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	11/14/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45484 Licensure Reference Number 175 NAC 12-006.17(A)(v) Based on record reviews and interviews, the facility failed to maintain a complete and accurate medical record for 1(Resident 1) of 5 sampled residents. The facility census was 118. Findings are: A record review of Resident 1's Admission Record printed 11/13/2024 revealed the resident was over [AGE] years of age, was admitted to the facility on [DATE] and had diagnoses including chronic kidney disease, diabetes, heart failure, and pressure injuries to their left heel and sacral area (the area at the base of the spine between the hips). The resident was discharged to an acute care hospital on 10/29/2024. A review of a communication app used by the facility to communicate with the Primary Care Provider (PCP) revealed the following information: On 10/11/2024 at 5:48 PM, from the facility iPad, an image of a handwritten note from the resident's cardiologist. On 10/21/2024 at 4:18 PM, from the PCP, a response to notification that the nurse had been unable to obtain ordered lab. On 10/22/2024 at 5:51 AM, from the facility iPad, a notification that the resident had refused bedtime medications on 10/21/2024. On 10/22/2024 at 7:37 AM, from the PCP, acknowledgement of the medication refusal. On 10/25/2024 at 9:55 PM, from the facility iPad, an image of lab results. On 10/25/2024 at 10:06 PM, from the PCP, an instruction to send the lab results to the resident's cardiologist. On 10/25/2024 at 10:09 PM, from the facility iPad, acknowledgement of the instruction. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/2024 at 4:42 AM, from the facility iPad, notification that Resident 1 was having a hard time breathing, that their oxygen saturation (O2 sat - a measure of how much oxygen is in your blood. In people over 70, it should be between 95-100%) was 72% and that the facility had applied oxygen at 2 liters per minute (a common flow rate), which brought the O2 sat up to 89%. A review of Resident 1's Progress Notes printed 11/13/2024 revealed no mention of the cardiology appointment or note on 10/11/2024, the PCP response to lab not obtained on 10/21/2024, the bedtime medication refusal, notification of the PCP, and PCP response on 10/22/2024, the lab being obtained, the results being sent to the PCP, the instruction to send them to the cardiologist, and the acknowledgement from the facility on 10/25/2024, or the low O2 sat and oxygen being applied on 10/25/2024. A review of the facility's undated Documentation in Medical Record policy marked Copyright 2024 at the bottom revealed that each resident's medical record should be accurate and contain enough information to provide a picture of the resident's progress, and that licensed staff and interdisciplinary team members should document all assessments, observations, and services provided in the resident's medical record prior to the end of the shift in which it occurred. In an interview on 11/14/2024 at 11:20 AM, the Director of Nursing (DON) confirmed that the nurses were putting information into the communication app and not into Resident 1's Electronic Health Record (EHR). The DON reported that the Assistant Directors of Nursing were reading through the app daily to find out about changes of condition and new orders. The DON confirmed that information entered into the communication app was not part of the medical record. In an interview on 11/14/2024 at 1:40 PM, the DON confirmed that information regarding the cardiology appointment or note on 10/11/2024, the PCP response to lab not obtained on 10/21/2024, the bedtime medication refusal, notification of the PCP, and PCP response on 10/22/2024, the lab being obtained, the results being sent to the PCP, the instruction to send them to the cardiologist, and the acknowledgement from the facility on 10/25/2024, or the low O2 sat and oxygen being applied on 10/25/2024 were not in Resident 1's EHR. In an interview on 11/14/2024 at 4:20 PM, the DON confirmed the facility policy regarding documenting in the medical record was not followed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45484 Licensure Reference Number 175 NAC 12-006.09(H)(iv)(1) and 175 NAC 12-006.18(B) Based on record reviews, observations, and interviews, the facility failed to ensure that Resident 2's indwelling urinary catheter was cleaned in a manner to prevent potential urinary tract infection and failed to ensure that Enhanced Barrier Precautions were maintained for in order to prevent the potential for cross-contamination for 2 (Residents 2 and 5) of 4 sampled residents. The facility census was 118. Findings are: A. A record review of the facility's undated Suprapubic Catheterization (SP catheter-a tube that goes into the bladder through the lower abdomen to drain urine) policy marked Copyright 2023 at the bottom revealed that the stoma (the opening the catheter goes into the bladder through) should be cleaned outward from the stoma in a circular motion. B. A record review of the facility's undated Enhanced Barrier Precautions policy marked Copyright 2024 at the bottom revealed that Enhanced Barrier Precautions (EBP) was an infection control intervention that employed the use of a gown and gloves to reduce transmission of multi-drug resistant organisms (MDROs) during high contact resident care activities. EBP should be in place for residents with wounds and/or indwelling medical devices such as urinary catheters. Further review revealed that high contact resident care activities included performing hygiene and device care and use. C. A record review of Resident 2's Admission Record printed 11/13/2024 revealed an admitted [DATE]. The resident had diagnoses of multiple sclerosis (MS-a disorder of the central nervous system marked by weakness, numbness, a loss of muscle coordination, and problems with vision, speech, and bladder control), quadriplegia (a medical condition that causes partial or total loss of movement and sensation in all four limbs and the torso), a pressure injury to the sacral area, and a neuromuscular dysfunction of the bladder (a condition that causes bladder control issues due to nerve, spinal cord, or brain problems). A record review of Resident 2's annual Minimum Data Set (MDS-a comprehensive assessment of each resident's functional capabilities) dated 09/30/2024 revealed a Brief Interview for Mental Status (BIMS- a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) score of 14. In an interview on 11/13/2024 at 2:00 PM, Resident 2 reported that they had a history of having urinary tract infections (UTIs). The resident reported that staff did not wear a gown when the catheter bag was emptied. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 11/13/2024 at 2:00 PM revealed a sign on the outside of Resident 2's room that indicated a resident in the room was on EBP, and provided information on what Personal Protective Equipment (PPE-protective items such as gown and gloves worn to protect the resident and staff member from infection) to wear and when. Further observations revealed PPE was inside the room and a catheter drainage bag was hanging from the bed frame. An observation on 11/14/2024 at 10:17 AM revealed Nursing Assistant (NA) A performing catheter cares and emptying the catheter drainage bag for Resident 2. NA A put on gloves, got 2 basins with warm water in them, and removed items from the resident's over bed table. NA A did not wipe off the table. The NA then removed their gloves, did not perform hand hygiene, and placed the basins, clean washcloths and towels, and cleansing solution on the over bed table. NA A washed their hands with soap and water for 6 seconds, took gloves out of their pocket and put them on. NA A was not wearing a gown. While leaning over the bed and touching the sheets, the NA got a washcloth wet, put cleansing solution on it, and wiped across the resident's abdominal fold from the left side to the right, lifting but not removing the gauze dressing over the resident's SP catheter insertion site and wiping under the gauze directly across the site. Using the same washcloth, NA A wiped down the left side of the groin from front to back, then the right side of the groin from front to back, then between the upper thighs. NA A got another washcloth wet and used it to wipe the cleansing solution off by wiping across the resident's abdominal fold from the left side to the right, lifting but not removing the gauze dressing over the resident's SP catheter insertion site and wiping under the gauze directly across the site, then wiping down the left side of the groin from front to back, then the right side of the groin from front to back, then between the upper thighs. NA A removed their gloves, did not perform hand hygiene, and got a new pair of gloves from a box offered to them by Assistant Director of Nursing (ADON) B. NA A dried the abdominal fold, groin areas, and between the upper thighs with a clean towel. The NA changed gloves without performing hand hygiene, got a clean washcloth wet and added cleansing solution, and wiped the catheter tubing, moving away from the insertion site, got a second washcloth wet and wiped the cleansing solution off the tubing, moving away from the insertion site. NA A then reported that they were going to empty the catheter drainage bag. Without performing hand hygiene, the NA changed gloves. NA A was not wearing a gown. The NA emptied the catheter drainage bag into a graduate cylinder and poured the urine into the toilet. NA A then changed gloves without performing hand hygiene, emptied the trash, and removed their gloves. An interview on 11/14/2024 at 10:38 AM with NA A confirmed that the NA had cleaned the SP catheter insertion site when they wiped across the abdominal fold and under the gauze. The NA confirmed that hand washing with soap and water should be done for 20 seconds, and that hand hygiene should be performed when changing gloves, and they had not done that. NA A revealed they were unsure of what EBP was, and that they had seen the EBP sign outside Resident 2's door, but had not read it. NA A then read the sign, and confirmed that they should have been wearing a gown during catheter cares and emptying the catheter drainage bag and they did not have one on. An interview on 11/14/2024 at 11:05 AM with ADON B confirmed that NA A should have cleaned off the over bed table prior to putting supplies on it, worn a gown during Resident 2's catheter cares and emptying the bag, washed their hands with soap and water for at least 20 seconds, and performed hand hygiene when changing gloves. An interview on 11/14/2024 at 4:20 PM with the Director of Nursing (DON) confirmed that NA A should have been wearing a gown when performing catheter cares and when emptying the drainage bag for Resident 2, and that SP catheter cares should be done by wiping away from the site in a circular motion. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. A record review of Resident 5's Admission record printed 11/14/2024 revealed an admitted [DATE]. The resident had diagnoses of a stroke (damage to brain tissue due to loss of blood flow), dementia (a term for several diseases that affect memory, thinking, and the ability to perform daily activities), and a flaccid neurogenic bladder (a bladder that doesn't empty because it doesn't contract enough) and had an indwelling catheter (tube placed into the bladder to drain urine). An observation on 11/13/2024 at 3:10 PM revealed a sign on the outside of Resident 5's room that indicated a resident in the room was on EBP, and provided information on what PPE to wear and when. PPE was inside the room. An observation on 11/14/2024 at 8:26 AM revealed Resident 5 was in bed. NA C was kneeling next to the bed and had gloves on, but was not wearing a gown. When the NA stood up, they were holding a graduate cylinder with urine in it with a catheter drainage bag hanging from the bed frame. An interview on 11/14/2024 at 8:29 AM with NA C revealed the NA knew what EBP was and that it meant to wear a gown and gloves when emptying the catheter bag or doing personal hygiene. NA C confirmed they were not wearing a gown when emptying Resident 5's catheter bag and should have been. An interview on 11/14/2024 at 11:05 AM with ADON B confirmed that NA C should have had a gown on to empty Resident 5's catheter bag. An interview on 11/14/2024 at 4:20 PM with the DON confirmed that NA C should have been wearing a gown when emptying a catheter bag.