report, dated 08/05/2025, revealed Discontinued Medications included tramadol (an opioid) 50 mg. Resident #90's Order Recap [Recapitulation] Report, for order dates from 08/01/2025 through 08/31/2025, included the following orders: -Pain monitoring every day and night shift, with an order to utilize an appropriate pain scale according to the resident's cognition, ordered on 08/05/2025. -Acetaminophen extra strength 500 mg, two tablets by mouth every six hours PRN for pain, with instructions to not exceed 4,000 mg per day, ordered on 08/05/2025. -Hydrocodone-acetaminophen 5-325 mg, two tablets by mouth every four hours PRN for acute pain, ordered on 08/05/2025 and discontinued on 08/12/2025. -Hydrocodone-acetaminophen 5-325, one tablet by mouth every six hours PRN for acute pain, ordered 08/12/2025. The Order Recap Report revealed no orders for non-pharmacological interventions for pain. Resident #90's Pain Evaluation, dated 08/05/2025, was incomplete. The evaluation indicated the resident was on a scheduled pain management regimen and received PRN and non-medication interventions for pain. The evaluation included a Pain Interview that indicated that the resident had almost constant pain over the previous five days that made it hard to sleep at night and limited their day-to-day activities. The evaluation revealed the sections for indicating the location of the pain, potential underlying causes of pain, pain intensity, pain relief, type of pain, timing and contributing factors, manner of expressing pain and associated symptoms, pain interference, laxatives ordered, and interventions were incomplete. The evaluation did not include the signature of the staff member who completed the evaluation. Resident #90's August 2025 Medication Administration Record [MAR], for the timeframe from 08/05/2025 (date of admission) through 08/15/2025 (the MAR report was printed on 08/15/2025 at 9:52 AM), revealed the following: - Staff documented monitoring the resident's pain each shift (6:00 AM shift and 6:00 PM shift), beginning on 08/05/2025. The record revealed that of the 18 times staff documented the resident's pain level, the resident's pain was a 10 (on a scale of 0-10, with 10 being the worst possible pain) 10 times; 9, one time; 8, two times; 6, two times; 5, two times; and 1, one time. - Staff documented Resident #90 received two tablets of hydrocodone-acetaminophen 5-325 mg one time on 08/05/2025, two times on 08/06/2025, four times on 08/07/2025, four times on 08/08/2025, four times on 08/09/2025, three times on 08/10/2025, three times on 08/11/2025, and three times on 08/12/2025. - Of the 24 administrations of two tablets of hydrocodone-acetaminophen 5-325 mg, staff documented the resident's pain level was rated 10, 12 times; 9, five times; 8, four times; and 4, one time. Two were not documented. - Hydrocodone-acetaminophen 5-325 mg was decreased from two tablets every four hours PRN to one tablet every six hours PRN on 08/12/2025. -Staff documented the resident received one tablet of hydrocodone-acetaminophen 5-325 mg three<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | times on 08/13/2025, four times on 08/14/2025, and one time so far on 08/15/2025. - Of the eight administrations of the medication, staff documented the resident's pain level was rated 10, five times; 9, one time; 8, one time; and 2, one time. Resident #90's August 2025 MAR revealed staff documented Resident #90 received two tablets of hydrocodone-acetaminophen 5-325 mg on 08/07/2025 at 6:44 PM (pain level 9) with an unknown effectiveness, and the next administration was at 11:06 PM (pain level 9). Resident #90's Progress Notes revealed an Administration Note, dated 08/07/2025 at 6:44 PM, that indicated the resident received two tablets of hydrocodone-acetaminophen 5-325 mg and a follow-up note at 9:14 PM indicated the effectiveness was unknown, indicating that the resident stated that they had vomited their medication. The resident's Progress Notes revealed no documentation of other follow-up or intervention until 11:06 PM, when the resident was given two more tables of hydrocodone-acetaminophen 5-325 mg. Resident #90's August 2025 MAR revealed staff documented Resident #90 received two tablets of hydrocodone-acetaminophen 5-325 mg on 08/08/2025 at 2:06 PM (pain level 10) and the effectiveness was unknown. The MAR revealed the next administration was at 6:47 PM (pain level 10). Resident #90's Progress Notes revealed an Administration Note, dated 08/08/2025 at 2:06 PM, that indicated the resident received two tablets of hydrocodone-acetaminophen 5-325 mg and their follow pain level documented at 6:45 PM (over four hours after administration) was 10 and the effectiveness of the administration was unknown. The resident's Progress Notes revealed no other follow-up or intervention was provided until 6:47 PM, when the resident was given two more tables of hydrocodone-acetaminophen 5-325 mg. Resident #90's August 2025 MAR revealed staff documented the resident received two tablets of hydrocodone-acetaminophen 5-325 mg on 08/09/2025 at 10:22 AM (pain level 10) and was ineffective. The MAR revealed the next administration was at 5:04 PM (pain level 10), which was also documented as ineffective. Resident #90's Progress Notes revealed an Administration Note, dated 08/09/2025 at 10:22 AM, that indicated the resident received two tablets of hydrocodone-acetaminophen 5-325 mg and their follow-up pain level documented at 4:18 PM (over six hours later) was 9 and indicated the administration was ineffective. The resident's Progress Notes revealed no other follow-up or intervention was provided until 5:04 PM, when the resident was provided another two tablets of hydrocodone-acetaminophen 5-325 mg. Per the notes, the follow-up pain level documented at 7:31 PM was 10 and indicated the administration was ineffective. The notes indicated the resident was given two tables of acetaminophen extra strength 500 mg at 7:32 PM and their follow-up pain level documented at 8:32 PM was 3 and indicated the administration was effective. Resident #90's August 2025 MAR revealed staff documented Resident #90 received two tablets of acetaminophen extra strength 500 mg on 08/10/2025 at 5:37 AM (pain level 10) with an unknown effectiveness. Resident #90's Progress Notes revealed an Administration Note, dated 08/10/2025 at 5:37 AM, that indicated the resident received two tablets of acetaminophen extra strength 500 mg and their follow-up pain level documented at 9:51 AM (over three hours after administration) was 10 and the effectiveness was unknown. The Progress Notes revealed an Administration Note, dated 08/10/2025 at 9:51 AM, that indicated the resident received two tablets of hydrocodone-acetaminophen 5-325 mg and their follow-up pain level documented at 1:46 PM (over four hours after administration) was 10, but it was documented that the administration as effective. Resident #90's Nursing Daily Skilled Charting, dated 08/10/2025 at 10:58 AM, indicated the resident rated their pain a 10. The record indicated that the resident displayed non-verbal indicators of pain, indicating that the resident was tearful at times. Resident #90's Nursing Daily Skilled Charting, dated 08/11/2025 at 3:07 PM, indicated the resident rated their pain a 10. The record indicated that the resident displayed non-verbal indicators of pain, indicating that the resident was tearful at times. Resident #90's August 2025 MAR revealed staff documented the resident received two tablets of hydrocodone-acetaminophen 5-325 mg on 08/12/2025 at 2:22 PM (pain level 10) and the effectiveness was unknown. Resident #90's Progress Notes revealed an Administration Note, dated 08/12/2025 at 2:22 PM that indicated the resident received two tables of<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | hydrocodone-acetaminophen 5-325 mg and their follow-up pain level documented at 7:23 PM (over five hours after administration) was unknown. The Progress Notes revealed no other follow-up or intervention was provided until 08/13/2025 at 3:57 AM (over seven hours later) when the resident was given one tablet of hydrocodone-acetaminophen 5-325 mg. Resident #90's Nursing Daily Skilled Charting, dated 08/12/2025 at 10:09 PM, indicated the resident rated their pain a 10. The record indicated that the resident displayed non-verbal indicators of pain, indicating that the resident was tearful at times. Resident #90's August 2025 MAR revealed staff documented the resident received one tablet of hydrocodone-acetaminophen 5-325 mg on 08/13/2025 at 5:04 PM (pain level 10) and the administration was ineffective. Resident #90's Progress Notes revealed an Administration Note, dated 08/13/2025 at 5:04 PM, that indicated that the resident received one tablet of hydrocodone-acetaminophen 5-325 mg and their follow-up pain level documented at 7:37 PM (over two hours later) was a 10 and indicated the administration was ineffective. The Progress Notes indicated that the resident received two tablets of acetaminophen extra strength 500 mg at 7:39 PM and their follow-up pain level documented at 9:47 PM was a 5 and indicated the administration was effective. Resident #90's August 2025 MAR revealed staff documented the resident received one tablet of hydrocodone-acetaminophen 5-325 mg on 08/14/2025 at 5:12 PM (pain level 10) and the administration was ineffective, and the next administration was at 11:40 PM (pain level 10). Resident #90's Progress Notes revealed an Administrative Note, dated 08/14/2025 at 5:12 PM, that indicated that the resident received one tablet of hydrocodone-acetaminophen 5-325 mg and their follow-up pain level documented at 8:27 PM (over three hours after the administration) was 10 and indicated the administration was ineffective. The resident's Progress Notes revealed no documentation of other follow-up or intervention until 11:40 PM when the resident was given another tablet of hydrocodone-acetaminophen 5-325 mg. Resident #90's record revealed no documented rationale for decreasing the resident's hydrocodone-acetaminophen. The record revealed no documentation of non-pharmacological interventions for pain offered or provided to the resident. During an interview and observation on 08/12/2025 at 2:47 PM, Resident #90 stated it took forever to get pain medications. The resident stated they had just gotten pain medication a few minutes earlier, but they had not had any since that morning. Resident #90 stated they had shoulder surgery and was supposed to get the staples out that Friday (08/15/2025). The resident grimaced in pain with the movement of the left arm. ˆ During an interview on 08/13/2025 at 10:06 AM, Resident #90 was lying in bed and stated the pain to their left shoulder was rated an 8 at that time, and they were unsure when they had last received pain medication but wished they could get something to help. ˆ During an interview on 08/14/2025 at 10:45 AM, Resident #90 stated they had increased shoulder pain that day. The resident stated the facility decreased their pain medication to one pill every six hours, and the resident did not know why. Resident #90 stated the physician had not come in and talked to them about their pain. The resident stated they were trying to work with therapy staff as much as they could but felt they (Resident #90) were limited due to the pain. Resident #90 grimaced when they moved their arm and was guarding it.ˆ During an interview on 08/14/2025 at 10:57 AM, Licensed Practical Nurse (LPN) Q stated they ran out of Resident #90's hydrocodone-acetaminophen 5-325 mg that was ordered for two tablets every four hours. They stated that they tried to get the pharmacy to refill the prescription on Tuesday (08/12/2025), and the physician sent the prescription for one tablet every six hours right before the end of their shift, so they were not the one to follow up on it. LPN Q stated the provider wanted to start weaning the resident off the pain medication since it had been a week since the resident's surgery. LPN Q stated the provider did not assess the resident prior to decreasing the resident's medication. LPN Q stated Resident #90 continued to rate their pain level at a 10. LPN Q stated the resident did not like to use ice, saying it made the pain worse. During an interview on 08/14/2025 at 11:50 AM, LPN Q stated they called the physician's office to follow up on the decrease in the pain medication and was told that it was their protocol to start decreasing the pain medications the further out from surgery that the resident got. LPN Q stated that the nurse practitioner was out at (continued on next page) |

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| Monument Healthcare and Nursing Center | 111 West 36th Street<br>Scottsbluff, NE 69361 |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | that time, but they would let them know to follow up with the resident the following morning since the resident was still complaining their pain level was 10 out of 10 most of the time.ˆ During an interview on 08/15/2025 at 4:44 PM, Unit Nurse Manager (UNM) U, who was the UNM where Resident #90 resided, stated residents should be assessed half an hour to an hour after receiving a PRN pain medication to see if it was effective. UNM U stated that if it was not effective, then other PRN medications or non-pharmacological interventions should be provided. They stated if there were still no positive results, the physician should be notified to get further orders on what to do. UNM U stated they had not been notified of Resident #90's pain levels and said it should have been followed up on prior to that day. UNM U stated that any time a resident had ineffective results from a pain medication, the nurse should follow up on it and do something more. UNM U stated they were not aware of Resident 90's pain levels. They stated it should have been reported and followed up on sooner. UNM U stated that even if the resident rated their pain 10 out of 10 every time, the staff should have used an alternate type of assessment to follow up on the resident's pain.ˆ During an interview on 08/14/2025 at 3:10 PM, the Director of Rehabilitation (DOR) stated Resident #90 was having a lot of muscle spasms that limited their range of motion (ROM). The DOR stated they tried to ensure the resident had been given pain medication prior to therapy. The DOR stated they were looking to see what they could do for the resident's pain and decreased ROM. During a concurrent interview on 08/15/2025 at 1:45 PM, Physical Therapist (PT) N, while providing ROM for Resident #90, stated the resident had been able to do more ROM in the previous two days than since they were admitted . PT N stated there was a concern about the swelling in the resident's arm, so the resident was going for an ultrasound at 2:00 PM. Resident #90 stated they spoke with a physician assistant (PA) about their pain, and the PA ordered an X-ray that was negative, an ultrasound, and some laboratory tests. The resident stated that the PA did not adjust their pain medication. PT N stated the resident's therapy had been limited due to the resident's staples and the limited ROM. PT N stated the resident's pain needed to be under control in order for therapy to be effective.ˆ During an interview on 08/15/2025 at 2:24 PM, Medical Assistant (MA) X, who was the MA for the resident's orthopedic PA, stated Resident #90 complained of pain at a level of 10 out of 10 pain before surgery and during the five days following the operation while they were in the hospital, even after getting intravenous (IV) pain medications. MA X stated that a nurse followed up with the resident 15 to 20 minutes after giving the pain medication, and the resident continued to rate their pain level at a 10 out of 10. MA X stated the resident did not know how to describe their pain. They stated the resident was seen by the orthopedic PA that morning due to the pain and swelling. They stated the X-ray was negative, and the PA ordered laboratory tests and an ultrasound to rule out deep vein thrombosis (a blood clot). MA X stated the resident had orders for hydrocodone-acetaminophen 5-325 mg, one tablet every six hours and could get acetaminophen in between. They stated that when the medication was decreased, they were not aware that the resident's pain was not controlled. MA X stated that all they knew was that the resident needed a new prescription for their pain medication and the PA followed the normal process of lowering the dose because of the amount of time that had passed since surgery. MA X stated the facility needed to be utilizing acetaminophen and trying other non-pharmacological interventions, like ice. The MA stated pain management was based on each individual patient. MA X stated if the resident felt that the tramadol would be more beneficial, they (MA X) could talk to the PA about it, but it would not be until Monday (08/18/2025), and if the facility needed something more for the resident before then, they needed to contact the resident's primary care physician. During a telephone interview on 08/15/2025 at 4:25 PM,ˆthe Medical Director (MD), who was the Resident #90's primary care physician, stated they expected the staff to contact a provider when a resident's pain was not being controlled within 24 hours. The MD stated Resident #90 always reported their pain level at a 10 but expected the resident 10 but pain after surgery. The MD stated the staff should offer ice packs, position changes, a lidocaine (an anesthetic) patch, distraction, and other activities. The MD stated they were not aware of the resident's complaint of uncontrolled pain or of the resident<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | being sent for an ultrasound. The MD stated Resident #90 did have some cognitive impairment and it was difficult to assess their pain, and the staff needed to use a clinical assessment with the resident's input to determine what the resident's pain level was. The MD stated tramadol was not effective for Resident #90 in the hospital, but it may be effective going forward if the resident felt it would be beneficial. The MD stated the resident's pain level needed to be controlled for them to participate in therapy to make progress.ˆ Resident #90's Order Recap Report, for order dates from 08/01/2025 through 08/31/2025, contained an order, dated 08/15/2025 and started on 08/16/2025, for lidocaine 4% patch, to be applied to the left shoulder in the morning and removed at bedtime. During an interview on 08/16/2025 at 9:52 AM, Resident #90 was lying in bed with their arm elevated on a pillow. There was notable swelling observed to the upper arm. The resident stated their pain was 10 at that time and they were waiting for pain medication. Resident #90 stated they had not noticed a difference with the medication changes. They stated they had a patch on their shoulder and stated that it was not effective. Resident #90 stated it had been so long since they had not had any pain that they did not know what a tolerable level of pain would be. The resident stated they were old and tired of being in pain. The resident stated having to wait six hours for pain medication was too long. The resident stated they wanted to be able to get the pain medication more often and wanted to know why they could not have tramadol back. Resident #90 grimaced in pain with movement and held onto their arm, guarding it with any movement.ˆ During an interview on 08/15/2025 at 4:50 PM, the Director of Nursing (DON) stated if a resident indicated they were having uncontrolled pain, the nurse should be evaluating the resident's pain and administering anything that was ordered, and if that was not effective, they should contract the physician to get further orders, and it should be documented. The DON stated they were not aware of Resident #90's unrelieved pain and stated the nurses should have contacted the orthopedic physician for further orders, and if the nurse did not get a response, then they should have contacted the resident's primary care physician. The DON stated if a resident indicated their pain management was ineffective, the physician should be notified to get further orders. The DON stated if the physician could not be contacted, the resident should be sent to the emergency room for further evaluation and pain management.ˆ During an interview on 08/16/2025 at 10:57 AM, the Administrator stated nursing staff should follow physician orders when administering pain medication, assessing residents to ensure their pain was being managed, and if it was not, they should try other interventions. The Administrator stated that if the pain was still not controlled, they should contact the physician to see what other interventions they want to try. The Administrator stated they should try repositioning or moving the resident to a different setting, and the staff should document what was being tried.ˆ |

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| F 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.<br><br>Number of residents sampled:<br><br>Number of residents cited:<br><br>Based on interview and facility document review, the facility failed to ensure that in the absence of a full-time registered dietitian (RD) or other clinically qualified nutrition professional, a qualified individual was designated to serve as the director of food and nutrition services. This had the potential to affect all residents receiving meals from the dietary department. Findings included: A document titled, Application for Employment, signed by the Dietary Manager (DM) on 01/23/2025, revealed the DM's work history included work as a cook/dietary aide. The application further revealed the DM received a high school diploma and completed one and a half years of education at a community college. The application did not reflect any food service education or previous employment as a food service director. The Dietary Manager's (DM) personnel file revealed the DM was originally hired by the facility as a cook on 1/23/2025. A document titled, Job Description and Performance Standards for the position of Food Service Director, signed by the Dietary Manager (DM) on 05/11/2025, revealed, The purpose of this position is to implement and maintain effective systems to operate the dietary department and provide foodservice to residents in a cost-effective efficient manner to safely meet residents' needs in compliance with federal, state and local requirements. The section titled, Education and/or Experience (to be completed by the facility) was left blank. A document titled, Information for Monthly Quality Assurance Performance Improvement (QAPI) Committee Meeting Minutes, dated 06/11/2025, revealed the Administrator (ADM) and RD H attended the meeting. The document indicated the facility had a new DM in place (specified the facility's current DM), and the facility would work with him on dietary items and continue training him on expectations. The document indicated the DM would start certified dietary manager (CDM) courses soon, which were expected to take a year for completion. During an interview on 08/11/2025 at 10:10 AM, the DM stated that he did not complete a certification course, he did not have a degree in food service, and he had not previously been employed as a dietary director or food service director. The DM stated he started at the facility in early 2025 as a cook and was promoted to DM in April 2025. The DM stated that prior to his employment at the facility, he was employed as a cook for over two years at two other nursing facilities. The DM stated that he planned to enroll in online CDM courses in a couple weeks but he was not currently enrolled. The DM stated that he did not have a food service certificate, and he did not have formal training as the food service director. He stated that he was not aware of the federal requirements for the role of director of the dietary department. During an interview on 08/14/2025 at 11:17 AM, ADM stated that she was aware the DM was not certified in food service when she started as the ADM on 06/01/2025. The ADM stated they discussed the DM's lack of food service certification during the June 2025 QAPI meeting, and the plan was for the DM to complete an online CDM course within a year. The ADM stated she was not aware of the federal requirements for the director of the dietary department, and her expectation was that the facility would employ a qualified food service director. During an interview on 08/14/2025 at 11:55 AM, RD H stated she provided onsite and remote consultation services to the facility for a total of eight to twelve hours of consultation per week. She stated she was not a full-time RD for the facility. She stated she was aware the DM was not certified, but a plan to get him certified was discussed during a QAPI meeting. RD H stated she expected all dietary employees to have the necessary qualifications to complete their assigned responsibilities.^ During an interview on 08/14/2025 at 4:02 PM, the Director of Nursing (DON) stated she was not aware of the federal requirements for the director of the dietary department, but she expected the DM to have the proper training to ensure the dietary department was managed appropriately. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, facility document, and facility policy review, the facility failed to ensure a complete and accurate medical record for 2 (Resident #76 and Resident #48) of 18 sampled residents.ˆ<br><br>Findings included:<br><br>ˆ<br><br>A facility policy titled, Charting and Documentation, revised 07/2017, indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, function or psychosocial condition, shall be documented in the resident's medical record. The policy also indicated, 2. The following information is to be documented in the resident medical record: a. Objective observations; b. Medications administered; c. Treatments or services performed.<br><br>1.An admission Record indicated the facility admitted Resident #76 on 02/01/2023. Per the admission Record, the resident had a medical history that included diagnoses that included unspecified schizophrenia, schizoaffective disorder, anxiety disorder, borderline personally disorder, major depressive disorder, and unspecified psychosis not due to a substance or known physiological condition.<br><br>An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/20/2025, indicated Resident #76 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition.<br><br>Resident #76's Care Plan Report, included a focus area revised 06/23/2025, that indicated the resident used psychotropic medications including Invega, related to behavior management. Interventions directed staff to administer psychotropic medications as ordered by the physician (initiated 04/13/2023).<br><br>Resident #76's February 2025 Medication Administration Record [MAR], contained an order entry for Invega Sustenna (an atypical antipsychotic) Intramuscular Suspension Prefilled Syringe 234 milligrams (mg)/1.5 milliliters (ml) with directions to inject 1.5 ml intramuscularly (IM) daily starting on the 11th and ending on the 12th every month. The MAR lacked documented evidence that the medication was administered to the resident.<br><br>A document titled, Medical Director Report, for medication regimen reviews performed between 02/01/2025 and 02/19/2025 revealed a finding/recommendation that indicated Resident #76's Invega 1.5 ml IM once monthly injection was NOT charted that it was administered on the MAR.<br><br>During an interview on 08/15/2025 at 2:39 PM, Resident #76 stated they got a shot every month.ˆThe resident stated they did not recall missing their monthly shot.<br><br>During an interview on 08/15/2025 at 2:10 PM, Licensed Practical Nurse (LPN) S stated they documented all medications that were provided to the residents on the MAR. LPN S stated aˆblank space on the MAR indicated that medication was not administered or was not documented that it was<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | given to the resident.ˆLPN S stated that when a medication was held, nursing staff were to let the DON know and make the doctor aware in case they had further instructions. LPN S stated the nurse needed to write a progress note explaining why medication was not provided and indicate the doctor's instruction.ˆˆ<br><br>During an interview on 08/15/2025 at 2:24 PM, LPN W stated all medications administered to residents were documented on the MAR with the nurse's initials.ˆLPN W stated that when there were blank spaces, it indicated the nurse forgot to document or the medication was not provided. Per LPN W, when the medication was not provided there should be a progress note explaining why the medication was not administered, and they needed to make the DON and doctor aware and follow their recommendation.<br><br>During an interview on 08/15/2025 at 12:11 PM, Unit Nurse Manager (UNM) F stated there was no documentation found regarding Resident #76 receiving their Invega shot or if the medication was held in February 2025. UNM F stated if medication was not available, they notified pharmacy and the provider to determine how to proceed. UNM F stated that when medication was available and not administered, it was documented in the resident's chart and the provider was notified of the missed medication. Per UNM F, they would proceed with the provider's recommendation and document the communication with the provider.ˆUNM F stated the medication was provided to Resident #76 or they would have been notified by the nurse that the nurse forgot to document it.<br><br>During an interview on 08/15/2025 at 12:09 PM, the Director of Nursing (DON) stated staff could not find any documentation that Invega was administered to Resident #76 in February 2025. The DON stated the resident received the medication, but the nurse did not document the administration. The DON stated the expectation was for staff to document all medications that were administered to residents and follow up with a progress note if medication was not provided and the reason the medication was not provided.ˆThe DON stated Licensed Practical Nurse (LPN) V, who was responsible for administration, no longer worked at the facility.<br><br>A phone call was made to LPN V. No voicemail was set up and there was no answer on 08/15/2025 at 12:20 PM and 4:10 PM or 08/16/2025 at 8:30 AM.<br><br>During an interview on 08/15/2025 at 4:38 PM, the Administrator stated they expected staff members to document all medications administered to residents. The ADM stated when Resident #76 received the shot in February 2025, it should have been documented on the MAR.<br><br>2. An admission Record indicated the facility admitted Resident #48 on 11/01/2022. According to the admission Record, the resident had a medical history that included diagnoses of neuromuscular dysfunction of the bladder, retention of urine, and extended spectrum beta lactamase (ESBL) resistance.<br><br>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/24/2025, revealed Resident #48 had severe impairment in cognitive skills for daily decision-making and short-term and long-term memory problems per a staff assessment of mental status (SAMS). The MDS indicated the resident had a Stage 3 pressure ulcer that was present on admission and received ulcer treatment that included nonsurgical dressings and applications of ointments/medications within the seven-day look back period.<br><br>Resident #48's Care Plan Report included a focus area revised 08/14/2025 that indicated the resident (continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | had impaired skin integrity related to a Stage 3 pressure ulcer injury to the low back/sacrum. Interventions directed staff to provide wound care as ordered (initiated 08/06/2025).<br><br>Resident #48's August 2025 Treatment Administration Record [TAR], included an order entry dated 08/06/2025 for Wound care: Lowback[sic]/sacrum- Cleanse wound with wound cleanser/NS [normal saline]. Apply [NAME] [sic]. Cover with sacral dressing. Per the TAR, the wound care was scheduled daily at 6:00 AM. The TAR lacked documented evidence that the wound care was completed on 08/08/2025.<br><br>Resident #48's TAR also included an order entry for Wound care: Lowback[sic]/sacrum- Cleanse wound with wound cleanser/NS. Apply silvercel [type of dressing] to the wound bed. Secure dressing with sacral border dressing. Per the TAR, the wound care was scheduled for the evening at 7:00 PM each Tuesday and Friday, with an order date of 07/22/2025 and discontinue date of 08/06/2025. The TAR lacked documented evidence that the wound care was completed on Friday, 08/01/2025 and Tuesday, 08/05/2025.<br><br>An additional review of the TAR revealed that Licensed Practical Nurse (LPN) T provided care for Resident #48 on the dates and times when the wound care was scheduled.<br><br>During an interview on 08/15/2025 at 2:42 PM, LPN T stated if she was scheduled to do a treatment, it was done, she just may not have documented the treatment. She stated she did all the treatments ordered for Resident #48; she just did not document it. She stated it was not on purpose; she either forgot or did not have time. She stated she was not sure and could not remember specifically but knew that she completed the treatment.^<br><br>During an interview on 08/16/2025 at 10:57 AM, the Administrator stated if there were incomplete sections on a TAR, then they could not prove that the medication or treatment was completed. She stated the medical record was incomplete. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Number of residents sampled:<br><br>Number of residents cited:<br><br>Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff used the proper personal protective equipment (PPE) during the care of a resident on Enhanced Barrier Precautions (EBP) for 1 (Resident #48) of 1 resident observed for wound care. Findings included: A facility policy titled, Enhanced Barrier Precautions, revised 08/2022, indicated, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. The policy continued, 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). The policy continued, 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: indicating, h. wound care (any skin opening requiring a dressing). The policy continued, 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devises regardless of MDRO colonization. An admission Record indicated the facility admitted Resident #48 on 11/01/2022. According to the admission Record, the resident had a medical history that included diagnoses of neuromuscular dysfunction of the bladder, retention of urine, and extended spectrum beta lactamase (ESBL) resistance. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/24/2025, revealed Resident #48 had severe impairment in cognitive skills for daily decision-making and short-term and long-term memory problems per a staff assessment of mental status (SAMS). The MDS indicated the resident had a Stage 3 pressure ulcer that was present on admission and received ulcer treatment that included nonsurgical dressings and applications of ointments/medications within the seven-day look back period. Resident #48's Care Plan Report included a focus area revised 08/14/2025 that indicated the resident had a urinary catheter system as well as an open wound to the low back/sacrum and bilateral ischium requiring enhanced barrier precautions. Interventions directed staff to assess wounds for signs and symptoms of infection during wound care (initiated 06/26/2025), utilize proper PPE while performing wound care (initiated 06/26/2025), and use proper PPE, including a gown during catheter care if splashing was expected (initiated 06/26/2025). Resident #48's Order Summary Report for active orders as of 08/16/2025 contained a physician's order dated 06/26/2025 for enhanced barrier precautions related to the urinary catheter and open wound to the lower back/sacrum. During an observation on 08/15/2025 at 10:50 AM, Licensed Practical Nurse (LPN) Q and Certified Medication Aide (CMA) R entered Resident #48's room, put on gloves, then performed wound care without putting on gowns. LPN S entered the room to replace CMA R and assist LPN Q and did not put on a gown before assisting with the wound care. During an interview on 08/15/2025 at 2:07 PM, Infection Preventionist (IP) O stated Resident #48 was on EBP due to the wound and the catheter. IP O stated Resident #48 had signage on the door, a red bagged trash can in the room, and supplies in the hall. IP O stated staff should wear gloves, gown, and mask to provide care and a face shield for splatter with catheter care. During an interview on 08/15/2025 at 1:58 PM, LPN Q stated Resident #48 was on EBP and they all should have worn gloves, gown, and mask when providing wound care. She stated it had just crossed her mind that they did not use the proper PPE.^ During an interview on 08/15/2025 at 2:00 PM, CMA R stated it did not even cross her mind that she needed to put on PPE when assisting with the wound care. She stated staff should have worn a gown and mask along with the gloves.^ During an interview on 08/15/2025 at 2:02 PM, LPN S stated she was not aware that the resident was on EBP, and additional PPE should have been worn while in the room. She stated she did not notice the signage on the door and did not<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | see the PPE outside the room. She stated she came in to replace the CMA and was just there to help.^ During an interview on 08/16/2025 at 10:57 AM, the Administrator stated staff should know if a resident required EBP because of the signage on the door, and staff should follow the EBP policy when providing care. |

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| F 0882<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.<br><br>Number of residents sampled:<br><br>Number of residents cited:<br><br>Based on interview and facility document and policy review, the facility failed to consistently employ a qualified infection preventionist. The facility's failure to employ a qualified infection preventionist to be responsible for the infection prevention and control program had the potential to affect all 78 residents residing in the facility. Findings included: The facility policy titled, Infection Preventionist, revised 09/2022, indicated, 1. The infection preventionist is qualified by education, training, experience and/or certification and has sufficient knowledge to perform the role. An undated facility document titled, Infection Control Preventionist, indicated the facility's previous infection preventionist (IP) P was the facility's IP for the timeframe from 08/01/2024 through 12/06/2024, Registered Nurse (RN) Y was the facility's IP for the timeframe from 12/16/2024 through 02/09/2025, and IP O was the facility's IP for the timeframe from 02/10/2025 to present. An award certificate for IP P revealed they completed the Centers for Disease Control (CDC) Nursing Home Infection Preventionist Training Course on 10/04/2024. As such, IP P served in the IP role without the necessary training from 08/01/2024 through 10/03/2024. An award certificate for IP O revealed they completed the CDC Nursing Home Infection Preventionist Training Course on 06/17/2025. As such, IP O served in the IP role without the necessary training from 02/10/2025 to 06/16/2025. During an interview on 08/14/2025 at 2:09 PM, IP O stated they had been in the IP position since 02/2025, and there had not been another qualified IP on staff. During an interview on 08/15/2025 at 4:39 PM, the Director of Nursing (DON) stated the facility was required to have a qualified IP. The DON stated the last qualified IP was IP P, until IP O completed the CDC IP training in June 2025. The DON stated the expectation was for the facility to have a qualified IP in that position with the appropriate training to run the Infection Control program. During an interview on 08/15/2025 at 2:33 PM, the Administrator (ADM) stated the facility did not have a qualified IP during the timeframe from 12/06/2024 (when IP P left) until 06/17/2025, when IP O completed their CDC IP training. During a follow-up interview on 08/15/2025 at 4:48 PM, the ADM stated the expectation was to ensure a qualified IP was in the IP position before they were given the title of IP. The ADM further confirmed RN Y never completed the IP training. |

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

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Monument Healthcare and Nursing Center | 111 West 36th Street<br>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 0577<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.<br><br>Number of residents sampled:<br><br>Number of residents cited:<br><br>Based on observation, interview, facility document review, and facility policy review, the facility failed to post notice of the availability of the most recent survey results in a prominent and accessible area for the public; failed to post the most recent survey results in a location that was readily accessible to residents and visitors; and failed to maintain reports with respect to any surveys, certifications, and complaint investigations from the preceding three years and have them available for any individual to review upon request. The deficiency affected 10 (Residents #1, #6, #15, #24, #28, #29, #63, #67, #80, and #83) of 10 residents interviewed during a Resident Council meeting and had the potential to affect all the residents in the facility. Findings included: A facility policy titled, Survey Results, Examination of, revised April 2007, revealed, Copies of survey results are maintained in the administrative office. The policy revealed, 1. Copies of all survey reports (e.g. [exempli gratia; for example], standard, complaint, and/or extended surveys, follow-up revisits, etc. [et cetera; and so on]), along with approved plans of correction (as applicable) for noted deficiencies, are on file in the administrative office. 2. A copy of the most recent standard survey, including any subsequent extended surveys, follow-up revisits reports, etc., along with state approved plans of correction of noted deficiencies, is maintained in a 3-ring binder located in an area frequented by most residents, such as the main lobby or resident activity room. 3. Copies of previous survey reports and state approved plans of correction are available upon request to the public, residents or their legal representatives (sponsors), designated ombudsman representative, and staff members. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/15/2025, revealed the facility admitted Resident #1 on 04/16/2024. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. A quarterly MDS, with an ARD of 06/17/2025, revealed the facility admitted Resident #6 on 02/09/2025. The MDS indicated the resident had a BIMS score of 15, which indicated the resident had intact cognition. An admission MDS, with an ARD of 07/17/2025, revealed the facility admitted Resident #15 on 07/11/2025. The MDS indicated the resident had a BIMS score of 15, which indicated the resident had intact cognition. An admission MDS, with an ARD of 05/27/2025, revealed the facility admitted Resident #24 on 05/21/2025. The MDS indicated the resident had a BIMS score of 15, which indicated the resident had intact cognition. An annual MDS, with an ARD of 07/04/2025, revealed the facility admitted Resident #28 on 06/30/2023. The MDS indicated the resident had a BIMS score of 15, which indicated the resident had intact cognition. A quarterly MDS, with an ARD of 06/19/2025, revealed the facility admitted Resident #29 on 08/18/2023. The MDS indicated the resident had a BIMS score of 15, which indicated the resident had intact cognition. A quarterly MDS, with an ARD of 08/03/2025, revealed the facility admitted Resident #63 on 04/24/2023. The MDS indicated the resident had a BIMS score of 15, which indicated the resident had intact cognition. A significant change in status MDS, with an ARD of 07/18/2025, revealed the facility admitted Resident #67 on 02/17/2023. The MDS indicated the resident had a BIMS score of 15, which indicated the resident had intact cognition. An admission MDS, with an ARD of 08/04/2025, revealed the facility admitted Resident #80 on 07/28/2025. The MDS indicated the resident had a BIMS score of 15, which indicated the resident had intact cognition. A quarterly MDS, with an ARD of 06/19/2025, revealed the facility admitted Resident #83 on 09/14/2023. The MDS indicated the resident had a BIMS score of 15, which indicated the resident had intact cognition. An observation on 08/11/2025 at 8:30 AM of the lobby area of the facility and the facility postings around the 100-Hall nurse's station revealed no posting regarding the<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| Monument Healthcare and Nursing Center | 111 West 36th Street<br>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.

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|---|---|
| F 0577<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | availability of survey results. An observation on 08/11/2025 at 3:45 PM of the 200-Hall revealed no posting of the availability of survey results. An observation on 08/11/2025 at 3:47 PM of the 400-Hall unit revealed no posting of the availability of survey results. During a Resident Council meeting on 08/13/2025 at 1:30 PM, Resident #67 stated that they were aware of the location of survey results. The resident stated that there was a book behind a reception desk, but they had to ask staff to provide it to them. The other 9 (Residents #1, #6, #15, #24, #28, #29, #63, #80, and #83) residents in attendance stated they were not aware the facility maintained a binder that included survey results or the location of the binder. During an interview on 08/11/2025 at 10:32 AM, the Director of Nursing (DON) stated they did not know the location of the survey results in the facility and asked the Administrator (ADM) to locate the survey results binder. During a concurrent observation and interview on 08/11/2025 at 10:34 AM, the ADM retrieved a binder titled, Survey Book from the top of a reception desk located in the lobby of the facility where multiple binders were located. The Survey Book was not accessible to a resident seated in a wheelchair or to a resident or visitor standing in front of the reception desk. The Survey Book revealed survey results for a complaint survey that was completed on 02/12/2024 were not included. The ADM stated the binder with the survey results was not accessible to residents or visitors without them having to ask for staff assistance to retrieve the binder. The ADM stated the survey binder should have been accessible to the residents and visitors without having to ask for assistance. During an interview on 08/14/2025 at 10:21 AM, the ADM stated the notice regarding the availability of the survey results binder used to be located on the reception desk, but they noticed about a week prior that the notice was no longer posted. The ADM stated that they did not locate the survey results for the 02/12/2024 complaint survey. The ADM stated that moving forward, they would make sure there was a sign posted in the main lobby that indicated that the survey results were readily accessible, ensure they maintained survey results from the previous three years, and they would designate a place for the survey results book. |