STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285054	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Banyan at Montclair	2525 South 135th Avenue Omaha, NE 68144

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50106 Licensure Reference Number 175 NAC 12-006.09 Based on record review and interview, the facility failed to monitor 2 (Resident 1 and 3) of 3 residents post procedural appointments. The facility identified a census of 132. Findings are: A. Record review of Resident 1's Census revealed an admitted [DATE]. Record review of Resident 1's Minimum Data Set (MDS, a federally mandated assessment completed to do care-planning) dated 4/15/24, revealed the resident's Brief Interview of Mental Status (BIMS, is a mandatory tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) had a score of 8, which indicated the resident was severely cognitively impaired. Record review of Resident 1's undated Diagnosis sheet revealed the following diagnoses: Alzheimer's Disease, inguinal hernia, chronic atrial fibrillation, pain, Vitamin D deficiency, benign prostatic hyperplasia, hypertension, inflammatory disorder of the scrotum, muscle wasting, insomnia, and chronic kidney disease. Record review of Resident 1's medical record revealed a post-surgical report for a local surgical extraction of a failing implant #19 (left lower molar) on 05-01/2024. The report also revealed that written instructions were discussed and given to the patient. A prescription for analgesics was dispensed and the patient was instructed to call if any questions or problems were encountered. Record review of Resident 1's Order Summary for 5-1-2024, revealed no new order for analgesics in the Resident 1's record. Record review of Resident 1's Progress Notes and assessments revealed no nursing assessment of the left molar area post surgically for Resident 1. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/3/24 at 10:00 AM with LPN-B revealed critical charting for an antibiotic should be done every shift (twice daily) by the nursing staff for the duration of the antibiotic and for 7 days after the antibiotic was completed. Interview on 6/3/24 at 1:10 PM with Registered Nurse (RN)-C revealed there is no facility policy for a change in condition charting or when a resident returns from a procedure. RN-C revealed the facility process was to initiate an E-Interact change in condition assessment which will then identify a change in a condition for a resident. RN-C revealed after the change in condition assessment is completed then critical charting is implemented. RN-C revealed critical charting is completed within the Progress Notes. RN-C then revealed the Assistant Director of Nursing (ADON) or the nurse on call, if after hours, will determine what and why to chart for critical charting which is to be completed twice daily until the issues are resolved. Interview on 6/3/24 at 2:30 PM with the Director of Nursing (DON) confirmed the nursing staff should have initiated critical charting for Resident 1 on the site where the resident's implant #19 had been extracted. The DON confirmed the instructions and post operative report of the extraction of the failing implant #19 had never been received by the facility until 6/3/24 and no new analgesic orders were initiated after the extraction. The DON also revealed Resident 1 was started on an antibiotic and the nursing staff should have completed critical charting for an antibiotic and assessed Resident 1 until the site was healed. Record review of Resident 1's Order Summary revealed a new order was received on 5/29/24 and initiated on 5/30/24 for Augmentin 875 milligrams (mg) 1 tablet orally twice daily for 7 days for oral infection. Record review of Resident 1's Progress Notes and assessments revealed no progress notes or assessment of an oral infection, monitoring the extraction site, or antibiotic charting. 49164 B. A record review of Resident 3's Electronic Health Record (EHR, is a digital version of a patient's paper chart) revealed Resident 3 had admitted to the facility on [DATE] with diagnoses of: acute compression fracture of the 3rd Lumbar Vertebrae and 8th rib, ground level fall, Diabetes Mellitus, neuropathy, and alcohol use with chronic pancreatitis. A record review of a list of residents, provided by the facility revealed Resident 3 was cognitively intact. An interview with Resident 3 on 6/03/24 at 11:30 AM revealed that Resident 3 had an appointment with an eye doctor on 5/29/24. Resident 3 stated a procedure was performed at the appointment that involved having (gender) left eye stitched shut. Resident 3 revealed the facility staff had not assessed [gender] eye upon return from the appointment. An observation on 6/3/24 at 11:30 AM revealed Resident 3's left eye was stitched closed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 3's documentation from the appointment on 5/29/24 revealed Resident 3 had a corneal abrasion and a temporary Tarsorrhaphy (the joining of part or all of the upper and lower eyelids so as to partially or completely close the eye. Temporary tarsorrhaphies are used to help the cornea heal or to protect the cornea during a short period of exposure or disease) of the left eye and provided orders from the doctor for an antibiotic. A record Review of Resident 3's Progress Notes revealed no mention of Resident 3 having an appointment on 5/29/24 or an assessment following the appointment. A Progress Note dated 5/30/24 revealed a nurse called the doctor's office for post procedure after care orders. A record Review of Resident 3's medical record from dates 5/29/24 through 6/03/24 revealed no documentation in regards to the left eye on 5/30/24. An interview on 6/3/24 at 3:00 PM with the Director of Nursing (DON) confirmed Resident 3 should have been placed on critical charting after having the procedure on the left eye and assessed by the facility nursing staff.