

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  285054	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/26/2024
NAME OF PROVIDER OR SUPPLIER  The Banyan at Montclair		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 04577</p> <p>Licensure reference: 175 NAC 12-006.10</p> <p>Based on record review and interview, the facility failed to ensure 1 [Resident 2] of 5 sampled residents was free from a significant medication error. The facility had a total census of 130 residents.</p> <p>Findings are:</p> <p>A review of Resident 2's Admission record revealed an admitted [DATE] with a diagnosis of Type 2 Diabetes Mellitus [a condition that involves the way the body regulates and uses sugar as a fuel].</p> <p>A review of Resident 2's hospital discharge orders dated 5/14/24 revealed a new order for Lispro insulin [fast acting insulin] sliding scale to be given with meals and night based on the following blood sugars:</p> <ul style="list-style-type: none"> <li>-151-200 give 2 units</li> <li>-201-250 give 4 units</li> <li>-251-300 give 6 units</li> <li>-351-400 give 8 units</li> <li>-More than 400 call MD [Medical Doctor]</li> <li>-Stop Lyumjev KwikPen U-100 insulin 100 unit/ml</li> <li>-Change insulin glargine U-300 300 unit/ml [Toujeo; a long-acting insulin] to 12 units subcutaneously nightly</li> </ul> <p>A review of APRN A [Advance Practice Registered Nurse] orders for Resident 2 dated 5/14/24 revealed the following order: Resume previous orders with changes per hospital discharge.</p> <p>A review of Resident 2's 5/2024 MAR [Medication Administration Record] revealed order for sliding scale Lispro Insulin was not listed.</p> <p>(continued on next page)</p>

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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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review Huco [a secure application used to communicate and receive orders from provider group] documentation for Resident 2 dated 5/15/24 at 8:36 PM revealed provider notification that Resident 2 had orders for both Toujeo and Lyumjev insulin at bedtime. Huco documentation revealed an order at 5/15/24 at 8:39 PM to discontinue Toujeo insulin.</p> <p>A review of Huco documentation and electronic medical record for Resident 2 between 5/15/24 and 6/24/24 did not reveal any orders to discontinue sliding scale Lispro insulin.</p> <p>In an interview on 6/24/24 at 4:24 PM, the Director of Nursing reported not transcribing Resident 2's sliding scale Lispro insulin order would be counted as a medication error.</p> <p>A review of Medication Error report for Resident 2 dated 6/24/24 revealed the following re-admission orders had been received on 5/14/24: resume previous orders with changes per hospital discharge and add physical therapy, occupational therapy and speech therapy. The hospital discharge order to start insulin lispro and stop Lyumjev kwikpen [fast acting insulin] was not entered or implemented. Further review of the Medication Error reported revealed Resident 2's physician was notified of incorrect entry of orders from hospital re-admission. Resident 2's physician did not want sliding scale Lispro Insulin order implemented.</p> <p>A review of Resident 2's 5/2024 MAR [Medication Administration Record] revealed Resident 2's blood sugar was being monitored once per day at bedtime and every Monday AM with blood sugars as follows:</p> <p>-5/16/24 158</p> <p>-5/17/24 321</p> <p>-5/18/24 218</p> <p>-5/19/24 281</p> <p>-5/20/24 AM 220</p> <p>-5/20/24 refused</p> <p>-5/21/24 217</p> <p>-5/22/24 217</p> <p>-5/23/24 209</p> <p>-5/24/24 other</p> <p>-5/25/24 278</p> <p>-5/26/24 254</p> <p>-5/27/24 AM 212</p> <p>(continued on next page)</p>		

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