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	07/09/2024

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45614 Licensure Reference Number 175 NAC 12-006.10(D) Based on interview and record review the facility failed to ensure 1 (Resident 4) of 4 was free from significant medication errors. The facility staff identified a census of 131. Findings are: A record review of Resident 4's patient profile sheet dated 6/23/2024 revealed Resident 4 was [AGE] years old. A record review of the residents' electronic health record medical diagnosis sheet revealed Resident 4 had the following medical diagnoses: Acute on Chronic Diastolic (Congestive) Heart Failure, Chronic Kidney Disease, Stage 4, Cirrhosis of Liver, Anemia, Type 2 Diabetes with Diabetic Polyneuropathy, Hypertension, Hypothyroidism, Vitamin D Deficiency, Constipation and Extended Spectrum Beta Lactamase Resistance (EBSL). A record review of Resident 4's quarterly Minimum Data Set (MDS - a federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes) dated 5/28/2024 revealed Resident 4 had a Brief Interview for Mental Status (BIMS - A federal mandated tool used to screen and identify the cognitive condition of residents in a long-term care facility) of 13 which indicated Resident was cognitively intact. A record review of Resident 4's hospital discharge paperwork dated 6/18/2024 revealed Resident 4 had been hospitalized from 6/10/2024 to 6/18/2024 for Acute Chronic Congestive Heart Failure (a condition that occurs when the heart tries to compensate for a loss of function that developed over time). (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 0760 Level of Harm - Actual harm Residents Affected - Few	A record review of page 6 of a 34 page hospital discharge document dated 6/18/2024 revealed Resident 4 was to start taking the following medications: levofloxacin (an antibiotic used to treat bacterial infection) 250 Milligrams (mg) tablet. Take 1 tablet (250 mg total) by mouth every other day for 1 dose starting on June 20, 2024. Metolazone (a medication used to treat fluid retention) 5 mg tablet, take 1 tablet (5 mg total) by mouth once a week for 30 days. Start June 24, 2024. Potassium chloride SA (a medication used to treat low potassium levels in patients) 20 milliequivalent (mEq - the number of grams of medication contained in a 1milliter solution) tablet. Take 2 tablets (40 mEq total) by mouth daily with breakfast for 30 days. Rifaximin (a medication used to treat hepatic encephalopathy - a condition that occurs when your liver does not work properly) 550 mg tablet. Take 1 tablet (550 mg total) by mouth 2 times a day for 30 days. Sevelamer carbonate (a medication used to lower the body's phosphorus levels in patient with chronic kidney disease) 800 mg tablet. Take I tablet (800 mg total) by mouth 3 times a day with meals for 30 days, torsemide 40 mg (a medication used to remove fluid buildup in the body). Take 40 mg by mouth 2 times daily for 30 days. Also on page 6 were the instructions to continue to take Acetaminophen (a mild pain medication) 500 mg tablet. Take 2 tablets (1,000 mg total) by mouth 3 times a day as needed for pain, Artificial tears, place 1 drop into both eyes once every 4 hours as needed for dry eyes. A record review of Resident 4's facility Order Summary sheet printed 7/8/2024 revealed the orders for levofloxacin (a antibiotic medication), metolazone (a diuretic), potassium chloride SA, rifaximin(an antibiotic medication), sevelamer carbonate, acetaminophen, artificial tears and torsemide did not appear on the Order Summary sheet. A record review of Resident 4's progress note dated 6/23/2024 at 11:09 AM revealed Resident 4's physician was informed Resident 4 was more confused than usual, chewing on their medication and attempting to dump water on their eyes. The physician ordered Resident 4 to be sent to the emergency room to be evaluated. A record review of a progress note dated 6/23/2024 at 2:28 PM revealed Resident 4 had been admitted to the hospital for Hepatic Encephalopathy (a brain dysfunction due to liver dysfunction). A record review of a progress note dated 6/24/2024 at 4:26 PM revealed the Director of Nursing (DON) received a call to confirm the current medication list for Resident 4 and found the following medications had not been implemented: Levaquin, Metolazone, Potassium Chloride SA, Rifaximin and torsemide. A record review of a progress note dated 6/26/2024 at 5:00PM revealed the residents Power of Attorney (POA) called the facility to let them know Resident 4 had passed away. A record review of the Facility Verification of Investigation sheet titled Significant Medication Error-#1070010, submitted to the state on 7/1/2024 revealed a signed typewritten note dated 6/28/2024 which revealed the person who placed the discharge orders into Point Click Care (PCC - a healthcare computer software provider for long-term care and senior care industries) had printed out the discharge orders from an e-mail and took them home to enter into the software system. The individual had left out pages 6 and 7 which had the residents new orders and therefore they did not enter the new orders into PCC. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	An interview on 7/8/2024 at 2:45 PM with the Director of Nursing (DON) revealed the facility had investigated the incident and reported a corporate employee had taken the orders home to enter them into the facility system. The DON reported the facility investigation confirmed the employee had missed the page containing the new and revised orders for the medications resulting in Resident 4 not receiving the ordered medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45614 Licensure Reference Number 175 NAC ,d+[DATE].12.(D)(iii) Licensure Reference Number 175 NAC ,d+[DATE].12.(D)(vi) Based on observation, interview and record review the facility staff failed to ensure that an insulin injector pen was labeled correctly for 1 resident (Resident 6), failed to ensure that an expired insulin injector pen for 1 resident (Resident 5) was discarded and failed to ensure that an insulin injector pen was identified and dated before it was placed in the medication cart. The facility staff identified there were 26 residents in the facility who receive insulin via insulin injector pens. The facility staff identified a census of 131. Findings are: An observation of the labels of the opened insulin injector pens for 26 residents were examined on [DATE] from 9:45AM to 10:05 AM A. An observation on [DATE] at 9:45 AM of a medication cart revealed 1 opened Victoza insulin pen was labeled with Resident 6's name. Further review revealed the Victoza insulin pen did not have an opened-on date or an expiration date on the pen. An interview on [DATE] at 9:50 AM with Registered Nurse D (RN) confirmed the pen was labeled with the resident's name and did not have an opened date or expiration date identified. B. An observation on [DATE] at 10:05AM of a medication cart revealed Resident 5's opened Lantus insulin pen had an expiration date was [DATE] and did not have an opened-on date. An interview with RN E confirmed Resident 5's Lantus insulin pen should have been discarded when it expired and should have had an opened-on date. C. An observation on [DATE] at 7:35 AM revealed 1 FLASP insulin pen had an expiration date but did not have a resident name or opened by date. An interview on [DATE] at 7:35 PM with Licensed Practical Nurse F confirmed it was unknown who the pen belonged to and it should be discarded. A record review of the facility's Insulin Pen policy dated [DATE] and revised on [DATE] revealed the following information. Policy Explanation and Compliance Guidelines: 2. Insulin pens must be clearly labeled with the resident name, physician name, date dispensed, type of insulin, amount to be given, frequency and expiration date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. If the label is missing, the pen will not be used; a new pen must be ordered from the pharmacy. 11 Procedure e. Check the expiration date on the pen. Discard if expired. An interview on [DATE] at 10:15 AM with Director of Nursing (DON),confirmed there was no name on the FLASP insulin injector pen, and it should have been discarded. The DON confirmed that the insulin injector pens should have been labeled with the date opened, date of expiration and the residents' name.