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	04/02/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49164 Licensure Reference Number 175 NAC 12-006.09(H)(iii)(1) and 12-006.09(H)(iii)(2) Based on observation, interview and record review the facility failed to evaluate, monitor, implement interventions for pressure ulcer prevention and promote healing for 4 (Resident 1,2,3 and 4) of 5 residents sampled. The facility census was 108. The findings are: Record review of the facility's policy titled Wound Treatment Management dated 04-01-2024 indicated the policy was to promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. The policy explanation and compliance guidelines revealed the following: -Wound treatments will be provided in accordance with physician's orders, including cleansing method, type of dressing, and frequency of dressing change. -In the absence of treatment orders, the licensed nurse will notify the physician to obtain treatment orders. -The effectiveness of treatments will be monitored through ongoing assessment of the wound. -Considerations for needed modifications include lack of progression towards healing, changes in the characteristics of the wound, such as pressure injury stage, the size, shape and depth of the wound. Record review of s facility policy titled Skin Assessment sheet dated 08-2024 indicated it is the facility policy to perform a full body skin assessment as part of the systematic approach to pressure injury prevention and management. The policy also indicated a full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/readmission, daily for 3 days, and weekly thereafter. The skin assessment should include the date and time of the assessment, the type of wound, a description of the wound to include measurements, color, type of tissue in the wound bed, drainage, odor or pain. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Record review of Resident 2's Minimum Data Set (MDS; a federally mandated assessment tool used for care planning) dated 12-30-2025 revealed the facility staff assessed the following about the resident: -Brief Interview of Mental Status (BIMS) was scored as a 13. According to the MDS Manual a score of 13 to 15 indicate a person is cognitively intact. -Required partial assistance with transfers. -Required extensive assistance with toilet hygiene, bathing, and lower body dressing. -Was at risk of developing pressure ulcers. Record review of Resident 2's Comprehensive Care Plan (CCP) dated 12-27-2025 revealed Resident 2 had the potential for the development of a pressure ulcer related to impaired mobility and incontinence. Resident 2's CCP also listed an intervention to conduct weekly skin checks to monitor for redness, circulatory problems, pressure sores, open areas and other changes in skin integrity and to report new conditions to the physician. Record review of Resident 2's Braden Scale (BS; a tool used to predict pressure ulcer development) dated 01-28-2025 revealed a scored at a 16. According to the Wound Care Education Institute, published in March 2024 a score of 16 indicates mild risk for pressure ulcer development. Record review of Resident 2's progress notes dated 03-17-2025 revealed the facility staff identified an open wound to the left buttock that had full thickness skin loss, with macerated wound edges that measured 2 centimeters (cm) length by 1 cm width by 0.1 cm depth. Record review of Resident 2's Treatment Administration Record (TAR) for March of 2025 revealed no wound treatment orders for the left buttock pressure ulcer. Record review of Resident 2's Weekly Wound Assessment (WWA) dated 03-25-2025 revealed the presence of a pressure ulcer to the buttocks without measurements or staging of the pressure ulcer. An observation on 04-01-2025 at 1:50 PM with Registered Nurse (RN) A revealed Resident 2 had a pressure ulcer to the right buttock that was approximately 0.8 cm in length by 0.2 width and 0.1 depth with a dry pale pink wound bed. RN A cleansed the area with wound cleanser and applied a moisture barrier cream to the area. An interview with the Director of Nursing (DON) on 04-01-2025 at 3:15 PM revealed the onset of Resident 2's wound was on 03-17-2025. The DON further confirmed a treatment was not obtained until 04-01-2025 and the wound had not been monitored with measurements since 03-17-2025. B. Record review of Resident 4's MDS dated [DATE] revealed the facility staff assessed the following about the resident: -BIMS was scored at a 10, according to the MDS Manual a score of 8-12 indicates moderate cognitive impairment. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Required total assistance with bed mobility and toileting. -had a hip fracture. -did not currently have a pressure ulcer and was at risk of developing a pressure ulcer. Record review of Resident 4's BS dated 03-07-2025 revealed Resident 4 was scored at a 17. According to the Wound Care Education Institute, published in March 2024 a score of 17 indicates mild risk for pressure ulcer development. Record review of Resident 4's CCP dated 03-04-2025 revealed Resident 4 had the potential for the development of a pressure ulcer. Resident 4's CCP indicated an intervention to conduct weekly skin checks to monitor for redness, circulatory problems, pressure sores, open areas and other changes in skin integrity and to report new conditions to the physician. Record review of Resident 4's Admission Assessment sheet dated 02-28-2025 revealed Resident 4 had an impairment of skin integrity from a left hip fracture. No other skin impairments were identified on the Admission Assessment sheet dated 02-28-2025 for Resident 4. Record review of Resident 4's Electronic Medical Record revealed there was no indications weekly skin checks had been completed between 02-28-2025 and 03-20-2025. Record review of Resident 4's progress notes dated 03-13-2025 revealed Resident 4 was seen by a wound practitioner for a deep tissue injury (DTI, a form of pressure induced damage to underlying tissues, including muscle, bone and subcutaneous layers while the skin surface may remain intact) to the left heel. Furthermore, the practitioner ordered betadine daily to the left heel, and to offload pressure to heels when in bed. An observation on 04-01-2025 at 9:50 AM of Resident 4 sitting in her wheelchair with the left foot in a pressure relieving boot and did not have a sock on. Resident 4 was able to lift the left leg revealing a black DTI to the left heel approximately 4 cm length by 4 cm width. An interview conducted on 04-01-2025 at 3:00 PM with Licensed Practical Nurse (LPN) C, the former wound nurse, revealed all residents are to have a weekly skin assessment and confirmed that interventions to prevent pressure to the heels was not initiated for Resident 4 until after the DTI was identified. An interview with the DON on 04-01-2025 at 3:15 PM revealed between 02-28-2025 and 03-20-2025 Resident 4 had not received a weekly skin evaluation and confirmed the DTI was acquired in the facility. C. Record review of Resident 1's Electronic Health Record (EHR) revealed Resident 1 readmitted to the facility on [DATE] and discharged from the facility on 03-28-2025. Record review of Resident 1's MDS dated [DATE] revealed the facility staff assessed the following about the resident: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-BIMS was not scored due to Resident 1 not being able to complete the interview. -Required total assistance with toileting, bathing, dressing, bed mobility and transfers. -currently had a pressure ulcer. Record review of Resident 1's BS dated 02-21-2025 revealed a scored of a 12. According to the Wound Care Education Institute, published in March 2024 a score of 12 indicates high risk for pressure ulcer development. Record review of Resident 1's readmission assessment dated [DATE] revealed Resident 1 had a stage 3 pressure ulcer (a pressure ulcer that has full thickness skin loss that extends into the subcutaneous tissue but not muscle or bone) to the sacrum measuring 2 cm in length by 4 cm in width by 0.2 cm depth. Record review of Resident 1's assessments revealed no weekly skin evaluations or weekly wound assessments were conducted after 02-21-2025 until 03-20-2025 Record review of Resident 1's CCP printed on 03-31-2025 revealed Resident 1 had the potential for impaired skin integrity related to decreased mobility and age-related fragile skin. The CCP indicated an intervention dated 12-18-2019 was for a weekly skin inspection and to observe and document location size and treatment of skin injuries and to report any abnormalities to the practitioner. Record review of a wound evaluation conducted by the wound practitioner on 03-20-2025 revealed Resident 1 had an unstageable pressure ulcer (a pressure ulcer that's depth is unknown because dead tissue obscures the extent of the tissue damage) to the sacrum measuring 4.63 cm in length by 3.83 cm in width by 0.3 cm depth and resident had a DTI to the right lateral ankle measuring 1.34 cm in length by 0.82 cm in width by 0 cm depth. An interview conducted on 04-01-2025 at 3:00 PM with Licensed Practical Nurse (LPN) C, the former wound nurse, revealed all residents are to have a weekly skin assessment. An interview conducted with the DON on 04-01-2025 at 3:15 PM confirmed weekly skin evaluations were not done for Resident 1 after 02-21-2025 and Resident 1 developed a new DTI to the right ankle. The DON further confirmed weekly wound assessments with wound measurements were not completed for the sacral wound and the sacral wound had worsened. D. Record review of Resident 3's MDS dated [DATE] revealed the facility staff assessed the following about the resident: -BIMS was scored at 9. According to the MDS Manual a score of 8-12 indicates moderated cognitive impairment. -required total assistance with toileting, bathing, dressing, bed mobility and transfers. -currently had a stage 3 pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 3's CCP dated 12-04-2024 revealed Resident 3 was admitted on [DATE] with a stage 3 pressure ulcer to the left lateral heel. The CCP indicated an intervention to provide wound care per physician's order. Record review of Resident 3's Treatment Administration Record (TAR) for March 2025 revealed an order dated 03-06-2025 for an alternating air mattress to the bed for the wound to the left heel. According to Resident 3's TAR for March 2025 there was an order dated 03-15-2025 directing staff to complete a treatment to Resident 1's left heel. The order dated 03-15-2025 for wound care to the left heel directed staff to cleanse the left heel with wound cleanser, lightly moisten a collagen dressing (wound dressing that promotes new tissue growth) and place in the wound bed then cover with a hydrofera blue (an antibacterial wound dressing) dressing followed by an abdominal pad (a drainage absorbing dressing) and kerlix with dressing changes every 3 days. Record review of Resident 3's progress notes revealed the following: -03-26-2025 resident is on a regular mattress and the Assistant Director of Nursing is evaluating the order. -03-27-2025 resident is on a regular mattress, and a work order was placed for maintenance to find an air mattress. -03-28-2025 resident is on a regular mattress and maintenance and the management team were working to get an air mattress. -03-28-2025 Regular mattress is in use for now and management is aware. -03-29-2025 maintenance is working on getting an air mattress. -03-31-2025 the team is looking for a functioning mattress. -04-01-2025 the team is working on obtaining an alternating air mattress. An observation on 03-31-2025 at 2:10 PM revealed Resident 3 was in bed lying on his back with the head of bed elevated. The mattress on the bed in use was not an air alternating mattress. An observation on 04-01-2025 at 6:55 AM revealed Resident 3 was lying in bed on their back without an alternating air mattress in use. An observation on 04-01-2025 at 1:45 PM of RN A providing wound care to Resident 3's left heel revealed the pressure ulcer to the left heel measured approximately 2 cm by 0.2 cm with pale pink wound edges. Further review of Resident 3's treatment revealed RN A applied a blue super absorbent dressing instead of the hydrotherapy blue dressing. An interview with RN A on 04-01-2025 at 7:00 am confirmed Resident 3 had an order for an air alternating mattress that was not in place. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled Wound Treatment Management dated 04-01-2024 revealed it is the policy of this facility to provide evidence-based treatments in accordance with the current standards of practice and physician orders. An interview with the DON on 04-01-2025 at 3:15 PM confirmed the blue super absorbent dressing was not the correct dressing to be used for Resident 3's wound care and further confirmed Resident 3 moved rooms on 3-26-2025 and the air alternating mattress was not moved with the resident.