

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2026
NAME OF PROVIDER OR SUPPLIER Monument Healthcare Brigham City		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible, and that each resident received adequate supervision and assistance devices to prevent accidents. Specifically, for 2 out of 20 sampled residents, the facility failed to implement new or revised interventions after consecutive falls. In addition, the locked unit was left without nursing staff supervision for multiple periods of time and a resident wandered into other resident's rooms. Resident identifiers: 13 and 21. Findings included: 1. Resident 13 was admitted to the facility on [DATE] with diagnoses which included senile degeneration of brain, muscle weakness, other abnormalities of gait and mobility, and unspecified dementia. The following observations of resident 13 were made: a. On 6/29/26 at 10:17 AM, resident 13 was observed to be in bed. The bed was in an elevated position. b. On 6/29/26 at 11:09 AM, resident 13 was observed in bed. The bed was observed in an elevated position and the call light was out of reach of the resident hanging upon the wall. c. On 6/29/26 at 12:07 PM, resident 13 was up in his wheelchair and leaning to the left side. A Certified Nursing Assistant (CNA) asked resident 13 if he was okay and to sit up in his chair. Resident 13 had his eyes closed and appeared sleepy. The CNA repeatedly asked resident 13 if he was okay. The CNA continued to assist with feeding another resident. d. On 6/29/26 at 1:23 PM, resident 13 was in bed in an elevated position watching television. The call light was pinned up on the wall and was not accessible by resident 13. e. On 6/29/26 at 1:48 PM, resident 13 was in bed sleeping. The bed was in an elevated position and the call light was not accessible by resident 13. A review of resident 13's progress notes revealed: a. On 1/10/25 at 2:48 PM, a nursing note documented, At approx 1350 [1:50 PM], nurse was alerted to pt [patient] having fallen. Upon arrival to pt's room, pt was observed to be sitting on floor, next to bed, with right arm on mattress. Asked pt what happened but got no response. ROM [range of motion] to all extremities performed. Good ROM without facial grimacing. No observed injuries. Assisted pt into w/c [wheelchair] via 2 person assist. The intervention implemented for this fall was to re-educate staff to lower the bed after cares. b. On 8/23/25 at 9:30 AM, an incident note documented, Nurse was walking past residents room and saw a CNA with [resident 13]. [Resident 13] was sitting on his foot rests watching television. He was fully clothed and wearing socks. Nurse assessed resident for injury. [Resident 13] was assisted back into wheelchair by staff. He was able to help with his feet. [Resident 13] was unable to state what happened, he just smiled. Assessed resident for injury. The intervention implemented for this fall was to follow the falling leaf program. c. On 9/4/25 at 10:20 PM, a health status note documented, At 2015 [8:15 PM], designated CNA alerted this nurse regarding 'resident being on the floor'. This nurse immediately ran to assess, with resident noted sitting on buttocks anterior to wheelchair, proximal to TV [television]. Resident displaying happy affect, unable (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lifted with hoier into bed without c/o [complaints of] pain. The intervention for the fall was to place bright colored tape on wheelchair brakes.h. On 6/16/26 at 10:28 AM, a progress note documented, [Resident 21] found lying beside bed stating he fell OOB [out of bed]. Assisted into WC with CNA assistance.The intervention for this was to complete a medication review. i. On 6/17/26 at 3:55 AM, a general note documented, Resident found on hands and knees with his forehead resting on the floor. Resident is unable to explain what he was doing as well as unable to state whether he hit his head. Resident assessed for injuries with none found and neurochecks completed. Resident is unable to state whether he is in pain and is currently oriented to name only.There was no intervention implemented after this fall.j. On 6/23/26 at 10:17 AM, a progress note documented, Resident found on the floor in the bathroom, no injuries, neurological status assessed and resident baseline. Resident up in wheelchair stating no pain from fall.The intervention for the fall was to perform neurological checks. It should be noted that neurological checks are a response to a fall, and not an intervention to prevent further falls. On 6/30/26 at 2:27 PM, an interview was conducted with CNA 7. CNA 7 stated that resident 21 would go into other resident's rooms and wandered around the locked unit all day long. CNA 7 stated that there had to be a staff member on the unit at all times and if staff were not located at the nurse's station then they were usually in a resident's room. CNA 7 stated that if she had to shower a resident then she would let nursing staff know that she was unable to observe the residents. CNA 7 stated that resident 21 was a fall risk and fell a lot. CNA 7 stated that she would walk past his room often and made sure that she took him to the bathroom every 2 hours. CNA 7 stated that there were some aggressive residents in the locked unit that did not like resident 21 entering their rooms and going through their belongings. CNA 7 stated that resident 21 required supervision at all times and assistance with transfers. On 7/1/26 at 8:07 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the locked unit contained residents with diagnoses of prior elopements, dementia residents, residents that wandered and were actively exit seeking. The DON stated that a CNA should be on the locked unit at all times and the north nurse was off and on the locked unit intermittently doing medication pass. The DON stated that CNAs should be doing their regular 2 hour rounding and there did not need to be any one to one supervision of residents. The DON stated that resident 21 was an active wanderer and she expected nursing staff to keep an eye on him. The DON stated that the recreation cart was used for resident 21 to give him activities and puzzles to keep him occupied. The DON stated that neurological checks were an intervention after falls because they increased supervision for 3 days. The DON stated that the falling leaf program was to let staff know that the resident had falls and the resident needed to have closer supervision. The DON stated that falls required new interventions after every fall.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, hand hygiene was not done according to professional standards and there were soiled areas in the kitchen. Findings include: 1. On 6/29/26 at 10:00 AM, an initial tour was conducted of the kitchen. The following was observed: a. The vents above the grill were observed to have dust on them. b. There were large bins labeled oatmeal, powdered sugar, flour and sugar that were observed to be soiled on the outside. c. Celery Seed and Mediterranean style ground oregano spices were open to air. d. The juice machine compressor had crumbs and debris on it. The compressor was on a tray that had crumbs and debris. 2. On 7/1/26 at 10:35 AM, a follow up observation of the kitchen was conducted. The following was observed: a. The vents above the grill were observed to have dust on them. b. There were large bins labeled oatmeal, powdered sugar, flour and sugar that were observed to be soiled on the outside. c. The juice machine compressor had crumbs and debris on it. The compressor was on a tray that had crumbs and debris. d. The Dietary Manager (DM) was observed to perform hand hygiene by placing soap on his hands and rubbing his hands together under water for less than 20 seconds. The DM was observed to put his hand in the glove box and removed 2 gloves which he placed on his hands. The DM was observed to cut pie, touch the pie and plate the pies with gloved hands. e. The DM was observed to remove his gloves, touch certificates on the wall, and then donned gloves. The DM was observed to continue plating pies and touching the pie with his gloved hand. No hand hygiene was performed prior to donning the gloves. f. The DM was observed to perform hand hygiene by placing soap on his hands, and rubbing his hands together under water for 4 seconds. g. [NAME] 1 was observed to perform hand hygiene. [NAME] 1 placed soap in her hands, and rubbed her hands together under water for less than 4 seconds. h. [NAME] 1 was observed to perform hand hygiene. [NAME] 1 placed soap in her hands, and rubbed her hands together under water for 10 seconds. A hand washing sign above the hand washing sink revealed to rinse hands, lather soap, rub hands together palm to palm, rub back of hands, rub fingers interlaced, base of thumbs, rub fingers, wash wrist, rinse hand well, dry with clean towel, turn faucet off with paper towel. Perform hand washing for at least 20 seconds under running water that is at least 110 degrees. On 7/1/26 at 10:49 AM, an interview was conducted with the DM. The DM stated washing hands under water should take as long as singing happy birthday 3 times really fast. The DM stated scrub, dry and then reglove was the procedure. The DM stated the vents above the grill and ovens were cleaned at least monthly by running them through the dishmachine. The DM stated it was not dust on the vents but it was build up from running them through the dish machine. The DM stated the juice machine compressor and tray were cleaned weekly. The DM stated there was a lot of debris on the compressor.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation and interviews, for 4 of 20 sampled residents, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. Specifically, a resident had a clothing protector placed on her by another resident as she said she was headed to the bathroom. The resident was observed to enter her bathroom and return to eat with the same clothing protector. Another resident's oxygen tubing was on the floor in the dining room and staff placed the tubing on her face and nasal cannula in her nose. In addition, the Hoyer lift was not sanitized between residents' use. Resident identifiers: 4, 6, 26, and 29. Findings included: 1. On 6/29/26 at 11:46 AM, resident 29 was observed to pass out clothing protectors. Resident 6 was observed to wheel herself toward the exit of the dining room when resident 29 placed the clothing protector on her. Resident 6 stated she had to go to the bathroom. Resident 6 was observed to enter her bathroom with her clothing protector and exited the bathroom with the clothing protector. At 11:50 AM, Resident 6 was observed to wheel herself back to the dining room and eat with the same clothing protector. 2. On 6/29/26 at 11:58 AM, an observation was made of resident 4. Resident 4 was wheeled into the dining room by 2 Certified Nursing Assistants, including (CNA) 5. CNA 5 was observed to pick up resident 4's nasal cannula off the floor of the dining room and placed it in the resident's nose. CNA 5 did not sanitize the equipment that was on the ground in the dining room prior to placing it on resident 4's face. On 7/1/26 at 10:18 AM, an interview was conducted with the Director of Nursing (DON). The DON stated staff should have replaced the oxygen tubing and not placed it on resident 4's face after being on the floor. The DON stated resident 6 should have been provided a new clothing protector prior to eating. 3. On 7/1/26 at 7:30 AM, an observation was made of 2 CNAs entering resident 26's room with the Hoyer lift. At 7:35 AM, the CNAs exited resident 26's room with the Hoyer lift and entered resident 29's room. On 7/1/26 at 7:42 AM, an observation was made of a CNA exiting resident 29's room with the Hoyer lift and placing the Hoyer lift in the hallway. It should be noted that the Hoyer lift was not sanitized in between resident 26's use and resident 29's use. On 7/1/26 at 7:48 AM, an interview was conducted with CNA 6. CNA 6 stated that she had not sanitized the Hoyer lift in between resident use and that she should have. On 7/1/26 at 9:03 AM, an interview was conducted with the DON. The DON stated that staff should be wiping down the Hoyer lift with a sanitizer cloth in between resident use.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility must ensure that a resident's physician was immediately consulted when there was a significant change in the resident's physical, mental, or psychosocial status. Specifically, a nurse failed to immediately consult with the resident's physician following a significant change in a resident's psychosocial and behavioral status involving homicidal threats and the subsequent withholding of ordered pain medication. Resident identifier: 33. Findings included: Resident 33 was admitted to the facility on [DATE] with diagnoses which included muscular dystrophy, disorders of teeth and supporting structures; major depressive disorder, dementia, and personality disorder. On 6/29/26 at 9:28 AM, resident 33 was interviewed. Resident 33 stated that an agency nurse refused to provide her PRN (as needed) 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 (Certified Nursing Assistants) 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 pain 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. Review of the physician orders dated 5/28/26 for Oxycodone-Acetaminophen 7.5-325 mg (milligram), to be administered by mouth every 6 hours as needed for moderate pain. A progress note dated 6/19/26 indicated that resident 33 reported almost constant mouth pain that frequently interfered with sleep, therapy, and daily activities, with pain scores fluctuating between 0 and 10 over the past month. Review of the resident's care plan, revised on 6/26/26, indicated an intervention to administer pain medications as ordered for chronic pain. The documented goal was for the resident to remain free from pain or at an acceptable level of discomfort. A facility progress note by Registered Nurse (RN) 1 on 6/25/26, at 11:40 PM indicated that two nursing assistants informed RN 1 that resident 33 was making comments regarding killing people with guns. RN 1 documented she entered the room and reiterated to the resident that threats were taken seriously and that the police would be called if further statements were made. The resident then demanded that RN 1 leave the room. A written statement by CNA 3 dated 6/26/26, indicated that at approximately 12:30 AM, Resident 33 asked for their night medication. CNA 3 informed RN 1 of the request and the remarks the resident was making. CNA 3 documented that RN 1 stated they could not give opioids to the resident while they were saying those things. It should be noted there was no documentation in the progress notes by RN 1 that she consulted with the Director of Nursing or the physician regarding the statements made by resident 33 or the resident's request for pain medication. 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 (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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! On 7/1/26 at 9:47 AM, RN 1 was interviewed. RN 1 stated that around 2:00 AM, CNA's reported that resident 33 was making threats about harming people in the building. RN 1 stated they spoke with the resident at 2:15 AM to hear their side, and the resident confirmed wanting to harm people. RN 1 reported resident 33 tried to play off her threats as a joke and when RN 1 indicated the statements were serious, resident 33's behaviors escalated and she screamed at RN 1 to leave her room. RN 1 stated that around 3:15 AM, a CNA requested pain medication for the resident. RN 1 stated they were concerned about whether it was safe to administer an opioid medication while the resident was making threats, but decided to give them to her after reviewing the MAR and noting she had not received pain medication for several hours. RN 1 confirmed they administered the pain medication at 4:09 AM. 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 while getting resident 33 ready for bed on the night of 6/25/26 with CNA 3, the resident began talking about killing people with water and paint guns. CNA 1 stated resident 33 mentioned she asked another resident what weapon to use. CNA 1 stated that she and CNA 3 informed RN 1 of the remarks and told RN 1 that the resident requested a pain pill. CNA 1 stated that RN 1 refused to give the resident the pain medication due to the threats she made. CNA 1 stated that the resident asked for the pain pill four times throughout the night, that RN 1 was informed of the pain medication requests, and that RN 1 did not call the doctor. On 7/1/26 at 12:30 PM, the DON (Director of Nursing) was interviewed. The DON stated that if a resident was in pain, the nurse must assess the resident and treat the pain. The DON stated that if an ordered medication was withheld or delayed due to behavioral concerns, the nurse must immediately notify the on-call provider for guidance. The DON confirmed that RN 1 failed to notify the physician or facility administration during the shift regarding resident 33's homicidal statements and the subsequent delay in pain management. The DON verified the physician was not notified until the morning of 6/26/26. Review of the facility's internal investigation report dated 6/26/26 confirmed that the medical provider was not timely notified by the nurse until the morning after report that the resident was having concerning behavior that poses a safety risk to others, and that the nurse did not feel comfortable administering the opiate medication until she was able to speak with the resident about her threats. The facility noted, This is a process and customer service issue that all nursing staff will be trained on. The facility's internal investigation also acknowledged the nurse did not fully document a thorough pain assessment when administering the opiate medication to the patient. The policy titled 001 - Resident Rights/Dignity: Abuse and Neglect - Clinical Protocol (effective date February 1, 2024) revealed under the Assessment and Recognition protocol, the policy specified: The nurse will assess the individual and document related findings. Assessment data will include: . B. Pain assessment. C. Current behavior . The nurse will report findings to the physician. As needed, the physician will assess the resident/patient to verify or clarify such findings, especially if the cause or source of the problem is unclear.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2026
NAME OF PROVIDER OR SUPPLIER Monument Healthcare Brigham City		STREET ADDRESS, CITY, STATE, ZIP CODE 775 North 200 East Brigham City, UT 84302	
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that each resident's drug regimen was free from unnecessary drugs. Specifically, for 1 out of 20 sampled residents, a resident taking an antidepressant medication for insomnia did not have hours of sleep monitored. Resident identifier: 21. Findings included: Resident 21 was admitted to the facility on [DATE] with diagnoses which included anxiety disorder, insomnia, and Alzheimer's. Resident 21 had a physician order started on 11/4/25 for traZODone HCl [hydrochloride] Oral Tablet (Trazodone HCl) Give 100 mg [milligrams] by mouth at bedtime related to INSOMNIAA review of resident 21's Medication Administration Record and Treatment Administration Record for May and June 2026 revealed that resident 21 was not being monitored for hours of sleep. On 7/1/26 at 8:26 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that trazodone required monitoring for antidepressant use and hours of sleep, unless a resident was just taking the medication for depression. The DON stated that resident 21 was taking trazodone for insomnia and sleep. The DON stated that resident 21 did not have his hours of sleep monitored.		

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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 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 (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.		