STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465093	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monument Healthcare Brigham City	775 North 200 East Brigham City, UT 84302

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, for 1 of 20 sampled residents, the facility did not ensure that pain management services were provided in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals. Specifically, a nurse failed to timely assess and administer a prescribed as-needed (PRN) opioid pain medication to a resident experiencing pain after repeated requests from the resident and alerts from multiple certified nursing assistants (CNAs). The resident experienced pain, which was described by the resident as agony, for more than four hours. Resident identifier: 33. Findings included:Resident 33 was admitted to the facility on [DATE] with diagnoses which included: Muscular Dystrophy, Unspecified; Other Specified Disorders of Teeth and Supporting Structures; Major Depressive Disorder, Recurrent, Moderate; Unspecified Dementia, Moderate, Without Behavioral Disturbance; and Personality Disorder, Unspecified. On 6/29/26 at 9:28 AM, the surveyor observed resident 33 in her room with CNA 4. Resident 33 and CNA 4 were observed teasing and joking with each other. Resident 33 stated to the surveyor that she liked to joke around but that some people could not take a joke. Resident 33 stated that an agency nurse refused to provide her PRN pain medication until approximately 4:00 AM a few nights before (June 25, 2026) despite her repeatedly asking for it. Resident 33 stated she had been joking with two CNAs about using a BB gun, paint gun, or water gun, to kill people and explained to them why those items would not work. Resident 33 stated the nurse threatened to call the police on her and refused to give her the medication. Resident 33 stated she was in agony for hours due to the pain and receiving no relief until she finally told a CNA she would call Adult Protective Services (APS) in the morning. Resident 33's care plan initiated on 5/8/26 and revised on 6/26/26, revealed a Focus area that indicated resident 33: has chronic pain and is on an Opiate medication. Resident 33, regularly rates pain as severe when requesting pain medication. The documented Goal was : I will remain free from pain or at a level of discomfort acceptable to me through the review date. A listed intervention included: Administer medication as ordered. A physician order dated 5/28/26 revealed Oxycodone-Acetaminophen Oral Tablet 7.5-325 MG [milligrams]; Give 1 tablet by mouth every 6 hours as needed for moderate pain. A second order dated 4/29/26 revealed, Acetaminophen tab [tablet] 325 mg; give 2 tablets by mouth every 8 hours as needed for pain. A progress note dated 6/19/26 indicated Mouth pain is reported almost constantly, frequently interfering with sleep, therapy, and daily activities, with pain scores fluctuating between 0 and 10 over the past month. Oxycodone-acetaminophen PRN dosing was changed from every 8 hours to every 6 hours as needed on 05/28/2026 due to increased pain . will likely need to have extractions of her teeth. The June 2026 Medication Administration Record (MAR) and the narcotic record book were reviewed. Resident 33 was administered a PRN dose of Oxycodone-Acetaminophen 7.5-325 mg on 6/25/26, at 9:29 AM, with a documented follow-up pain scale rating of 3. [Note: The pain scale was 0-10 with 0 being no pain and 10 being excruciating pain.]No pain medications were administered to resident 33 until 6/26/26 at 4:09 AM when Oxycodone-Acetaminophen was administered. It should be noted resident 33 was not administered pain medication for over 18 hours and over 4 hours after the initial request for pain medication. A progress note dated 6/25/26 at 11:40 PM by Registered Nurse (RN) 1 revealed This (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse was alerted by two CNAs that had just left the pt [patients] room stating that the pt was making comments regarding killing people with guns. This nurse inquired with the pt why she was making the statements . This nurse reiterated that the staff takes statements such as this very seriously and that the police will be called if she makes further statements regarding threatening other peoples safety and lives . The pt then demanded that the nurse leave her room and not come back, this nurse agreed and left her room. Review of this note revealed no documentation that RN 1 conducted a pain assessment, addressed the resident's request for pain medication, or contacted the provider or facility management.A progress note dated 6/26/26 at 4:11 AM by RN 1 revealed, At med [medication] pass for pain med this pt was calling this nurse profanities, yelling and screaming at her, and threw her med cup at her. She went on to say to give her her pain medication and to 'get the hell out of my room!' . She took her medication and demanded that this nurse perform cares .On 6/30/26 at 5:29 PM, RN 1 provided a written statement to the facility Administrator regarding the incident with resident 33 on 6/25/26. RN 1 stated that on 6/26/26 at approximately 2:00 AM, she was approached by two CNAs who were concerned because resident 33 had been making repeated statements expressing a desire to kill staff and residents within the facility. They reported that she stated she intended to shoot everyone in the building and described the types of firearms she would use. They further reported that, earlier during the day shift, she had spoken with another resident regarding obtaining an automatic rifle and had allegedly asked him to acquire one for her so she could carry out these statements. RN 1 stated that she entered resident 33's room at approximately 2:15 to 2:30 AM to discuss the issue, but that the resident became increasingly hostile. RN 1 stated that at approximately 3:00 to 3:15 AM, she was informed by a CNA that resident 33 was requesting pain medication and that this was the first time I had been notified during my shift that she was requesting pain medication. Upon entering the resident's room to administer the pain medication, the resident began complaining that she had been waiting all night for her pain medications, and later threw a cup of water at RN 1 telling the nurse to get out of her room while yelling things such as This is abuse! Review of the June 2026 Medication Administration Record (MAR) revealed that when resident 33 was administered her pain medication on 6/26/26 at 4:09 AM, the resident's pain level was documented as a 1. On 7/1/26 at 11:41 AM, CNA 1 was interviewed. CNA 1 stated that she and CNA 3 assisted resident 33 into bed between 11:30 PM and midnight on 6/25/26. CNA 1 stated she observed resident 33 to be crying because no one knew her routine, and she began talking about killing people at the facility with a BB gun, a paint gun, and a water gun. CNA 1 stated that resident 33 requested her pain medication once she was in bed. CNA 1 stated she was with CNA 3 when CNA 3 informed RN 1 of the statements and told her resident 33 was requesting her pain medication. CNA 1 stated RN 1 went to speak to resident 33 and when she left resident 33's room, the resident informed CNA 1 that the nurse refused to give her the pain pill. CNA 1 stated she then asked RN 1 to give the resident the medication, but RN 1 stated she would not provide it due to the statements the resident had made. CNA 1 stated approximately 5 minutes later, resident 33 activated her call light again and CNA 2 answered the call light and told RN 1 resident 33 needed a pain pill. CNA 1 stated RN 1 called out down the hallway, She is not getting it. CNA 1 stated that resident 33 activated her call light multiple times, threatened to call the police, and requested her pain medication a total of 4 times before RN 1 finally administered it before the morning shift arrived.On 7/1/26, the surveyor reviewed a written statement from CNA 3 dated June 26, 2026. The statement noted that at approximately 12:30 AM, resident 33 requested assistance getting ready for bed and talked about using a BB gun, paint gun, or squirt gun to kill people. CNA 3 wrote: She asked for her night medication. We let the nurse know about the medication, and also told her about the remarks she was making. The nurse then told us that she can not give her opioids with her having/saying those things.On 7/1/26 at 10:31 AM, CNA 2 was interviewed. CNA 2 stated that she answered resident 33's call light after the two CNA's had gotten her to bed for the night. CNA 2 stated resident 33 was crying, sad, and complaining that RN 1 refused to provide her pain medication, stating she felt the nurse was bullying resident 33. CNA 2 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she informed RN 1 that the resident wanted her pain medication, and RN 1 responded that she would get to her when she had time.On 7/1/26, at 9:47 AM, RN 1 was interviewed. RN 1 stated she worked the night shift on 6/25/26, through 6/26/26, from 6:00 PM to 6:00 AM. RN 1 stated that around 2:00 AM, two CNAs reported that resident 33 was making threats about harming residents and staff with an assault rifle. RN 1 stated she spoke with the resident at 2:15 AM, and when she asked the resident if she wanted to harm people, the resident said yes. Resident 33 tried to play off her threats by saying she was joking. When RN 1 said this is serious, the resident went into a rage, called her the worst nurse ever, and told her to leave. RN 1 stated that around 3:15 AM, a CNA informed her that the resident wanted pain medication. RN 1 checked the MAR and debated whether it was safe to give an opioid medication to a resident making threats. RN 1 provided the medication just after 4:00 AM on 6/26/26, as the resident had not received pain medication since 6/25/26 at 9:29 AM. When asked if she obtained a specific pain level rating before administering the medication, RN 1 stated the resident's response was broad, and that the Resident said, It is always a 10! RN 1 denied that the resident was joking.On 7/1/26, the surveyor reviewed documentation provided to the Administrator by Registered Nurse (RN) 2 who spoke with resident 33 on 6/26/26. Resident 33 was upset and sad about an incident during the night shift. The note specified resident 33 reported she repeated her request for a pain pill, but the nurse said, 'I am not giving pain medication to someone who is threatening people to kill people.' Resident 33 reported she tried to explain to RN 1 that it was a joke but RN 1 said it was not funny. Resident 33 said she again asked for pain medication and rated her pain a 10/10 but the nurse just left. The resident continued to request medication a few times an hour but was not given relief until 4:00am.On 6/30/25 at 1:04 PM, the Administrator was interviewed. The Administrator stated that resident 33 had a dark sense of humor and was severely depressed. The Administrator stated that the night nurse made a decision to hold the resident's opioid medication so that behaviors would not worsen. The Administrator confirmed that the resident felt the nurse withheld her medication to punish her, that the resident did not receive her medication until 4:00 AM, and that the nurse had since been suspended pending the investigation.On 7/1/26 at 12:30 PM, the Director of Nursing (DON) was interviewed. The DON stated that pain must be treated subjectively based on the resident's report. The DON stated that if a CNA reported a resident was in pain, the nurse must assess the resident and treat the pain quickly as a priority. The DON acknowledged the medication was not provided until 4:09 AM. The DON stated that there was no documentation of a pain assessment prior to the 4:09 AM administration. The DON stated that if a nurse had safety concerns regarding administering a prescribed narcotic due to a resident's behaviors or threats, the nurse must contact the on-call medical provider or facility clinical leadership for guidance.