

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 05/12/2026
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)		
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to investigate and report a fall with significant injury within the required time frame for 1(Resident 63) of 1. The facility reported a census of 111. Findings are: A record review of Resident 63's Clinical Resident Profile (a sheet containing residents name, code status, primary diagnosis, admission date, personal contacts information and medical professionals contact information) revealed Resident 63 was admitted to the facility on [DATE].A record review of Resident 63's Minimum data set (MDS - a federally mandated, standardized assessment tool used in Medicare/Medicaid-certified nursing homes to evaluate a residents functional, medical, psychosocial and cognitive status) dated 4/5/2026 revealed Resident 63 had a Brief Interview for Mental Status (BIMS - a standardized assessment used in nursing homes to assess cognitive function, specifically memory and orientation) of 5 indicating Resident 63 was severely cognitively impaired.A record review of Resident 63's care plan (CP - a personalized, actionable document that outlines a patient's health needs, goals and specific interventions to manage their care) revealed Resident 63 had the following diagnoses: Vascular dementia - a decline in thinking, memory and behavior caused by conditions that block or reduce blood flow to the brain, depriving it of oxygen and nutrition, essential hypertension - high blood pressure with no single identifiable medical cause, Chronic kidney disease, stage 3 - moderate kidney damage, where kidneys do not filter waste and fluids as efficiently as they should, Pain, Diabetes type 2 - a chronic condition where the body cannot properly use or make enough insulin, leading to high blood sugar levels, peripheral vascular disease - a slow progressive circulation disorder involving narrowing, blockage or spasms in blood vessels outside the heart and brain, obstructive sleep apnea - a serious sleep disorder where breathing repeatedly stops and starts because throat muscles relax and block the airway during sleep, spinal stenosis - chronic narrowing of the spaces within the spinal canal causing pain, major depressive disorder - a serious mental health condition characterized by persistent severe low mood, sadness or a loss of interest in activities lasting at least 2 weeks, morbid obesity - a body mass index of 40 or higher or 35 or higher accompanied by a serious, obesity related health condition. Further review of Resident 63's CP revealed Resident 63 was considered to be at risk for falls related to Type 2 diabetes, Hypertension, spinal stenosis, weakness, and decreased mobility.A record review of Resident 63's progress note by RN L revealed Resident 63 had a fall on 5/2/2026 resulting in a laceration (a torn or jagged wound caused by the tearing or stretching of soft body tissues, often resulting from blunt trauma) to their left eyebrow requiring sutures (medical devices used to hold body tissues together and approximate (bring the edges together) tissues). The progress note revealed Resident 63 was found on the floor and did not reveal how the laceration occurred. Resident 63 was transferred to the emergency department where they received sutures in the laceration. An interview on 5/12/26 at 1:45PM with Director of Nursing (DON) confirmed the facility did not report the residents fall with significant on 5/2/2026 and did not perform an investigation.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 285054	Facility ID: 285054 If continuation sheet Page 1 of 14

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(iii)(1) Based on observation, interview, and record review, the facility failed to implement interventions to prevent the potential for pressure injuries on 1 (Resident 15) of 5 sampled residents. The facility census was 111. Findings are: A record review of the facility's Use of Support Surfaces policy with a date reviewed/revised of 2/26 revealed a support surface was a specialized mattress, overlay, or chair cushion to manage pressure, shear, microclimate, or friction on tissue. Support surfaces would be utilized in accordance with manufacturer's recommendations. A record review of the facility's Turning and Repositioning policy with a date reviewed/revised date of 2/2026 revealed all residents at risk of or had existing pressure injuries would be turned and repositioned. The frequency of turning and repositioning would be documented in the resident's care plan. If the resident had a pressure redistribution support surface in use, turning and reposition was still required but may be less frequent. If the resident was in bed, the staff was to ensure heels were floated off the surface of the bed. If the resident was in a chair, staff was to ensure feet were properly supported on the footrests. A record review of the undated SpanAmerica's Geo-Mattress Pro Pressure Redistribution Foam Mattress information sheet revealed the mattress had a exclusive heel slope that had a subtle taper to redistribute load to pressure tolerant lower legs and reduce heel pressure by 27 percent (%) compared to a flat mattress. Patient indications were general patient population, with moderate to high risk for skin breakdown, had decreased mobility, and was repositioned frequently by self or a caregiver. A record review of Resident 15's Clinical Census dated 05/07/2026 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 15's Medical Diagnosis dated 05/07/2026 revealed the resident had diagnoses of Unspecified Dementia, Stage III Chronic Kidney Disease, Polymyalgia Rheumatica (inflammatory disorder causing severe muscle pain and stiffness), and Osteoarthritis Of The Left Knee (cartilage breakdown resulting in pain, stiffness, and reduced mobility). A record review of Resident 15's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 03/10/2026 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 00 which indicated the resident was severely cognitively impaired (confused). The resident required setup/clean-up assistance with eating, partial/moderate assistance with oral hygiene (cleaning), substantial/maximal assistance with footwear, dressing, and personal hygiene, and was dependent on staff for toileting hygiene and bathing. The resident required partial/moderate assistance with rolling left and right, and required substantial/maximal assistance with all other bed mobility and transfer needs. The resident was at risk of developing a pressure ulcer/injury and the resident did not have a pressure ulcer (wound) at the time of the assessment. A record review of Resident 15's Wound Assessment Report dated 04/30/2026 by the Nurse Practitioner revealed the resident had a new stage 3 pressure ulcer/injury to the right heel that measured 1.10 centimeters (cm) in length, .60 cm in width, and .10 cm in depth, and light exudate (wound drainage). The wound was acquired 04/28/2026 in house (at the facility). A record review of Resident 15's Progress Notes dated 03/31/2026 - 04/29/2026 revealed: - On 03/31/2026 the resident's provider seen the resident and no wounds were documented. - On 04/02/2026 the facility identified a 1.8 cm long by 1.2 cm wide area to the resident's right heel and orders were obtained for betadine 2 times per day. It appeared the skin alteration was possibly due to improper footwear (Crocs, with no socks) and the resident's family was to bring a different pair of shoes. - On 04/29/2026 the nurse assessed the area on resident's right heel was open again. The nurse cleaned with wound cleanser, applied betadine, and secured with bordered dressing. A record review of Resident 15's Progress Notes dated 04/30/2026 revealed the Nurse Practitioner (NP) evaluated the wound and changed the orders. The NP documented that previously the wound care nurse thought the right heel wound was healed out, but discovered the wound was reopened. The resident's wound was (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's shoes, nothing for when the resident was in bed. LPN-C confirmed the facility used pressure redistribution mattresses on all beds to assist on pressure reduction to the heels. In an interview on 05/11/2026 at 2:27 PM, LPN-C confirmed Resident 15 had a Span-America 54668 Pressure Redistribution Foam Mattress on the bed, but the tag on the mattress that said Foot End was by the bed's headboard and therefore the heel slope was on the wrong end of the bed. In an interview on 05/11/2026 at 3:40 PM, the facility's Maintenance Director (MD) confirmed the MD moved the resident to room [ROOM NUMBER] and put the mattress on the bed and did not pay attention to there being a specific direction that mattress needed to go. The MD confirmed the maintenance staff and NAs apply the mattresses to the beds. The MD confirmed the staff had not been educated on that mattress. In an interview on 05/12/2026 at 10:05 AM, the facility's Administrator confirmed the staff had not had a competency (education) on the placement of the SpanAmerica's Geo-Mattress Pro.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.10(D) Based on interview and record review, the facility failed to ensure that 2 (Resident 5 and 15) of 5 sampled residents were free of significant medication errors. The facility census was 111. Findings are: A record review of the facility's Medication Errors policy with a date last reviewed/revised of 2/2026 revealed a significant medication error meant one which causes the resident discomfort or jeopardizes the resident's health and safety. The facility should ensure medications were administered according to physician's orders. A record review of the facility's Medication Administration policy with a date reviewed/revised of 02/2026 revealed medications would be administered by staff who are legally authorized to do so, as ordered by the physician, and in accordance with professional standards of practice. A. A record review of Resident 15's Clinical Census dated 05/07/2026 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 15's Medical Diagnosis dated 05/07/2026 revealed the resident had diagnoses of Unspecified Dementia, Stage III Chronic Kidney Disease, Infrarenal Abdominal Aortic Aneurism (a dangerous bulge in the main blood vessel), Cardiac Murmur (unusual sound during a heartbeat), and Essential (Primary) Hypertension (high blood pressure). A record review of Resident 15's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 03/10/2026 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 00 which indicated the resident was severely cognitively impaired (confused). The resident required setup/clean-up assistance with eating, partial/moderate assistance with oral hygiene (cleaning), substantial/maximal assistance with footwear, dressing, and personal hygiene, and was dependent on staff for toileting hygiene and bathing. The resident required partial/moderate assistance with rolling left and right, and required substantial/maximal assistance with all other bed mobility and transfer needs. A record review of Resident 15's Care Plan Report with an admission date of 08/26/2025 revealed a focus area of the resident had hypertension and an intervention of medication as ordered. A record review of Resident 15's Order Summary Report dated 05/07/2026 revealed the resident had a provider's order for Hydralazine Hydrochloride (HCL) oral tablet 25 milligram (MG). Give 1 tablet by mouth three times per day. HOLD FOR SPB (systolic blood pressure) LESS THAN (<) 115 millimeters of hemoglobin (mmHg). A record review of Resident 15's Medication Administration Record and Treatment Administration Record (MAR & TAR) dated February 2026 with Licensed Practical Nurse (LPN)-B revealed the resident's Hydralazine HCL was to be held if SBP < 115 mmHg and was administered with an SBP of < 115 mmHg on: - the 02/15/2026 2:00 PM dose the SBP was 113 mmHg - the 02/15/2026 PM dose the SBP was 109 mmHg (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- the 02/26/2026 AM dose the SBP was 114 mmHg - the 02/27/2026 AM dose the SBP was 112 mmHg A record review of Resident 15's MAR & TAR dated April 2026 with LPN-B revealed the resident's Hydralazine HCL was to be held if SBP was < 115 mmHg and it was administered with an SBP of < 115 on: - the 04/11/2026 AM dose the SBP was 113 mmHg - the 04/13/2026 AM dose the SBP was 104 mmHg - the 04/13/2026 2:00 PM dose the SBP was 112 mmHg A record review of Resident 15's MAR & TAR dated May 2026 with LPN_B revealed the resident's Hydralazine HCL was to be held if SBP < 115 mmHg and was administered with an SBP of less than 115 on: - the 05/07/2026 PM dose the SBP was 112 mmHg - the 05/08/2026 PM dose the SBP was 102 mmHg In an interview on 05/12/2026 at 10:13 AM, LPN-B confirmed that LPN-B reviewed the above values and confirmed Resident 15's Hydralazine HCL was administered on the above dates with and SBP of < 115 mmHg and should not have been. LPN-B confirmed that would be a medication error. A record review of Resident 5's Clinical Resident Profile (a sheet containing residents name, code status, primary diagnosis, admission date, personal contacts information and medical professionals contact information) revealed Resident 5 was admitted to the facility on [DATE]. A record review of Resident 5's Care plan (Care Plan &ndash; a personalized, actionable document that outlines a patient's health needs, goals, and specific interventions to manage their care) revealed the following diagnoses: Essential Hypertension (high blood pressure with no single, identifiable medical cause), Cardiomyopathy (a disease of the heart muscle, causing it to become enlarged, thick or rigid, making it harder for the heart to pump blood effectively to the rest of the body), Paroxysmal Atrial Fibrillation (a type of irregular, rapid heart rhythm that starts and stops suddenly, with episodes typically lasting less than 7 days, often resolving on their own) and Hypotension (abnormally low blood pressure, generally lower than 90/60 mmHg (mmHg &ndash; a standard unit used to measure blood pressure). A record review of Resident 5's Order Summary (a consolidated, authorized record of instructions from a licensed provider detailing a resident's care, treatment, medications, and services) dated 5/11/2026 revealed the following orders: -Daily BP (blood pressure &ndash; the force of blood pushing against the artery wall) and HR (heart rate &ndash; the number of times a heart beats in a minute); Call if HR>115, SBP (systolic blood pressure &ndash; the first number in a blood pressure reading, measuring the maximum pressure in your arteries when your heart beats and pumps blood out) <90 or SBP>180. every shift for BP & (heart (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rate) HR monitor. Date: 09/10/2024 -Midodrine HCl (a prescription medication used to treat a sudden drop in blood pressure upon standing which works by restricting blood vessels to increase blood pressure) Oral Tablet 5 MG (Midodrine HCl) Give 1 tablet via PEG -Tube (Percutaneous Endoscopic Gastrostomy & a soft flexible feeding tube inserted through the abdomen directly into the stomach to deliver nutrition fluids, and medication) three times a day for hypotension (low blood pressure) Hold if SBP> 120 mmHg sitting; take at least 4 hours prior to bedtime. Dated: 12/20/2025 -Metoprolol Tartrate (a prescription medication used to treat high blood pressure by slowing the heart rate and reducing strain on the heart) Oral Tablet 25mg. Give 12.5 milligrams (mg) by mouth two times a day for HTN Hold if SBP <90 or HR <60 Dated: 02/02/2026. A record review of Resident 5's Medication Administration Record (MAR) revealed the following information: Residents 5's morning HR on 4/8/2026 was 58 beats per minute (bpm), on 4/10/2026 it was 58, on 4/17/2026 it was 58, on 4/20/2026 it was 43, and on 4/29/26 it was 56. Resident 5 received Metoprolol Tartrate 12.5mg on each of these days. The medication order the Metoprolol was to be held (not given) for HR of less than 60. Resident 5's morning BP was 72/40 on 4/5/2026. It was 81/29 on 4/12/2026, 78/56 on 4/14/2026 and 88/58 on 4/29/2026. Resident 5 received Metoprolol Tartrate 12.5mg on each of these days. The medication order stated Metoprolol Tartrate should be held for SBP of less than 90. Resident 5's BP was 131/81 on 4/1/2026 at 2:00PM, 128/60 on 4/2/2026 at 2:00PM, 125/85 on 4/9/2026 at 2:00PM, 133/84 on 4/10/2026 at 2:00PM, 125/81 on 4/16/2026 at 2:00PM, and 132/76 on 4/19/2026 at 2:00PM. Resident 5 received Midodrine HCL 5mg on these dates for the mid-afternoon medication pass. The medication order stated Midodrine HCL was to be held if the SBP was greater than 120. An interview on 5/11/2026 at 10:20 AM with RN J confirmed the Metoprolol should not have been given on 4/1/2026, 4/10/2026, 4/17/2026, 4/20/2026, and 4/29/2026 due to Resident 5's heartrate was less than 60 on these dates. An interview on 5/11/2026 at 10:20 AM with RN J confirmed the Metoprolol should not have been given on 4/5/2026, 4/9/2026, 4/12/2026, 4/14/2026, and 4/29/2026 because Resident 5's SBP was less than 120 on these dates. An interview on 5/11/2026 at 10:20 Am with RN J confirmed the Midodrine should not have been given for Resident 5's 2:00 PM BP on 4/1/2026, 4/2/2026, 4/9/2026, 4/10/2026, 4/16/2026 and 4/19/2026. RN J confirmed the Midodrine was to be held if the SPB was greater than 120. RN J confirmed each instance was a medication error.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18 Based on observations, record reviews and interviews: the facility staff failed to utilize handwashing and gloving techniques for 4 (Residents 5, 15, 28, and 41), failed to implement Enhanced Barrier Precautions (EBP) on 2 residents (Residents 5 and 15), failed to store equipment to prevent potential cross contamination for 1 resident (Resident 5), failed to implement isolation procedures for 1 (Resident 102) and fails to provide personal care in a manor to prevent potential infection for 1 (Resident 28). The total sample size was 53 and the facility census was 111. Findings are:Record review of the facility's Hand Hygiene policy with a revision date of 10/23/2025 revealed the following: 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves. Record review of the facility's undated Hand Hygiene Table revealed the following: Before applying and after removing personal protective equipment (PPE), including gloves. Before preparing or handling medications. Before performing resident care procedures. A. Record review of Resident 28's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 3/2/2026 revealed the facility staff assessed the following about the resident: -Had a diagnosis of retention of urine. -Frequently incontinent of bowel. -Brief Interview of Mental Status (BIMS) was scored as 15/15. According to the MDS Manual a score of 15 indicated cognitively intact -required total assistance with toileting, shower/bath, putting on or taking off footwear, sit to stand, chair/bed transfers and tub transfers. An observation on 5/11/2026 at 12:30 PM revealed Nursing Assistant (NA)-G completed hand hygiene, applied gown and gloves. NA-G removed Resident 28's brief, did not complete hand hygiene, did not change soiled gloves and obtained cleansing wipes. NA-G used one wipe to cleanse the furthest thigh, folded the wipe, cleansed the furthest thigh again and then discarded wipe. NA-G obtained a new wipe to cleanse the closets thigh, folded the wipe, cleansed closet thigh again and then discarded the wipe. NA-G did not remove the soiled gloves, did not complete hand hygiene, and obtained a new wipe to cleanse around the head of the penis, folded the wipe, cleansed the tubing away from the urinary meatus (a pathway leading into the body) and discarded the wipe. Resident 28 rolled to himself to (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the left side, NA-G obtained a new wipe and cleansed the anus wiping towards the front of the residents' body and discarded the wipe. NA-G obtained a new wipe, cleansed the anus wiping towards the legs, folded the wipe, wiped again and discarded the wipe. NA-G removed gloves, completed hand hygiene and put on new gloves. NA-G placed brief under Resident 28 and did not fasten the brief. NA-G removed gloves, did not complete hand hygiene and applied new gloves. NA-G fastened the brief and covered Resident 28 with a blanket. An interview on 5/11/2026 at 12:52 PM NA-G confirmed that hand hygiene was not completed between glove changes and should have been. An interview on 5/11/2026 at 12:52 PM NA-G confirmed that NA-G was wiping Resident 28 from back to front and should have been wiping from front to back. An interview on 05/12/2026 12:00 PM Licensed Practical Nurse (LPN)-B confirmed that staff should be completing perineal care by cleansing front to back. LPN-B confirmed that cleansing back to front introduces bacteria to the urinary tract. B. An observation during medication administration on 05/11/2026 at 1:00 PM Medication Aide (MA)-F gathered medications for Resident 41 and went into Resident 41s room. MA-F gave Resident 41 the medication in the medication cup. MA-F did not complete hand hygiene and put gloves on to administer muscle rub to Resident 41s bilateral knees. An interview on 5/11/2026 at 1:07 PM MA-F confirmed that hand hygiene was not completed prior to putting on gloves and should have been. C. A record review of Resident 5's Clinical Resident Profile (a sheet containing residents name, code status, primary diagnosis, admission date, personal contacts information and medical professionals contact information) revealed Resident 5 was admitted to the facility on [DATE]. A record review of Resident 5's Minimum Data set (MDS &ndash; a federally mandated, standardized assessment tool used in Medicare/Medicaid-certified nursing homes to evaluate a residents functional, medical, psychosocial and cognitive status), dated 2/11/2026, revealed Resident 5 had a Brief Interview for Mental Status (BIMS &ndash; a standardized assessment used in nursing homes to assess cognitive function, specifically memory and orientation) of 15, indicating Resident 5 was cognitively intact. A record review of Resident 5's Care plan (CP &ndash; a personalized, actionable document that outlines a patient's health needs, goals, and specific interventions to manage their care) revealed the following diagnoses: Chronic obstructive pulmonary disease (COPD- a progressive, treatable and preventable lung disease characterized by chronic airflow obstruction, making it difficult to breathe), blindness in both eyes, personal history of malignant neoplasm of larynx (a previous diagnosis of laryngeal cancer that has been treated and is no longer present), unspecified severe protein-calorie malnutrition (a life-threatening condition resulting from inadequate intake of protein and calories, leading to severe weight loss, muscle wasting and immune system failure), Muscle wasting and atrophy (the loss of muscle tissue, resulting in smaller, weaker muscles caused by inactivity, aging, malnutrition, or nerve damage). (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER The Banyan at Montclair		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 South 135th Avenue Omaha, NE 68144	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 5's Baseline Care Plan (BCP &ndash; a preliminary individualized care strategy developed in nursing homes within 48 hours of a resident's admission) revealed Resident 5 was admitted with a feeding tube in place. A record review of Resident 5's Order summary (a consolidated, authorized record of instructions from a licensed provider detailing a resident's care, treatment, medications, and services) revealed the following orders: -Order dated 09/10/2024 - Enteral Feed (a method of delivering nutrients directly into the gastrointestinal (GI) tract using a flexible tube) Order every shift Check g-tube (a soft, flexible, medically placed tube that delivers nutrition, fluids and medication directly into the stomach through a small opening in the abdomen) placement by introducing air and listening for air sounds on the stomach area as the air is introduced using a syringe. -Order dated 5/28/2025 - Enteral Feed: Cleanse enteral tube feeding site with Normal saline and apply dry dressing. Assess for abnormalities to insertion site. Report changes to PCP (primary care provider) every shift for monitoring. -Order dated 12/02/2025 - Enteral Feed Order two times a day related to unspecified severe protein-calorie malnutrition. Administer Jevity 1.5, (a high-protein, fiber-fortified and calorically dense liquid formula manufactured to provide complete, balanced nutrition for tube feeding) 300milliliters (ml &ndash; a unit of measurement for liquid) by gravity (a method that used gravity to deliver formula at a slow, controlled rate) through feeding tube. Prior to and post (after) feed, flush tube with 30ml of tap water for line patency (the state of the line or tube being open, unobstructed, and functioning properly) prior to and post feed. May substitute equivalent options of Isosource (liquid nutritional formula) 1.5 or osmolyte (liquid nutritional formula) 1.5. -Order dated 12/21/2025 - Enteral Feed Order four times a day related to unspecified severe protein calorie. Flush feeding tube with 110ml tap water four times daily by gravity. -Order dated 08/13/2025 - Enhanced Barrier Precautions due to percutaneous endoscopic gastrostomy (PEG) tube placement. Ensure appropriate PPE is used during resident care activities. every shift for infection prevention. An observation on 5/7/2026 at 9:40 AM of tube feeding provided by Licensed Practical Nurse (LPN) I revealed the following: LPN I entered Resident 5's room and placed 2 graduated cylinders and a 60ml syringe on the bedside table. LPN I placed a clean towel on Resident 5's abdomen and lap area. LPN I turned on the faucet and filled one cylinder with an unmeasured amount of water. LPN I then uncapped a box of Jevity 1.5 liquid formula feed and poured it into the second graduated cylinder. LPN I washed their hands and donned gloves but did not don a gown. LPN I approached Resident 5 and informed them of what they were about to do. LPN I verified placement of the g-tube by using the syringe to push 10cc of air through the g tube into the stomach while listening to the abdomen sounds with a stethoscope. LPN I placed the stethoscope around their neck and removed the syringe from the g-tube to remove the plunger part and reattach the syringe. LPN I poured 60ml of water into the syringe to flush the tube. The water did not flow in by gravity so LPN I pushed it through with the syringe plunger. LPN I removed the syringe and attached the tube section back to the g-tube after removing the plunger. LPN I poured the formula solution into the syringe. The feed did not flow through with gravity so LPN I added an unmeasured amount of water to thin it out. When it still did not (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Providers and staff must wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting. Device care or use: Central line, urinary catheter, feeding tube, tracheostomy. Wound care: any skin opening requiring a dressing. A record review of a document titled Tube feeding: Process at Montclair: dated 12/2025 revealed the following: Washed hands and donned appropriate personal protective equipment. Adhered to infection control principles throughout the procedure. Flushed feeding tube with prescribed amount of fluid. Administered gravity feeding appropriately, as ordered. A record review of a document titled Enteral Feeding: Administration by syringe bolus dated 8/1/2016 and revised 11/16/2017 revealed the following: 9. Verify tube placement. 12. Flush tube with at least 50ml of water and instill by gravity. 13. slowly pour formula directly into syringe and instill using gravity. 14. Avoid letting the syringe empty completely. Increase or decrease the solution's flow rate by raising or lowering the syringe. Keep flow rate slow enough to spread feeding time over at least 20 minutes. 15. when all of formula is finished, flush with at least 50ml of water and instill by gravity. D. A record review of Resident 5's order summary revealed the following provider order dated 05/05/2026: Change nebulizer mask and tubing weekly; date and place in dated plastic bag. Date tubing. Place in dated bag when not in use. every night shift every Sat. For Infection Control Place in dated bag when not in use. An observation on 5/6/2026 at 1:45 PM of Resident 5's nebulizer mask (a medical device used to deliver liquid medication in the form of a fine mist directly into the lungs through the nose and mouth) and tubing placed directly on top of a table in Resident 5's room. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 5/12/2026 at 8:10 AM of Resident 5's nebulizer mask and tubing resting on Resident 5's bedside table. An interview on 5/6/2026 at 1:45 PM with RN J confirmed the nebulizer mash should have been stored inside a dated plastic bag and not on top of a bedside table. An interview on 5/12/2026 at 8:10 AM with Medication Aide (MA) F confirmed the nebulizer mask and tubing should have been stored in a dated plastic bag and not lying on Resident 5's bedside table. E. An observation on 5/6/2026 at 1:45 PM of a urinal (a portable handheld container designed for collecting human urine) full of urine on Resident 5's bedside table beside a graduated plastic cylinder (plastic containers designed for measuring liquid) holding a 60ml syringe used to introduce water and a nutritional formula into Resident 5's stomach via a flexible tube. An interview on 5/6/2026 at 1:45 PM with Registered Nurse (RN) J confirmed having the urinal full of urine beside the graduated cylinder and syringe used to deliver the liquid formula constituted an infection control issue. F. A record review of the facility's undated Enhanced Barrier Precautions (EBP) sign revealed providers and staff must wear gloves and a gown for high-contact resident care activities such as dressing, transferring, changing linens, providing hygiene (cleaning), changing briefs of assisting with toileting, and device care. A record review of Resident 15's Order Summary Report dated 05/07/2026 revealed the resident had orders to cleanse the right heel with wound cleanser, apply honey hydrogel sheet (a wound dressing) to the wound bed, and cover with a border dressing. It did not reveal orders for pressure wound prevention measures. An observation on 05/11/2026 at 7:56 AM revealed that Nursing Assistant (NA)-A was already in the room with a gown and gloves on and had changed the resident's brief. Licensed Practical Nurse (LPN)-K was in the room to observe MA-A and there was an EBP to the left of the door as you enter the room. NA-A removed NA-A's gloves and applied a new pair without performing hand hygiene between glove changes. NA-A drained the resident's colostomy (an opening on the abdominal wall that allowed the colon to divert waste into an external bag) bag. The colostomy was leaking, so NA-A called for the nurse to replace it. The colostomy had leaked onto the resident's shirt, so NA-A removed gloves, got the resident shirt, gloved, without hand hygiene, and wiped the colostomy site again and removed NA-A's gloves. The nurse entered and started to change the colostomy and NA-A lifted the resident's hands out of the way without gloves on, then applied gloves without performing hand hygiene. The nurse completed the colostomy change, and NA-F rolled the resident to the left and to the right as NA-F removed the reusable chux (absorbent pad), pulled the resident's pants over the resident's brief, removed NA-A's gloves, re-gloved without hand hygiene, assisted the resident to a (continued on next page)		

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